Parliamentary and Health Service Ombudsman

RESOLVE

News from the Ombudsman service

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Featured story

More investigations for more people

From this week we are changing the way we deal with complaints about government departments, other central government organisations and the NHS in England. Our new approach means we'll be conducting full investigations into thousands more complaints each year.

As well as helping to resolve more individual problems, we'll be able to ensure that more learning from complaints is fed back to public service providers, to help them improve everyone's experience of public services.

We're the final step in the process for anyone wanting to complain about central government services and the NHS in England. We were set up by Parliament 45 years ago to give a voice to anyone who has been struggling to get their complaint heard. Crucially, we are independent of Government and of the hundreds of organisations we have the power to investigate complaints about, and our service is free to everyone.

From families struggling on low incomes to farmers frustrated by bureaucracy, from the carers of elderly parents to couples seeking fertility treatment, we help to put things right for individuals and communities when public services have failed them. Throughout our history, our investigations and reports have shown what it's like to be the member of the public at the sharp end. Our work has led to improvements in the delivery of services, shaped public policy and generally helped to make things better.

As well as helping to resolve more individual problems, we'll be able to ensure that more learning from complaints is fed back to public service providers, to help them improve everyone's experience of public services.

But we want to do more. Our new strategy explains what we plan to achieve in the next five years, and our strategic plan, which we will publish soon, will explain how. Our new approach to complaints, which will see us investigating many more individual grievances starting this week, is one example of how we are changing the way we work, so that we can have more impact for more people.

Previously we did a lot of preliminary work on complaints before deciding whether we needed to carry out an investigation. Now, provided a complaint meets some basic tests, we will usually begin an investigation straightaway. The change will benefit individuals, public service providers and the wider public.

More individuals who have been struggling to get the answers they want to a complaint will get an independent, formal and final ruling from us. Providers will get to see and learn from more of the complaints that come to us each year, enabling them to identify opportunities to develop and improve their services. We also plan to share more information about the complaints we see, and the themes we identify, more widely to help ensure that public services are held to account.

You can find out more about our new approach to complaints on our website. For examples of complaints we've resolved for people, see 'From our casebook' in this newsletter.

How we can help

Most of the time people have no reason to complain about public services. But when things do go wrong, it can be difficult to know how to go about making a complaint in the first instance and who to turn to next if you're not happy with the outcome. We're here to help resolve complaints when attempts to deal with them locally have failed. We want to reach more people who have a complaint that we might be able to help with, and MPs, advice organisations and support groups can help us with this.

We realise it's not always easy for advisers to know which complaints to pass on to us and when. We hope the key facts below will help, but if you're in any doubt about whether to refer a particular complaint to us or would simply like some more information about our work, please contact us. Call our main helpline on 0345 015 4033 or our MP helpline on 0300 061 4953, and we'll be happy to help. You will also find useful resources on our website, including leaflets and forms for making a complaint.

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10 key facts about us

1. Our experience and research tells us that when something goes wrong, the public want to know what happened, they want an apology and they want to prevent the same problem happening to others. We can help them with this.
2. We investigate complaints about the NHS in England, UK government departments and other central government organisations.
3. We were set up by Parliament and our powers are set down in law.
4. We are a completely independent organisation; we undertake impartial investigations and make impartial decisions.
5. The range of organisations and the issues we can look into is vast: from complaints about GPs striking people off their practice lists, to problems with benefits and tax credits, we help people at all stages of their lives and in all kinds of situations.
6. It's right that complaints get resolved locally wherever possible, so we usually ask that people come to us after they've complained to the organisation they're unhappy with and have had a final response from them.
7. There are time limits for bringing complaints to us, so it's important for people to get in touch as soon as possible once they've exhausted the organisation's own complaints process.
8. Complaints about government departments and other central government organisations need to be passed on to us by an MP (this isn't the case for complaints about the NHS, which anyone can bring to us direct).
9. Our investigations result in positive outcomes for people: proper explanations, apologies, compensation payments or other action by the organisation. We can also ask organisations to tell us how they plan to prevent the same mistakes being repeated for other service users.
10. We will be regularly publishing information about the individual complaints we see and any trends we're spotting, so that all public service providers can take stock and consider what lessons they can learn from them.

From our casebook

An injustice that can never be put right: the loss of a much-loved family member

Good complaint handling needs to be at the heart of the new NHS. We are working with the Department of Health on the Clwyd and Hart review of NHS hospital complaints commissioned by David Cameron and with the NHS Commissioning Board to support the development of guidance on complaint handling for Clinical Commissioning Groups. We want to ensure that good complaint handling is embedded as the standard across the new NHS in England. Miss G's story highlights the ongoing improvements required in the NHS for individuals with learning disabilities, a problem starkly set out in our 2009 report *Six lives*.

Miss G, a woman in her early 50s with learning disabilities and a history of bipolar disorder, was diagnosed with gallstones and needed surgery. She was admitted to a hospital run by a hospital trust. They could not operate immediately due to inflammation and she was sent home until the operation could be done. In the meantime, Miss G was unable to cope with the pain, and she was sectioned to the psychiatric ward run by a care trust, because of her behaviour. Her medical notes were not acquired by them and they would not listen to her family. She did not have her operation for four months. Following the surgery, she developed a bowel blockage, for which she had another operation. Sadly, she died two weeks later. While these events took place, Miss G was transferred back and forth between these two trusts, despite the fact that they were in the same building.

Miss G's brother and sister-in-law, Mr and Mrs A, complained to us, supported by Mencap. We investigated and found that Miss G's care had not been properly co-ordinated or managed. There was no evidence that the trusts had taken Miss G's disabilities into account when planning her care, although this was a legal obligation under disability discrimination law. In particular:

- Nursing records did not clearly say what care was planned, what decisions had been made, or what care had been delivered.
- Communication between nurses, doctors and other clinical staff and with Miss G and her family was ineffective, and they did not help her to understand what was happening. This meant distressing events were made even more distressing for Miss G.
- Neither trust made adequate use of community learning disability services to make sure that Miss G had support for her specific needs.
- When Miss G missed appointments at the hospital trust, they did not consider how to ensure that she attended her appointments. This meant that her gallstones were untreated for over five months, which would have made her feel unwell and in pain.
- After surgery, nobody took account of her specific needs, and she ended up very agitated and 'running around'.
- Doctors at both trusts failed to adequately assess and manage Miss G's condition after the second operation, and she was transferred back to the care trust prematurely.
- The psychiatrist at the care trust did not ensure that her care was properly co ordinated and managed.
- Staff at the care trust did not listen to the people who knew her best – the team that cared for her and members of her family – or allow them to be involved.

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These failings meant Miss G experienced unnecessary physical and mental suffering. If this period of poor care had not occurred, it is likely that Miss G's death could have been avoided. Mr and Mrs A suffered the loss of a much loved member of their family: an injustice that can never be remedied. We

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An injustice that can never be put right: the loss of a much-loved family member - continued

upheld their complaints about both trusts.

Both trusts agreed to acknowledge and apologise for their failings and to offer Mr and Mrs A compensation of £15,000. Both trusts also agreed to put together action plans that described how they had learnt from their failings and what they would do to stop them happening again.

Six months after the investigation was finished, Mencap told us that Mr and Mrs A were very pleased with the action taken by the hospital trust.

To find out more about our work on NHS complaints, read *Listening and Learning* available from our website.

Marooned and penniless: administrative mistake by UKBA has personal consequences

The administrative giants, like the UK Border Agency and HM Courts and Tribunals Service, are familiar names in our casework. The themes we see tend to be ordinary ones of delay, failure to reply to their customers, or unclear information about what they expect from customers. But, as one Australian backpacker found out, sometimes ordinary mistakes can have big personal consequences.

Mr P, an Australian backpacker, wanting to be in England just long enough to catch a flight home to Australia, ended up stranded in Paris for six weeks. He was sick, almost penniless, unable to speak the language and only got home thanks to help from the French government. The UK Border Agency had detained him, then sent him back to France instead of letting him pick up his flight connection at Heathrow.

Our investigation found that the Agency's mistake was failing to realise that Mr P had a ticket for a flight to Australia within a day. When he complained, the Agency had persisted in overlooking their mistake. We obtained compensation of £2,250 for Mr P, and £430 with interest for the cost of his wasted air ticket.

In December we published our parliamentary complaint handling report, which gives more details of complaints we have looked into about government departments and other government organisations. You can read more about it in this edition of *Resolve*, and the report is available in full from our website.

New reports

Annual assessment of government complaint handling

Our report, *Responsive and Accountable?*, reveals how people are struggling to get government departments and public organisations to put right basic mistakes, causing distress, inconvenience and, in some cases, financial hardship. The report, our assessment of parliamentary complaint handling in 2011-12, shows just how difficult it can be to get your voice heard when things have gone wrong.

It tells the stories of some of the many people who turned to us for help when all other attempts to get simple problems resolved had left them with nowhere else to go. It includes the stories of:

- A father who was deprived of child support for years because of mistakes made by the Child Support Agency.
- A family that was left without tax credits for five months and had to borrow from relatives to make ends meet.
- A man who was unable to work because of a delay in processing his HGV licence.

The report also demonstrates how resolving complaints quickly, rather than letting them escalate, is better for the public purse. In one case an incorrect legal aid decision not only prolonged the court action but ended up costing the taxpayer £135,000 in legal fees. Had the mistake been cleared up at the first time of asking, it would have cost just under £30,000.

Read the full report on our website.

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Want to know more?

Contact us
www.ombudsman.org.uk

Email: phso.enquiries@ombudsman.org.uk

Tel: 0345 015 4033

Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London SW1P 4QP