Ombudsman's **Commentary**

JULY 2010 REPORTS

The SPSO laid five investigation reports before the Scottish Parliament today. Four relate to the health sector, and one to local government. Our investigation reports form only one part of our work. In June, we determined 310 complaints, including 60 resolved after detailed consideration.

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

- **Upheld 4 complaints**
- **Did not uphold 5 complaints**
- **Made 12 recommendations**

Ombudsman's Overview

This month I would like to focus attention on the consultation on public sector complaints handling that we published in mid June (available on www.valuingcomplaints.org.uk). I am very pleased with the level of engagement and the positive responses we have received so far from a large and varied range of people and organisations representing all our stakeholder groups. I would encourage those who have not yet read or responded to the document to do so before the consultation closes on 8 September.

At the end of last month, we held our annual Council Liaison Officer Conference, which was attended by over 40 delegates from 23 different councils. The centre-piece of the day was a set of workshops focussing on different aspects of the consultation:

- the principles of good complaints handling
- recording and learning from complaints
- the process (how can organisations achieve the frontline resolution and investigation approaches recommended in the model complaints handling guidance?)

I found discussion at the workshops very constructive. The feedback provided a positive reality check for us and some food for thought, along with good ideas and examples of best practice. I am grateful to the liaison officers for their energy and input.

Other engagement on the consultation has largely been in the housing sector where we have held meetings or delivered presentations to the Scottish Housing Regulator, the Scottish Federation of Housing Associations and two tenant representative groups (TRAG and TPAS). Through Consumer Focus Scotland's Consumer Network, we are working to ensure that we receive views from the public. And we have plans for engagement with other sectors over the summer months and beyond, as we consolidate the work of establishing the Complaints Standards Authority.

The Council Liaison Officer event was also an opportunity for us to raise awareness of our new literature. We have updated our leaflets to reflect changes in our process. An Easy Read version and audio versions are also available. We now have 15 information leaflets about subjects that are most often brought to us by the public, including:

- Planning
- Council tax banding
- Antisocial behaviour/neighbour problems
- Social work
- Council tax and housing benefit
- Being removed from a dental or a GP practice list
- NHS Continuing Care

The leaflets aim to help people understand what kinds of subjects and organisations we can look at. For a person who has a concern about something we cannot look at, the leaflet signposts them to the right place for advice and support. The leaflets can be downloaded from the Online leaflets section of our website, or please contact our Advice Team for copies.

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case reports

Health

Waiting times; complaint handling
Lothian NHS Board (200901871)

Mr C was referred to hospital for surgery on a lump in his groin. He was seen by a consultant colorectal surgeon but was not offered a date for surgery until almost five months later. Mr C complained to me that there was an unacceptable delay between the referral for surgery and being offered an appointment, and that the Board failed to provide a clear and consistent explanation for the delayed appointment. I upheld his complaints as I found that the Board failed to give him a date for surgery after his visit to the colorectal surgeon, and that they did not explain this to him. They also failed to explain to me the reasons for the delay. I recommended that they apologise to Mr C for the failures identified in my report (including the failure to adhere to the date that he was eventually given, which turned out to be wrong). I also recommended that the Board review the way they carry out and monitor referrals for surgery.

Clinical treatment; diagnosis; record-keeping; supervision
Borders NHS Board (200903306)

Mrs A had a history of cancer with complications caused by deep vein thrombosis (DVT). When she developed a swollen leg, her GP referred her to hospital. She attended there twice, and test results for DVT were negative. She was seen there by a junior doctor (the doctor) and did not receive a firm diagnosis. Her GP referred her to the hospital again a few days later. This time, an ultrasound scan was taken and the cause of the swelling was found to be DVT. Ms C, an advice worker, complained on Mrs A's behalf that the doctor failed to examine and assess Mrs A appropriately, and that the management of her care and treatment was inadequate. After taking advice from my medical adviser I upheld both of these complaints, as although it seemed that the doctor treated Mrs A appropriately, the lack of information in her medical notes gave me cause for concern and the evidence I saw suggested that the doctor had not examined Mrs A's leg directly. I was also concerned that a consultant did not review Mrs A, and my adviser pointed out that clinicians did not appear to engage in critical clinical thinking to establish what the cause of the swelling could be, if it was not DVT. I recommended that the Board review the adequacy of the supervision of junior doctors; share my report with the doctor concerned; ensure he discusses it with his current clinical supervisor; and that the discussion is filed in his training logbook. Mrs A died before my report was issued and I also recommended that the Board apologise to her family for the failings I have identified.

Diagnosis; clinical treatment
A Medical Practice, Highland NHS Board (200903057)

Ms C complained on behalf of her sister, Ms A, about the treatment that Ms A's late partner, Mr B, received from his general medical practice. Mr B was a fit young man who was seen by GPs from the Practice three times in four days because he was displaying flu-like symptoms. On the day of the third appointment, he later attended hospital as an emergency patient and was admitted with respiratory problems and multi-organ failure. Ms C felt that the Practice did not take Mr B's concerns seriously and complained that they did not do enough to investigate his symptoms, and failed to diagnose severe sepsis which developed as a result of community acquired pneumonia, and from which he later died. Although I could entirely understand why Ms C and Ms A felt this, I did not uphold this complaint as after advice from my medical adviser I found that, given the symptoms that Mr B was displaying when he saw each GP, the care and treatment provided by the Practice was reasonable in the circumstances. In the circumstances I had no recommendations to make.

Care of the elderly; diagnosis; delay in treatment; communication; complaint handling
Lanarkshire NHS Board (200901320)

Mrs A suffered from heart and bowel problems. Her son, Mr C, raised a number of concerns about the care and treatment that the Board provided to his mother. He complained of delays in Mrs A's treatment, incorrect diagnosis of her bowel problems, poor communication and poor complaints handling. I did not, however, uphold most of his complaints. I found that a delay in carrying out heart surgery was not unreasonable given Mrs A's other health conditions and the consequent need to obtain medical reports; that her bowel condition was not misdiagnosed, and that complaints handling was carried out in line with NHS procedures. I did, however, criticise the Board's record-keeping and their communication with Mrs A, and recommended that they apologise to her for these and remind staff that they should ensure that notes are made at the time of seeing the patient. I upheld the complaint about communication as I found that one of the hospitals involved failed to communicate adequately with her GP and with other hospitals, impacting on Mrs A's care. I recommended that the Board apologise to Mrs A for this.

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JULY 2010 REPORTS

case reports

Local Government

Policy/admin; record-keeping; risk assessment

Midlothian Council (200802628)

A young people's organisation leases a property from the Council. The property is situated in a country park and accessed by a driveway. Following a risk assessment the Council told the organisation that, as complaints had been received about speeding cars, they would enforce an amendment to the lease restricting the organisation from using the driveway. Negotiations about this brought about a further change to the lease, but the organisation were unhappy with the way in which the Council handled the matter and complained to me. I did not uphold the complaint that after an amendment to the lease, the Council's administrative handling of the organisation's proposed solutions, representations and subsequent complaints was poor, as I did not find evidence of maladministration in their handling of the matter. I did, however find that they could have handled it better. I recommended, therefore, that they give the organisation appropriate consideration in any future decisions, record complaints about any incidents in the park involving vehicles and pedestrians, and provide guidance to the organisation about how they can improve their control of use of the driveway.

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
21 July 2010

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

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SPSO Scottish Public Services Ombudsman

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.spso.org.uk**

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