SPSO NEWS

APRIL 2013

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today, about two different health boards. We also laid a report on 90 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in March 2013), we received 377 complaints. In addition to the four reports we laid before Parliament, we determined 419 complaints and of these we:

- gave advice on 262 complaints
- resolved 111 in our early resolution team
- resolved 46 by detailed consideration
- made a total of 84 recommendations in decision letters.

Ombudsman's Overview

Mental health matters

One of this month's reports is about the care and treatment provided to a young man before he committed suicide. The Mental Welfare Commission for Scotland (MWC) conducted a review into Mr A's death and published a report on this in February 2012, which can be seen at http://www.mwcscot.org.uk/media/62794/hard_to_help.pdf. Although, given our different roles and remits, the MWC review and our investigation examine some different areas, the two reports complement one another in many ways and several of the conclusions are similar. We look at the individual experience of the person who has brought the complaint, usually a relative and in this case the father of the young man. The MWC used Mr A's case to raise broader concerns about how services respond to young people with multiple problems. In my view, both approaches carry insights and add value. There are lessons to be learned for all those involved in treating and caring for people with complex problems such as those with which this young man presented.

Prison healthcare

Responsibility for providing healthcare to prisoners transferred from the Scottish Prison Service to the NHS in November 2011. Consequently, we became the final stage for complaints about healthcare from prisoners. Today, I report on an investigation into a complaint from a prisoner who suffers from glaucoma, a condition which requires daily medication to prevent a significant, permanent deterioration in his eyesight. He complained that after his transfer to prison he was not prescribed with on-going medication. I upheld his complaint and also found that the health board had lost his clinical records. I made a number of recommendations for redress and improvement, which can be read in full in the report.

Complaints Standards Authority Update

SPSO publishes model CHP for the Scottish Government, Scottish Parliament and associated public authorities in Scotland

We published the model complaints handling procedure (CHP) for this sector on 28 March 2013 and wrote to all relevant bodies to tell them that they are required to adopt the CHP by the end of March 2014. The CHP covers all central government public authorities, including the Scottish Government, Scottish Parliament and relevant agencies, NDPBs and associated bodies under the SPSO's jurisdiction.

The model CHP and associated documents are available on our Valuing Complaints website: www.valuingcomplaints.org.uk. By 30 September 2013 each organisation should provide the SPSO with a compliance statement, and a self-assessment of compliance to confirm that their CHP complies with the published model, or will comply with it by 31 March 2014.

Any questions about the model CHP, or the requirement to implement should be emailed to the CSA team at: csa@spso.org.uk

Local authority and housing CHPs now live

From 1 April 2013 the model CHPs for these sectors are operational across the local authority and RSL sectors in Scotland. We continue to liaise with both sectors in terms of providing training and ad-hoc guidance on the CHP and its operation.

Local authority complaints handlers network

The next local authority complaints handlers network will meet on 26 April at Stirling Council and will consider the performance reporting framework, including the final draft performance indicators. We will also take the opportunity to consider feedback on the operation of the CHP from those councils that introduced the model from 1 April 2013.

Higher education

In partnership with the University of Abertay and Universities Scotland, we hosted a higher education model CHP implementation workshop on 18 April. The event was attended by representatives of all higher education institutions in Scotland. The workshop provided a detailed overview of the higher education model CHP and its requirements, as well as a presentation from the University of Edinburgh outlining their experience of planning for and implementing the CHP across all university services following their early adoption of it.

Attendees shared their experience of implementation so far, including the development of their CHP products, training and awareness for staff (including senior management), recording and reporting requirements and learning from complaints. We also agreed the potential for introducing a higher education complaints handlers network.

Feedback from the event has been very positive. It is clear that progress is being made by individual institutions and all attendees were confident of meeting the requirement to have implemented the model CHP by 30 August 2013. For further information on the content and agreed action points please contact the CSA team at: csa@spso.org.uk.

Further education

We continue to liaise directly with Scotland's Colleges and with individual colleges regarding the implementation of the model CHP in this sector. Positive progress is reported, with the sector confident that all colleges will introduce the CHP by 30 August 2013.

Further and higher education – e-learning materials

We will be working closely with representatives from both further and higher education to develop e-learning materials appropriate to the sectors, to help with training and awareness-raising for frontline staff involved in complaints handling. Representatives from the sectors interested in assisting with the development of these training packages are asked to contact the CSA team by email at csa@spso.org.uk or call Paul McFadden on 0131 240 2964.

The CSA team is always available to provide specific advice or support to complaints handlers across the public sector. Please email any questions about the model CHPs, or the requirement to implement, to csa@spso.org.uk.

Investigation Reports

Investigation report ref: 201003482

Psychiatry; mental health care; risk assessment; follow-up treatment; incident review; communication

Tayside NHS Board

Summary

Mr C's son (Mr A) took his own life at the age of 22. Mr A had a complex history including pre-existing developmental problems, emotional difficulties and a previous diagnosis of Attention Deficit Hyperactivity Disorder. He had used alcohol and taken drug overdoses, and had been treated in hospital and mental health centres. Mr C complained about the mental health care and treatment his son received during the 12 months before his death. He was also unhappy with the level of family involvement in the board's Adverse Significant Incident review after Mr A's death, and their root cause analysis.

Mr C raised a number of concerns, and these are detailed in full in the report. They cover a wide range of issues, including the lack of risk assessment tool; a lack of co-ordination of care; missed opportunities for engagement; the appropriateness of timed observations; self-discharge and detention under the Mental Health Act; discharge without follow-up; referral to external agencies rather than being treated by the board; delay in discharge letters to Mr A's GP; lack of action following missed appointments and the board's lack of implementation of Commitment 13. (This is a commitment of the Scottish Government's mental health delivery plan, Delivering for Mental Health, which covered the period 2006-2011.)

The investigation report discusses all of these areas, taking into account the information received from Mr C and the board. I also obtained independent advice from a mental health adviser. The complexities of each area cannot be easily summarised and should be read in full in the report. My overall conclusion is that Mr A's mental health care and treatment fell below an acceptable standard. I made nine recommendations for improvement, which can also be read in full in the report.

I upheld Mr C's complaint about the level of involvement of his family in the Adverse Significant Incident review and root cause analysis. The board's Significant Event Management Policy says that relatives must be given the opportunity to contribute to and receive feedback following a Significant Clinical Event Analysis (SCEA) but should not necessarily be asked to attend. Relatives should be involved in an Adverse Significant Incident review and a root cause analysis unless there are compelling reasons that make this inadvisable or impracticable. The level of involvement is likely to vary on a case by case basis, but at the very least, the family should be asked for their views and for any specific questions or concerns they might have, and that they wish the review to address. My report concludes that it is reasonable that, as a minimum requirement, the family should be told the conclusions of the report, including learning points and planned actions designed to minimise the risk of recurrence. I did not see evidence that Mr C was adequately involved in the reviews, or that he was asked for his views or for any specific questions or concerns he might have. In a previous report that I published about the same board (Case ref: 201003783, December 2011), I recommended that the board review their process for involving families in Significant Incident Reviews and root cause analysis. I am satisfied that the board have implemented this recommendation and addressed this issue and so I did not make any recommendations on this aspect of the complaint. I did, however, make a general recommendation, that the board apologise to Mr C for the failings identified in my report.

The previous report (Case ref: 201003783) also considered the use of a risk assessment tool. In it, I recommended that the board make the use and review of a risk-screening tool – to complement and inform the risk assessment process – mandatory for all patient assessments after a self-harm / suicide attempt. The board have indicated that they are taking this forward. They have also accepted all my recommendations in today's report, and will act on them accordingly.

Investigation report ref: 201201084

Gynaecology and Obstetrics Maternity; maternity care; clinical treatment; record-keeping

Lothian NHS Board – University Hospitals Division

Summary

Mrs C had a number of complaints about different aspects of her care and treatment in hospital, which can be read in full in my report. Mrs C's complaints included that she suffered a bad tear during the delivery of her baby, as well as issues about monitoring, examination and hygiene, and a failure to meet her psychological needs.

Before she complained to us, Mrs C had complained to the board and they had accepted that they had failed in several areas. They confirmed that Mrs C's temperature had not been monitored as it should have been, and that because Mrs C was not examined it had not been known that she needed to be transferred to the labour suite. They also acknowledged that bedding was stained and unchanged. The board had apologised and told Mrs C that matters had been taken up with the staff concerned and that they had been asked to reflect on their practice.

My investigation, however, criticised the board for failing to answer all of Mrs C's concerns. I received midwifery advice from my independent adviser. She found that essentially, nothing could have been done to prevent the tear and noted that this was well repaired and healed. She also concluded that there was not enough information in the medical notes to comment on Mrs C's psychological state and needs. However, the adviser was of the view that the handling of certain injections amounted to medical errors which should have been treated with 'the utmost seriousness'. She also said that matters of basic hygiene, basic observations and vital signs recording, as well as basic communication with Mrs C and her husband fell well below acceptable standards of care. Finally, she said that the 'reflection' offered by the board was not sufficiently explained to Mrs C. Overall the adviser said she was 'taken aback by the apparent low key approach' that the board adopted to address the acknowledged shortcomings of the midwives concerned. I accepted the adviser's views, upheld Mrs C's complaint that the care and treatment given to her were below a reasonable standard, and recommended that the board:

- formally apologise to Mrs C for all their failures in providing care and treatment to her;
- satisfy themselves that proper reflection is carried out by the staff concerned;
- review their process of written and electronic note taking to ensure that the 'story' of an untoward, unusual or exceptional event is clearly recorded and that steps taken to mitigate the situation are highlighted; and
- take steps to ensure that missed vital signs observations and missed medication administration are alerted appropriately.

Investigation report ref: 201200953

Prison – record-keeping; clinical treatment; complaints handling

Lothian NHS Board

Summary

Mr C, who is a prisoner, suffers from glaucoma, which requires daily medication to prevent a significant, permanent deterioration in his eyesight. After his transfer to a prison he requested repeat medication. He made this request four times but was not given the medication. It also became evident that staff at the prison health care centre could not find his clinical records. After Mr C complained to healthcare centre staff and then to the board, he was given his repeat medication. However, during investigation it became apparent that his clinical notes were missing. To date, despite repeated searches, they have not been found.

I upheld Mr C's complaint that it was unreasonable that the healthcare centre did not prescribe his repeat medication and lost his clinical records. I was critical that the board did not accept that Mr C had first made them aware of his problems receiving medication at the end of March 2012. Although there was evidence that he had done so, the board continued to say that Mr C had not made them aware of the problem until mid-April 2012. I was also critical that the board initially told my office and Mr C that his clinical records had been located, when this was not the case.

I made several recommendations to the board, including that they make a full apology to Mr C for the loss of his clinical records, for the potential impact that his lack of medication may have had on his eyesight, and for the poor handling of his complaints. On the matter of Mr C's clinical records, I found the poor handling to be evidence of maladministration. The board explained to me what they have done to address the administrative failings, I also recommended, however, that they confirm that the healthcare centre now uses electronic records that include lists of prescribed drugs for prisoners, and the date this was implemented, and that they confirm their review of the process of transferring clinical records between establishments. I also recommended that they confirm the scope and findings of a current NHS review of the pharmacy process, and the timescales for that review. Finally, I asked them to provide evidence that they have reviewed their complaints handling procedure in relation to complaints about prison healthcare.

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.

Jim Martin, Ombudsman, 24 April 2013

The compendium of reports can be found on our website: **http://www.spso.org.uk/our-findings**

For further information please contact:
SPSO
4 Melville Street
Edinburgh EH3 7NS

Emma Gray
Tel: **0131 240 2974**
Email: **egray@spso.org.uk**

The 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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

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

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 complaints handling in bodies under our jurisdiction.