



Ombudsman's Commentary

JUNE 2008 REPORTS

I laid 12 investigation reports before the Scottish Parliament today. Seven relate to the health sector, four to the local government sector and one to a Scottish public authority.

Ombudsman's Overview

In this month's Overview, I am highlighting ways in which we seek to work with organisations under my Office's jurisdiction to meet our common goal of improving front line complaint handling. The aim is for grievances to be resolved as speedily and effectively as possible by the organisation involved, to prevent complaints from escalating unnecessarily to the SPSO.

Alongside this, there are other good reasons for seeking to improve the way complaints about public services are handled. When, for example, complaints are poorly handled, members of the public may lose confidence and trust in public services. And information generated through handling complaints provides vital feedback and learning for service providers and scrutiny bodies, as the evidence from complaints helps inform improvement.

Earlier this month, representatives from almost all of Scotland's 32 Councils attended our **2008 conference for Local Authorities**. The day was made up of presentations from the SPSO, the Scottish Mediation Network and the Improvement Service, and three workshops. The workshops focused on: the benefits of good complaint management (our "Valuing Complaints" initiative); how and why we use our discretionary powers to decide what we should and should not investigate; and how we come to conclusions and decide on redress at the end of an investigation. We received

valuable feedback from the authorities, both on our work over the year and on the event itself. A common theme of the feedback was the usefulness of the practical sessions, with many participants expressing a wish that these could have been longer so that discussion could have continued.

Building on the conference's success, I look forward to **further events** that we shall facilitate later in the year. Among those planned is a seminar for Registered Social Landlords to be held jointly with the Chartered Institute of Housing, which will focus on Customer Service excellence. We also expect to hold a seminar jointly with Local Authorities and the NHS – again focusing on the importance of valuing complaints, and on how the lessons from complaints can be fed back in order to improve the delivery of public services.

For further information about our programme of Outreach activities, visit:

<http://www.spsa.org.uk/news/article.php?ssi=16>

Professor Alice Brown, Ombudsman 18.06.2008

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The reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Hospital referral, complaint handling Highland NHS Board (200600461)

Ms C was receiving ongoing treatment for back pain. She raised a number of concerns about delays in obtaining a neurosurgery appointment at a hospital in another Health Board area, to which she was to be referred by Highland NHS Board. I upheld her complaint that the Board failed to refer her appropriately and partially upheld her complaint that the Board's response did not address the complaint that she had raised. The Board are currently undertaking a pilot system of recording and tracking referrals made to other Health Boards.

I recommended that the Board review the current pilot and let me know the outcome; consider introducing a system to ensure that a referral has been received by the receiving clinic; provide a local contact for a patient to be able to enquire about their referral; and apologise to Ms C for the additional delay she experienced. I also recommended that they apologise to Ms C for failing to provide a further response to her complaint; ensure they have a mechanism in place to follow up on any outstanding issues when an offer of a local resolution meeting has been made and declined; and that they take into account, where appropriate, any potential problems faced by a complainant who is offered a meeting at a venue that is not local to him/her.

Nursing care, hygiene, record-keeping Highland NHS Board (200702119)

Mrs C complained that her husband, Mr C, failed to receive appropriate nursing care while in hospital. She said that proper skin hygiene was not maintained, and that he was discharged from hospital with areas of skin in poor condition.

I fully upheld this complaint and recommended that the Board write to Mr and Mrs C and apologise for the condition of Mr C's skin when he was discharged from hospital. I also suggested that, in cases where the risk of skin ulcers is identified, an appropriate care plan is formulated and followed, with a record in discharge notes saying whether the situation has been resolved.

Diagnosis, clinical treatment, communication Lanarkshire NHS Board (200701982)

Mr C raised concerns that his hospital diagnosis and treatment resulted in what he believed to be the unnecessary removal of his right kidney. Staff had told Mr C that they suspected a lump on his kidney was cancerous and that the kidney should be removed. After the operation, Mr C was told by letter that the removed kidney was non-cancerous. He had concerns that staff decided to remove the kidney without taking a biopsy and believed that as a result he became dialysis dependent much earlier than expected. He also complained that the way in which he was told the result of tests on the removed kidney was insensitive.

I upheld the complaint that the way in which Mr C was told about the pathology of the removed kidney was insensitive. He was attending hospital regularly and the opportunity should have been taken to give him the results when he was on the premises. I recommended that the Board make a further full and meaningful apology to Mr C. I did not uphold the complaint about the decision to remove the kidney as the independent clinical advice I received is that the decision was appropriate in the circumstances of the known diagnostic risks in such cases. I did, however, recommend that the Board review their method of obtaining informed consent for such procedures.

Diagnosis, clinical treatment Highland NHS Board (200603988) and a Medical Practice, Highland NHS Board (200701202)

Mrs C raised a number of concerns about the diagnosis of her late husband, Mr C, and his treatment for what was eventually diagnosed as small bowel obstruction. She said that Mr C's GP Practice had failed to diagnose his condition early enough and so delayed referring him to hospital, and she also said that the Board failed to provide appropriate care and treatment. Mr C had suffered abdominal pain for two days when he was seen by an out-of-hours service GP who thought he might have viral gastritis. He was advised to contact his own GP the next day if he was no better. As he was not, Mrs C rang Mr C's GP Practice, and was given advice about gastritis although Mr C was not seen or examined. When he was no better next day, another GP from the Practice visited, diagnosed a possible intestinal obstruction and referred him to hospital.

I upheld the complaint that the GP Practice failed to fully reassess Mr C after his initial consultation by the out-of-hours service. I recommended that the Practice apologise to Mrs C for this failure, review their protocol for telephone consultations to ensure that patients are seen by a doctor when necessary, and reconsider the management of severe abdominal pain by telephone. I did not uphold the complaint about the care and treatment that Mr C received after he was admitted to hospital.

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Health

Policy/administration, communication, clinical treatment

Borders NHS Board (200700599)

Mrs C cancelled her planned hysterectomy. She complained that poor administration by hospital staff led to the temporary loss of her clinical records, leaving her with doubts as to the competence of the staff caring for her. Mrs C also had a number of concerns over the treatment that she was offered and did not feel that sufficient consideration was given to her family's medical history or to her reaction to certain medications.

I upheld the complaint that administration was poor, as Ms C's medical records could not be traced through the relevant tracking procedures when they were required. Referral to records is crucial when clinical decisions are to be taken. I have recommended that the Board review their tracking procedures and remind staff that they are responsible for updating these when records move. I did not uphold Ms C's other three complaints about information and treatment provided.

Policy/administration, communication

Forth Valley NHS Board (200701273)

Mr C suffered from cataracts in his eyes which meant he would find it increasingly difficult to work. The Board placed him on a waiting list for surgery but later, for clinical reasons, felt they should not operate at that time. Mr C complained that he was not then offered information about where else he might be referred, although he was kept on the waiting list. In the circumstances, he felt that in order to receive treatment he would have to (and did) pay for private surgery.

I partially upheld the complaint, but only to the extent that the Board missed an opportunity to consider a referral for Mr C as an option. I recommended that the Board write to Mr C expressing their sincere regret that they missed an opportunity to consider all the options in relation to future treatment.

I did not uphold the following complaint about a Health Board

Clinical treatment (podiatry)
Western Isles NHS Board
(200700092)

Local Government

Education: school transport
South Lanarkshire Council
(200701326)

An MSP complained on behalf of his constituent, Mrs A. Mrs A's son was entitled to free school transport during his primary school education. The Council had made a mistake by placing him in a particular primary school, and there were consequences for his transport entitlement in his secondary placement, in that he was not guaranteed a place on school transport to attend secondary school. The MSP complained that the Council failed to properly address the consequences of their original error in placing Mrs C's son at the wrong primary school, and that they should have guaranteed him a place on the school bus until the end of his secondary education.

I upheld the complaint that the Council unfairly withdrew Mrs A's son's right to free transport on his transfer to secondary school. I recommended that the Council formally apologise to Mrs A for their errors, and that they put in place arrangements to provide her son with free school transport while he remains at his current secondary school.

Planning: policy/administration
The Highland Council
(200602924)

Mr and Mrs C raised concerns about the Council's handling of a planning application to build a new property next to their home. I upheld their complaint that the Council failed to ensure that the new property was the approved distance from the property boundary. I did not uphold two other complaints – that the Council failed to ensure that the footprint of the new house did not exceed 25 percent of the plot area, and that the Council did not respond

appropriately to their complaints about the height of the new house. I recommended that the Council review the case to establish if there are any lessons to be learned for future similar developments.

Planning: policy/administration
South Lanarkshire Council
(200600025)

Mr C raised several concerns about the Council's handling of a planning application that he submitted on behalf of a client. I did not uphold Mr C's complaints that a Council letter resulted in unnecessary delay, and that the Council failed to register the application and failed to issue a letter that was required by statute. I upheld his complaint that the terms of the Council's letter were inaccurate, and recommended that they apologise for this to Mr C.

I did not uphold the following complaint about a Council

Housing: compensation for damage
Fife Council (200601777)

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Scottish Government and devolved administration

I did not uphold the following complaint about a Scottish public authority:

Policy/administration, complaint handling

Scottish Commission for the Regulation of Care (200601455)

Compliance and Follow-up

In line with SPSO practice, my Office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

The compendium of reports can be found on our website, www.spsso.org.uk

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The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: www.spsso.org.uk

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