

Ombudsman's Commentary

MAY 2010 REPORTS

The SPSO laid seven investigation reports before the Scottish Parliament today. Six relate to the health sector and one to the local government sector. Our investigation reports form only one part of our work. In April, we determined 297 complaints, including 43 resolved after detailed consideration.

Each investigation may contain several complaints, and overall the seven reports laid today:

- **Upheld 9 complaints**
- **Did not uphold 5 complaints**
- **Made 18 recommendations**

Overview

The **local government sector** report (Case 200803019) sets out the findings and conclusion of an investigation into a complaint that a council decided to close a number of facilities without consulting the public. I received 54 complaints from local residents who were unhappy about the council's decision, and, in line with our procedure on multiple complaints, I identified one complainant as the representative and conducted the investigation in his name. The remaining complainants were informed at the outset and received a copy of the final report.

I did not uphold the complaint as I found no specific duty or requirement on the council to consult the public about a decision to close a facility or centre. I did, however, find some deficiencies in the council's communication and engagement with the public, and I made recommendations for attention to these areas.

There is much discussion about the potential impact on services of possible public sector cuts. The SPSO has no locus in councils' decision-making about where any axe might or might not fall. Local authorities are democratically elected, and answerable not to this office but to the public. There are, I think, two main lessons from this investigation – one for us, and one for councils generally. For the SPSO, the complaint highlights how important it is that we communicate as best we can to the public that this office cannot alter decisions properly made by local authorities:

what we can look at is whether the decisions were, in fact, made properly. This is an important distinction and not an easy one to put across but we will step up our efforts to do so. One way we intend to do this is through publishing in the next few weeks a series of leaflets about what the SPSO can, and cannot, investigate and the kind of changes we can, and cannot, bring about. The lesson from today's report for local authorities is to be open and consistent about engaging and communicating with the public, especially when it is clear that opposition from residents is likely.

The **health complaints** this month include a range of clinical treatment issues including surgery, maternity services, care in A&E and dentistry. Inadequate record-keeping, communication and complaint handling are also areas I draw attention to in several reports. The complaints are serious and the consequences of the failings in most instances irreparable. In these cases, redress for the patient or the family member complaining on their behalf usually takes the form of an explanation or apology for what went wrong. Other recommendations to the Boards concerned are that policies are adhered to, or where those policies have been found deficient, that they are reviewed. In many cases, I ask for individual investigations to be brought to the attention of the relevant staff. All of these measures aim to encourage learning and bring about improvement.

Business Review Update

Earlier this month, we started to implement the changes brought about by the review of our process, which we announced last October. Its scope was 'to review all aspects of SPSO complaint handling policies, guidance, procedures and practices within SPSO, including challenges, appeals and complaints about our service, and to produce revised policies and a structure which will be customer focussed, cost efficient and deliver excellent service to complainers and bodies under jurisdiction, and will take account of the needs and aspirations of all our stakeholders.'

Structural changes

The main change to our service is a greater emphasis on early resolution of complaints. We have made structural changes to support this aspiration – our three investigation teams are now two teams: one charged with providing advice to both the public and complaint handlers within public sector organisations and discussing possible solutions at an early stage; the other with a more forensic examination of the issues raised.

There have been other changes to our structure, and these are detailed in the organisational chart on our website. Some titles have changed – for example, we now refer to complaints reviewers rather than complaints investigators, and our determination letters are now called decision letters. Our outreach team has become the advice and outreach team. We also have a new process for dealing with complaints about our service and our decisions.

Early resolution

It is because we believe that it is in everyone's interest for things to be sorted out quickly and as close to the problem as possible that we are putting greater resource into 'early resolution'. It is the keystone of our service and the part where people will experience some change, both complainants and people working in organisations we take complaints about. At this early stage, complaints reviewers will also be clarifying that a complaint is about an organisation and a subject that we can look at. If it is not, wherever possible we will try to find another organisation that may be able to help.

Investigation

Here the emphasis is on greater clarity. At the outset, the complaints reviewer and the complainant will agree what the complaint is about and what the complainant wants to happen to put matters right. As has always been the case, the reviewer's job is to be impartial and take into account both sides of the story, and to do this they will collect and consider evidence in the same fashion as before.

We will continue to report our findings and conclusions – in most cases this will be in a decision letter. As before, we will send reports of some cases to the Scottish Parliament. Before the final report is published, we will as previously send the complainant and the organisation a draft of the report, to give them both a chance to highlight any factual inaccuracies. And as previously, learning from the reports will be shared through the Ombudsman's Commentary.

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case reports

Local Government

Leisure facilities: closure; policy/administration; communication

South Ayrshire Council
(200803019)

A number of local residents were unhappy that the Council decided to close various municipal facilities, including a swimming pool, without consulting the public. The residents believed that this was not in accordance with the Council's practice and statutory procedures. I did not uphold the complaint as I found no specific duty or requirement on the Council to consult the public about a decision to close a facility or centre. I did, however, find that the Council's approach to engaging with the public after the closures were announced was piecemeal, and communication was inconsistent. I, therefore, recommended that in the interests of good practice the Council should ensure that their strategy to communicate and engage with the community incorporates clear directives in relation to consistency in communication and engagement where it is proposed to close a Council facility or centre.

Health

Taking medical history; clinical treatment; follow-up care

Ayrshire and Arran NHS Board
(200801946)

Mr A, who had Peripheral Vascular Disease (PVD – a narrowing of the arteries) fractured his left ankle, which was treated with surgery. The wound, however, failed to heal and he had to have his leg amputated. His wife, Mrs C, raised concerns about the orthopaedic

treatment provided. She felt that Mr A's wound was managed inappropriately and that, as a result, his leg was unnecessarily amputated. I upheld her complaints that there was a failure to recognise Mr A's existing vascular condition, and that both the decision to operate and Mr A's post-operative treatment were inappropriate. In particular I found that the clues to the PVD lay within Mr A's medical history, which was inadequately explored by medical staff, and that his treatment for the fracture would have been differently managed had this been identified. I could not, however, say that this would have led to a different outcome, given the nature of PVD. I recommended that the Board highlight this report to the relevant staff, particularly junior doctors, to ensure that they are aware of the deficiencies identified. I also recommended that the Board apologise to Mr A for their failure to identify and take into account his vascular condition when deciding to operate on his ankle fracture, and for the delay in referring him for vascular review when his surgical wound failed to heal.

Clinical treatment; record-keeping

Greater Glasgow and Clyde
NHS Board (200801865)

Miss A experienced considerable pain during the birth of her daughter by caesarean section. Initially she was given an epidural top-up but this did not control the pain, and she was eventually given a general anaesthetic after the caesarean procedure.

An advocacy worker complained on Miss A's behalf that the pain management was unreasonable. I upheld this complaint and also identified concerns relating to the quality of the written records of

Miss A's care. I recommended that the Board highlight the issues raised in my report to maternity unit staff and that they emphasise the importance of keeping detailed records. I also recommended that they offer Miss A an appointment in an obstetric anaesthetic clinic to discuss the safety of the epidural procedure for her in any future delivery, and that they apologise for the failings identified in my report.

Clinical treatment; communication; support/information; policy/administration

Greater Glasgow and Clyde
NHS Board (200901216)

Ms C underwent a medical termination of a pregnancy (MTOP). She then experienced bleeding for over a month afterwards, and reported this to medical staff on several occasions. Ms C felt that her concerns were not addressed and that she was not provided with adequate care and treatment. She also complained that she received contradictory information about bleeding and that complaint responses from the Board contained inaccurate information. I upheld all her complaints as I found that there were earlier opportunities when medical staff could have taken steps to investigate and resolve the bleeding. I recommended that the Board apologise to Ms C for the inadequate care and treatment provided to her and that they devise a protocol for the management of retained products of conception following an MTOP. I also recommended that they apologise to Ms C for providing inaccurate information in complaint responses.

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Health

Clinical treatment; diagnosis; communication; record-keeping

Lothian NHS Board (200802971)

Mr A was taken by ambulance to a hospital's Accident and Emergency (A&E) department, complaining of chest pain. He was discharged with a diagnosis of indigestion, but some weeks later collapsed and died. A post mortem examination found that Mr A had been suffering from acute heart disease. His mother, Mrs C, complained about the care the Board provided to her son. I upheld her complaint that an electrocardiogram (ECG) performed by the ambulance crew was not available to or checked by the doctor in A&E. There were changes between this and an ECG taken at the hospital, which could have indicated that his pain was cardiac in origin. I did not uphold her complaint that guidelines for patients presenting with chest pain were not adequately followed or other investigations carried out, as I found that this was reasonable in the circumstances. I recommended that the Board review verbal and documentary communication between ambulance staff and clinical staff in A&E; that they remind clinical staff of the importance of ensuring that all ECGs are available for review where patients present with chest pain; that findings are documented in the patient's clinical records; and that the Board's audit procedures in relation to ECG sign-off are followed. I also recommended that they remind staff of the importance of seeking details and documenting any family history of cardiac problems from patients presenting with chest pain. Finally, I

recommended that the Board apologise to Mrs C for the failings identified.

Patient dignity; communication; policy/administration

Lothian NHS Board (200901774)

Mrs A was admitted to hospital, where she was found to have an infection and so was barrier nursed in a side room. During her stay in hospital, a male patient with dementia entered her room in the night, causing her anxiety and distress. Mrs C, an advocacy worker, complained on behalf of Mrs A about the Board's care and treatment of Mrs A. I did not uphold complaints that the Board failed to prevent the man from entering Mrs A's room on a number of occasions (as there was insufficient evidence to demonstrate that this had happened more than once), that Mrs A was barrier nursed for too long or that the reason given for moving her to a different ward was not correct. I did, however, find that when responding to the complaint the Board failed to explain what specific action they took to prevent a repetition of the type of incident involving the male patient. I recommended that in future responses to complaints the Board ensure that they explain the action taken. My clinical advisers also told me that the Board's action plan did not show they had addressed the challenges of nursing patients with dementia in a wider context than that of Mrs A's unfortunate experience. I, therefore, also recommended that the Board review their action plan in the light of these comments, to ensure that it is comprehensive.

Dental care and treatment; record-keeping

A Dentist, Western Isles NHS Board (200802564)

Ms C was unhappy with the root canal treatment she received from her dentist, which resulted in her attending her local hospital in great pain and with a swollen face. I found that there was no evidence that the dentist established the working lengths of the root canals concerned or that she kept appropriate records of the treatment provided. I, therefore, upheld Ms C's complaint that the dentist provided an inadequate level of treatment. I recommended that the dentist apologise to Ms C for the failings identified in my report, and that she reflects on my dental adviser's comments about her technique in root canal treatment, and her record-keeping.

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Compliance & 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.

Jim Martin, Ombudsman
19 May 2010

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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