

Monthly news from the Scottish Public Services Ombudsman

This month we are laying three reports about the NHS and one report about a local authority before the Scottish Parliament. We are also laying a report on 75 decisions about all of the sectors under our remit. These can be read on our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in August), we received 498 complaints. We determined 466 complaints and of these we:

- gave advice on 303 complaints
- considered 99 complaints at our early resolution stage
- decided 64 complaints at our investigation stage.

We made a total of 73 recommendations.

Ombudsman's Overview



NHS reports: upholding carers' rights; improving communication and record-keeping

One of today's investigations raises a hugely important recurring theme – how to respect the rights of patients who are unable to make decisions for themselves, and the rights of their carers. There is legislation designed to ensure that the people who know patients best are involved in their care and consulted on decisions about their treatment. However, people's rights under this legislation are all-too-frequently breached, as in this complaint from a woman who felt excluded from decisions about her husband's care, despite having put in place the necessary legal arrangements so that she could be involved (case 201301611). This can have a devastating emotional effect at a time when carers – often wives, husbands, children or parents – and their loved one are in a particularly vulnerable situation. While this complaint is about one health board, I have found similar problems across a number of boards, and have repeatedly highlighted failings in staff awareness about, and the implementation of, legislation and people's rights in relation to dementia, incapacity and mental health. I would, therefore, encourage all health boards to read this report and consider my recommendations for improvement in relation to their own staff and systems.

A regular learning point from our NHS investigations is the critical importance of robust communication channels between the different people and organisations involved in providing health treatment. In another of today's reports, a man's liver cancer became known much later than it should have because of a mix-up over who had responsibility for communicating results (case 201303189). By the time the man was told the results, the cancer was inoperable and he died six and a half months later.

Another of today's reports (case 201302879), highlights a recommendation I made to address the lack of formal records of communications between two hospitals about a neurosurgery referral. This came to light in my investigation into a health board's failure to address a woman's symptoms as requiring an urgent scan.

Local government report: complaints-handling

This investigation (case 201305794) brought to light a council's failure to deal with concerns about additional support needs for a school pupil through the appropriate channels. The council also made mistakes in their handling of the complaint, including not taking steps to clarify it, or to discuss what their investigation would do and what outcome the complainant was seeking. They did not establish key facts and appeared to have accepted the school's version of events, despite a lack of supporting evidence. They also missed a deadline, and failed to draw any learning points from the complaint after they looked into it.

These failings are all the more glaring because local authorities now operate standardised complaints handling procedures, developed by us in partnership with the sector. These were developed to benefit service users and improve services. They are underpinned by principles and standards, and supported by guidance and training. I invite all councils to read this report, and in particular the recommendations, to assure themselves that they are getting their own complaints handling right.

Investigation Reports



Investigation report ref: 201302879

Diagnosis, communication, record-keeping

Greater Glasgow and Clyde NHS Board

SUMMARY

Mrs C attended her local A&E department on a Saturday, having woken up to find that her leg, foot and buttock were numb. She also had lower back pain and had no feeling when she urinated. She was admitted to hospital with a possible diagnosis of cauda equina syndrome, a serious condition caused by compression of the nerves in the lower spine.

As magnetic resonance imaging (MRI) scans were not carried out at the hospital at weekends and out-of-hours, staff immediately sought specialist advice from the neurosurgery department of a second hospital in a different health board area. After discussion with the on-call neurosurgical doctor at the second hospital, it was decided that an MRI scan was not urgently needed. On the Monday a scan was carried out at the first hospital, which showed that Mrs C had a large prolapsed disc in her spine. She was transferred to the second hospital that day and had surgery on her spinal cord the next day.

Mrs C felt that her symptoms should have been treated as a medical emergency and complained that the decision to delay the scan resulted in her being left with permanent nerve damage, muscle wastage and bladder problems. She wanted the board from whose hospital the neurosurgical advice was sought to admit that the scan should have been carried out within 24 hours of her attending the first hospital. In investigating her complaint, I reviewed the relevant guidelines on standards of care for established and suspected cauda equina syndrome and took independent clinical advice from a consultant neurosurgeon. He told me that the condition is exceedingly rare and can be difficult to diagnose. Although he considered that the diagnosis in this case was not entirely clear, he was in no doubt that he and the majority of neurosurgeons would have recommended that Mrs C be urgently scanned on the Saturday. I therefore upheld Mrs C's complaint that staff at the second hospital failed to assess her symptoms as requiring an urgent MRI scan.

Given the seriousness of Mrs C's condition and the potential implications for her, the report noted my concern that the board were unable to produce actual records of the discussions which took place between the two hospitals on the Saturday. It is of paramount importance that clinicians involved in a patient's care keep clear and accurate records particularly where, as in the case of Mrs C, more than one hospital and doctor are involved in a decision. This did not happen in Mrs C's case, and I made a recommendation to address this failing.

I also highlighted my concern that the board concerned have no written neurosurgery department policy for out-of-hours scanning. They told me that Mrs C's local health board should have a mechanism in place for arranging this. The first hospital's MRI scanner is not staffed at weekends and out-of-hours, and all patients who arrive there needing spinal surgery are referred to the neurosurgery department at the second hospital (which is the responsibility of the different health board) whose instruction and/or advice is then followed. I was, therefore, concerned that these two health boards do not appear to have in place formal protocols, policies or guidance to regulate this, and made a further recommendation to address this.

Unfortunately, Mrs C continues to suffer ongoing problems and I appreciate how distressing this must be for her. However, my adviser said that it is impossible to say with any certainty that the outcome for Mrs C would have been better if the surgery had been carried out earlier.

Investigation Reports



Investigation report ref: 201303189

Diagnosis, communication, record-keeping

Fife NHS Board

SUMMARY

Mr A had a magnetic resonance imaging (MRI) scan. The findings suggested he had liver cancer and the radiologist recommended that he be referred to a specialist centre for further investigation and treatment. The scan results were sent to Mr A's GP, who assumed that a hospital specialist would follow them up. However, the hospital specialist did not receive the results and discharged Mr A from his care.

Eight months later, Mr A asked his GP about the MRI scan and it then became clear that the findings had not been acted on. A second scan was carried out two months later, which showed that Mr A had inoperable liver cancer. He died six and a half months later.

Mr A had started his complaint a few months before he died, and it was taken forward by Mr C who complained that there was an avoidable delay in the cancer diagnosis. In investigating the complaint, I sought independent advice on the clinical aspects of the complaint from a medical adviser, who is a cancer specialist. The adviser's view was that the delay in diagnosis was not reasonable, although it was the result of complex miscommunication rather than the fault of any individual. The adviser explained that because of the complexities of the case it was difficult to identify any one individual who should have assumed responsibility for following up the abnormal results of the first MRI scan.

The relevant guidance recommends that the clinician who ordered the tests is responsible for receiving and acting on the results. In this case, the GP requested an initial ultrasound scan, but later scans were arranged directly by the radiology department. This was done with the best of intentions, to speed further investigation. By the time the scans had been performed, Mr A had been referred to a hospital specialist on the basis of the ultrasound findings and the GP assumed, not unreasonably, that the hospital would take any further action that was necessary. Unfortunately, the hospital specialist was not sent a copy of the MRI scan report and so did not act on it.

In their investigation, the board acknowledged the failing, apologised and made changes to their systems of reporting abnormal scan results. While they acknowledged that the delay in the referral process was unacceptable, they said that clinically, even with an earlier diagnosis, surgery would not have been an option because Mr A also had other significant health concerns. My adviser said, however, that while it was unlikely that surgery was feasible, palliative treatment at an earlier stage might have made a difference to Mr A in the last few months of his life.

I concluded that the delay in the diagnosis was unacceptable and, potentially, impacted adversely on the end of life care Mr A received. As I say in my report, this was clearly extremely distressing for his family and I cannot imagine what Mr A went through because of the delay.

In light of the adviser's comments, I recommended that the board review their processes for communicating abnormal results to include referral to an appropriate lead clinician in the hospital as well as the referring doctor. The board should also consider my adviser's comments to ensure that their system for communicating such results is as robust as it can be so that this does not happen again.

Investigation Reports



Investigation report ref: 201301611

Adults with Incapacity, dementia, communication

Highland NHS Board

SUMMARY

Mr C had advanced Alzheimer's, type 2 diabetes and ischaemic heart disease. He was admitted to hospital following a home visit by a community psychiatric nurse. Later the same day he was detained under a short term detention order and an application was made for a hospital-based compulsory treatment order (CTO), which was granted several weeks later. Mr C was transferred to a second hospital where he stayed until he was discharged to a nursing home. At this point the CTO was suspended and ultimately revoked. Mr C was later readmitted to hospital.

His wife (Mrs C) was concerned at the lack of consultation and involvement of her as a carer during her husband's admissions to two of the board's hospitals. She had financial and welfare power of attorney (POA) for her husband and she was also his Named Person (which provides certain rights, for example to be consulted about decisions about someone's care in certain situations). Mrs C explained to us that she was Mr C's main carer before his first admission to hospital. They had been married for many years and as his wife, his Named Person and the person holding POA for him, she believed she should have been extensively involved in any decisions about his care and treatment in hospital. However, she felt excluded and said that decisions were being made in line with systems and processes and not in response to her husband's individual circumstances or needs.

During my investigation, I sought independent advice from a specialist mental health nurse. He noted significant omissions in assessment templates, which gave the sense that the views of carers, and their participation, were not viewed as priority matters. As well as incomplete documentation, there was a lack of opportunity to ensure Mrs C's views were taken into account in decision-making, which resulted in communication being reactive rather than proactive on most occasions. The adviser also found that there was no coherent carer communication plan or means of supporting Mrs C's participation in her husband's care in a systematic and premeditated manner. The lack of apparent involvement in multi-disciplinary meetings was of particular concern in the absence of any other planned and regular communication forum.

Although in the second hospital there was some improvement in communication between the care team and Mrs C, there was no bespoke carer communication strategy built around her needs and wishes and recorded in Mr C's notes. The care pathway document did not prompt meaningful carer involvement, which is a fundamental aspect in the care of people with dementia. The adviser concluded that Mrs C's rights as her husband's POA and Named Person had not been afforded appropriate respect and the Mental Health (Care and Treatment) (Scotland) Act 2003 principle of 'respect for carers' had not been effectively observed. I accepted this advice, and upheld the complaint that the board did not reasonably include Mrs C in decisions about her husband's care and treatment.

While I note that the board made a number of improvements after Mrs C met with a dementia nurse consultant, I made three recommendations to address the failings I identified, including that they apologise for failing to properly involve Mrs C in decisions about her husband's care, comprehensively review their approach to communicating with carers of people with dementia and take action in relation to their record-keeping.

Investigation Reports



Investigation report ref: 201305794

Complaints handling

Glasgow City Council

SUMMARY

Mrs C complained that the secondary school her daughter (Miss A) attended failed to provide adequate support for Miss A, who has dyslexia and other conditions for which she needs additional support. Mrs C also complained that, when she complained to the council about this, they did not investigate properly. She was concerned that the school's failure to provide adequate support was affecting her daughter's ongoing studies, particularly as Miss A was sitting national exams.

I could not investigate the complaint about the school's failure to provide adequate support for Miss A. This was because Mrs C had an alternative avenue of appeal, which included access to independent mediation and adjudication, and an appeal to the Additional Support Needs Tribunal for Scotland. Under section 7 (8) of the Scottish Public Services Ombudsman Act 2002, I cannot investigate a complaint where there is a right of appeal to a tribunal that the person might reasonably be expected to use.

I could, however, investigate how the council handled Mrs C's complaints. In doing so, I found that the council made a number of mistakes. When they first received the complaint, they dealt with it under their complaints handling procedure rather than under their policy for providing support for children with additional needs. This was inappropriate and contrary to the complaints procedure, which sets out that where separate specific review and appeal procedures exist, complainants should be directed to the relevant procedure. It was clear that Mrs C's concerns about her daughter related to ongoing problems, which would more appropriately have been addressed under the policy.

I also found that the council's investigation did not comply with their complaints procedure. There was no evidence that they contacted Mrs C to acknowledge her complaint within three working days, as the procedure requires. Nor was there any evidence that they took any steps to clarify Mrs C's complaint, or to discuss with her what their investigation would do and what outcome she was seeking. I also found that during the investigation the council failed to establish key facts on which Mrs C and the school disagreed. Instead they appeared to have accepted the school's version of events, despite a lack of supporting evidence.

I am also critical of the council for failing to use Mrs C's complaint to improve their procedures. Although they accepted a version of events that showed that there were communication problems between Miss A's primary and secondary schools, they did not investigate this any further or draw any learning points from Mrs C's complaint. Overall, I concluded that the council did not act reasonably or in line with their policies and that their investigation appeared to have been superficial and lacking in objectivity.

I made six recommendations for redress and improvement which can be read in my detailed report.

Complaints Standards Authority update



Health

Discussions are ongoing with key NHS stakeholders on the recommendations arising from the Scottish Health Council's review of NHS feedback and complaints. The recommendations relate to developing a standardised model complaints handling procedure in the NHS as well as training, good complaints culture and accessibility for complainants. Further information for NHS Boards and complaints handlers will be available from the Scottish Health Council in due course.

Please email CSA@spsa.org.uk if you would like information on the recommendations relating to the revised process or advice on how to progress the recommendations relating to training.

Local government

As we have reported previously, the model complaints handling procedure (CHP) requires local authorities to report annually on their performance in handling complaints. The [SPSO performance indicators \(PDF, 123KB\)](#) for this were designed to help councils understand their complaints handling performance in more detail, ensure that they capture consistent and directly comparable information., and understand how the learning from them is shared both within and across local authorities.

We will be considering the annual reports we have seen from councils and look forward to discussing this further with the sector through the complaints handlers network and our own local authority sounding board. Councils that have not yet provided us with an annual complaints report may do so by emailing CSA@spsa.org.uk

Local authority complaints handlers network

The next meeting of the network is on 31 October, where the theme will be benchmarking of complaints performance. Attendees will consider progress, and review the findings of the pilot approach to benchmarking performance which is currently being rolled out. This should help finalise the benchmarking methodology, including the agreed approach of adopting 'families' of similar local authorities.

If any local authority representatives would like more information about the network, please contact CSA directly on CSA@spsa.org.uk

Local authority knowledge hub

A knowledge hub has been set up for the network to share information about meetings as well as advice and guidance on good practice or areas of interest. The hub is becoming a valuable resource for complaints handlers in the sector as more people contribute to it, and we would encourage all councils to register so that they can access this support. For further details, contact CSA@spsa.org.uk

Housing

The Scottish Housing Regulator (SHR) has published information on all registered social landlord (RSL)s' annual return on the Scottish Social Housing Charter. This provides all the data from each RSL on how they are performing against the outcomes of the Charter as outlined in the SHR's performance indicators, including in relation to complaints volumes.

As highlighted previously RSLs should also report on their complaints handling performance in line with SPSO model CHP requirements. We have provided self-assessment complaints indicators for the housing sector, developed in association with the Chartered Institute of Housing, the Scottish Housing Best Value Network and HouseMark, to monitor performance against the requirements of the model CHP. The indicators, which are linked to the core recording, reporting and publicising requirements in the CHP, [can be found on this website \(PDF, 187KB\)](#). The information RSLs publish will allow them to compare their complaints handling performance across the sector, building on their existing benchmarking arrangements.

Complaints Standards Authority update



Higher education

We would remind universities that they are required to report on complaints handling performance annually in line with SPSO requirements. These requirements are in the **CHP implementation guide (PDF, 101KB)**. We will be discussing the sector's progress with a group of university complaints practitioners in October, and providing further guidance on these requirements.

Please direct any queries about the model CHP or monitoring and compliance arrangements to the CSA team at **CSA@spsso.org.uk**.

Further education

As with other sectors, we would remind all colleges of the requirements to report annually on their performance in handling complaints in line with SPSO requirements. The **CHP implementation guide (PDF, 103KB)** provides these indicators.

The complaints handling advisory group have agreed to hold a session on complaints reporting at a future meeting of the Quality Development Network at which we will provide further information on benchmarking and provide further guidance to the sector on these requirements.

Any sector representatives who want to join, or to learn more about the advisory group, should contact the CSA team directly at **CSA@spsso.org.uk**.

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 September 2014

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

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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.



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