SPSO NEWS

MAY 2014

Monthly news from the Scottish Public Services Ombudsman

We laid two detailed investigation reports before the Scottish Parliament today, both about the NHS. We also laid a report on 81 decisions about all of the sectors under our remit. All the reports can be read on our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in April), we received 475 complaints. In addition to the five full investigation reports we laid before Parliament, we determined 450 complaints and of these we:

- gave advice on 329 complaints
- considered 84 complaints at our early resolution stage
- decided 37 complaints at our investigation stage.

We made a total of 87 recommendations.

Ombudsman's Overview

Investigation reports

One of today's two detailed investigation reports about the NHS sets out very serious matters raised in a complaint about a surgical operation on an elderly man that ended in his paralysis (case 201204510). There were multiple failings – in clinical treatment, in the lack of necessary surgical equipment, in acquiring consent, in nursing care and in record-keeping. The report highlights my great concern that the board's own investigation did not address the medical staff's failures in assessment and communication. The staff's action or lack of action resulted in a significant personal injustice. With the help of the recommendations I have made, the board as a whole and the individuals involved must reflect on how this situation arose and ensure that these failings are not repeated.

The other report (case 201203602) is about the death of a young man with a history of mental health problems and drug and alcohol abuse. The investigation highlighted the gap in provision for patients who present to NHS services with both substance abuse and mental health problems. My recommendations included that the board concerned develop a protocol for dealing with such patients who arrive at A&E, and I would urge other boards to read the report and consider whether there is learning for them there as well.

NHS complaints handling

This month's overview focuses on complaints handling in the NHS. From the outside, it may seem that delays and administrative errors in complaints handling are minor issues. This, however, is to misjudge the enormous emotional toll that poor complaints handling can exact. People complaining about the NHS are often bereaved, or aggrieved because they feel that they or their loved one have been unnecessarily harmed. They are in in search of answers that will move them towards completing the grieving or the recovery process. In this context, delays and mistakes in the handling of their complaint can cause significant additional distress and create distrust.

There are several examples of poor complaints handling in today's reports. In one of the detailed investigations (case 201203602), the parents of the young man who died did not receive a full reply to their complaints until some two months after they complained, and it took over three months to arrange a meeting that they had requested meanwhile. It then took the board more than two months to respond fully to the issues they raised. In another case, an advocacy worker complained to us on behalf of a client who had received no reply after complaining about his care and treatment (case 201304213). For about 15 months she tried to make his complaints or receive updates on them. We found that the board only responded directly to four of her 15 contacts. In another instance, we found mistakes in a board's response to a complaint about the care and treatment of a woman who died in hospital (case 201300802). And although the woman's daughter told the board that they had written to her at the wrong address, it was three months before she received a reply to her complaint, as they used the same address again.

There are also examples of poor complaints handling in relation to prison healthcare. In one example we found that even after a prisoner told a manager that she had not received a response to her complaints, she still did not get a reply (case 201204664). Her complaints were logged but not responded to, contrary to the NHS complaints handling guidance. We also found that some complaints information was inappropriately held in her medical records.

Poor complaints handling also represents a massive missed opportunity for health professionals and governance teams to learn from the mistakes that happen and to put things right. I am therefore very pleased with the outcome of the Scottish Health Council (SHC)'s recent review of NHS complaints handling, which recommends a role for the SPSO in supporting improvement. We have been asked to lead on the development of a more succinctly modelled, standardised and person-centred complaints process for NHSScotland, in collaboration with the public, NHS boards and the SHC. There are further recommendations relating to the e-learning modules we have developed with NHS Education for Scotland and other direct training we have provided to the NHS. We are currently considering the report and the way in which this can best be taken forward. The SHC's report is at: **http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx**

Investigation Reports

Investigation report ref: 201203602

Clinical treatment; psychiatric assessment; hospital admission/discharge; complaints handling

Lothian NHS Board

SUMMARY

Mr A had a history of mental health problems and drug and alcohol abuse. He had been trying to resolve his problems with the help of various agencies and departments. In late 2011, when he had been drug-free for some time, he relapsed into drinking alcohol and taking drugs. He became very distressed and pleaded with his parents (Mr and Mrs C) for help. After taking advice from staff at the Royal Edinburgh Hospital (a mental healthcare hospital), Mr and Mrs C took Mr A to the accident and emergency department (A&E) at the Royal Infirmary of Edinburgh. When they expressed their concerns about Mr A's mental health to the doctor there, including that he had suicidal thoughts, the doctor asked the on-call mental health nurse from the Royal Edinburgh Hospital to come and carry out a psychiatric review. The nurse, however, said that Mr A was too intoxicated for this. He was discharged from A&E, and the board said that his parents were told how he could later refer himself for a mental health assessment. Mr A was found dead at home three days later, from a suspected accidental overdose of drugs and alcohol.

Mr and Mrs C complained that the board provided inadequate care and treatment to Mr A in A&E. They also thought that their son should have been admitted to hospital until he had a mental health assessment, and that the way the board handled their complaint was inadequate.

The board said that Mr and Mrs C were given appropriate information about how Mr A could refer himself to the mental health team, but also acknowledged that as they were very distressed, it was not clear how much of this information they might have taken in. The discharge letter sent to Mr A's GP contained the same information, and the board acknowledged that it would have been helpful to have given Mr and Mrs C a copy of this. They pointed out that there is a national gap in service provision for those who cannot be assessed because of intoxication, and confirmed that they did not have a protocol to deal with this where mental health issues are also involved.

My investigation included taking independent advice from an A&E consultant and a mental health nurse. Both advisers agreed that there is a gap in provision for patients who present to NHS services with both substance misuse and mental health problems. The consultant adviser said that, had Mr A been at risk from the drugs and alcohol he had taken, he should have been admitted. However, the medical records showed that he was not medically at risk, and he was appropriately discharged to the care of his parents. The mental health adviser agreed that Mr A's physical signs were normal, and the doctor had correctly identified him as being in need of psychiatric assessment. However, the adviser was concerned about the lack of a mental health assessment. The on-call nurse wrote nothing in Mr A's medical notes, but wrote to his GP saying that a mental health assessment was required. However, the nurse also said in the letter that he could not assess Mr A because he was unable to wake him. This does not sit well with the medical assessment that said Mr A was conscious and alert an hour before. The adviser said that the nurse should have made every effort to wake and assess him, and that the nurse appeared to have disregarded Mr A's parents' concerns about the mention of suicide earlier that day. Although Mr A was physically fit for discharge, as there was no psychiatric assessment there was no evidence about whether he was mentally fit for this.

I, therefore, upheld the complaint, while recognising that this was a difficult situation. My main concern was that Mr A was discharged without an appropriate mental health assessment. The nurse said that he was unable to assess Mr A, but I found no evidence to support this. I recommended that the board apologise to Mr and Mrs C for the failings identified in my report, and that they create a protocol for dealing with patients who attend A&E with issues relating to both substance misuse and mental health. I did not uphold the complaint about discharge, as there was no medical reason to keep Mr A in hospital, and I could not determine from the available information whether there was a psychiatric reason for him to be admitted.

Finally, Mr and Mrs C did not receive a full reply to their complaints until some two months after they complained, and it took over three months to arrange a meeting that they meanwhile requested. The reason for the delay in providing a meeting date remains unclear. The board then took more than two months to respond fully to the issues Mr and Mrs C raised there. I upheld their complaint about complaints handling, while again noting that this was a difficult case involving staff at two different sites. The relevant guidance acknowledges that sometimes it will not be possible to meet the normal time targets for responding to complaints. However, complainants should be kept informed of the reasons for this, and told when they can expect a response. This did not happen here and demonstrated a lack of empathy towards the bereaved parents.

Investigation Reports

Investigation report ref: 201204510

Care of the elderly; clinical treatment; consent; nursing care

Lothian NHS Board

SUMMARY

Mrs C's late father-in-law (Mr A) had an operation at the Royal Infirmary of Edinburgh to repair an aneurysm (a bulge or dilation of the main artery) under epidural (spinal) anaesthetic. Mrs C complained that the operation took too long because all the necessary surgical equipment was not available. She said that a nurse did not alert doctors when Mr A could not move his legs after surgery. He was found to have developed a complication, and the lower part of his body became completely paralysed. Mr A later contracted an infection, and his lower left leg was amputated. He died some twenty* months after the original operation.

Mr A had a complex medical history and was noted as being at increased risk of complications. The operation took a long time, including an extra three to four hours because a piece of equipment was not available to deal with a leakage of blood, and had to be brought from another city. After Mr A returned to the ward, a nurse became aware that he had no motor power (i.e. he could not move his legs) but did not tell medical staff about this over the course of the evening. The next day Mr A was found to have an epidural haematoma (a collection of blood pressing on the spinal cord or nerves). Further surgery did not relieve this and Mr A was left paralysed.

The board said that the operation was difficult, but that it did take longer than normal in Mr A's case. The missing equipment was removed because it was out-of-date, and had not been replaced. They also said that their investigation found that staff were unaware of when to expect motor power to return after an epidural anaesthetic and there was a lack of understanding of the significance of Mr A having no motor power. They said that the nurse should have made it clear that Mr A was not moving his legs. They offered their sincere apologies that Mr A endured a rare complication and that there was a delay in identifying it, but said it was difficult to be sure about the consequences of the delay, as it was a very serious complication even when identified promptly.

During my investigation I took advice from four advisers; a vascular surgeon, an anaesthetist, a neurosurgeon, and a surgical nurse. My vascular surgeon adviser said that the lead clinician should have ensured that the necessary equipment was on-site beforehand. This, together with a failing to anticipate all the potential problems, did not follow relevant guidelines, and was unacceptable. When the blood leak occurred, the surgeon had to fix it, but the adviser took the view that the prolonged surgery affected the outcome for Mr A. He said that the risk of haematoma was rare, but was well-recognised and potentially catastrophic. It should have been discussed with Mr A when seeking his consent for the operation, but there was no evidence that this happened.

My nursing adviser said that it seemed that contributing factors and system failures meant that no-one raised concerns when Mr A still could not move his legs some time after the operation. The problem should also have been spotted by medical staff who saw him. There were significant failures in record-keeping, including a number of missing documents. The anaesthetist adviser thought that a lack of awareness and assessment reduced Mr A's chances of recovering from the complication. My neurosurgical adviser said that had the haematoma been diagnosed earlier, it was possible that early diagnosis and management might have resulted in a better outcome. However any potential for this was lost by the delay of over 12 hours in picking up the problem.

I concluded that several very serious failings led to a significant personal injustice to Mr A. These included not ensuring that all necessary equipment was available before the operation, or that the risks were fully explained in advance. There were a number of significant failings by staff to act on the fact that Mr A was unable to move his legs after the operation. Failures in record-keeping and to place Mr A in a properly appropriate ward after the operation also put him at risk. I am extremely concerned about all these failings and am very critical that the board's investigation did not address such serious failures in assessment and communication by medical staff. Although I cannot say for sure that delays in detecting the haematoma resulted in Mr A's paralysis, a potential opportunity to successfully treat the problem was missed. This meant that Mr A and his family endured extreme emotional and psychological distress.

I made a number of recommendations to address this, which can be read in full in my report. These included apologising to Mrs C, taking action to improve surgical safety and record-keeping, and providing guidance on obtaining consent for surgical procedures. I also recommended that the failures identified are raised during the annual appraisal process of relevant staff and that the board address any training needs.

**In the original version of this newsletter, we incorrectly stated that Mr A died eight months later.*

Complaints Standards Authority update

Local government

The local authority model complaints handling procedure (CHP) requires councils to report annually on their complaints handling performance. The requirements for this are set out in *'SPSO performance indicators for the Local Authority Model Complaints Handling Procedure'* which was developed in partnership with the local authority complaints handling network.

There are a number of ways in which a council may publicise their 2013/14 performance, and it is for each council to decide which is most appropriate for them. We are not prescriptive about how they do this. Councils may, for example, elect to publish the information on their website, and/or include it in their annual report. We understand that the timescales required to publish an annual report mean that the information may not be in the public domain until later in the year, but by also publishing the complaints performance information on their website, councils can ensure that the data is publicly available as early as possible. The information will help to facilitate continuous improvement in complaints handling, and benchmarking of performance.

The next meeting of the local authority complaints handling network takes place on 20 June 2014, in Glasgow. The theme of the day will be 'Service improvement/good practice'. The network will consider examples of complaints that have led to service improvement, and good practice in complaints handling, with a view to sharing this information across the sector.

The network is run by the sector for the sector and is open to all complaints handlers, managers and senior managers across it. Those who regularly attend the meetings recognise its contribution to adding value. If you are interested in becoming involved, please contact the CSA team directly at **csa@spso.org.uk**.

Housing

The model CHP for registered social landlords (RSLs) also requires them to report on their performance in handling complaints. The requirements are set out in *'SPSO complaints self-assessment indicators for the housing sector'*, developed in partnership with HouseMark, the Scottish Housing Best Value Network and the Chartered Institute of Housing. The indicators complement and build on the Scottish Social Housing Charter's annual return on the charter indicators and will provide important information when RSLs report to their tenants, as complaints outcomes can provide clear evidence of listening and responding to tenants' needs.

As with the local government sector, there are a number of ways in which an RSL may choose to publicise their annual performance. These include publishing the information on their website to ensure that the data is publicly available at the earliest opportunity, and including the information in their annual report. Again, this will help to facilitate continuous improvement in complaints handling and benchmarking between RSLs.

The next meeting of the housing network is planned for June. As with the local authority complaints handling network, the housing network is run by the sector for the sector and we would encourage those who may be interested in attending to contact the CSA team directly at **CSA@spso.org.uk**.

Complaints Standards Authority update

Further education

We continue to work closely with Scotland's Colleges Quality Development Network and sector representatives. The next meeting for the FE complaints handling advisory group is also planned for June, where we will seek to agree detailed terms of reference for the group, which will then be presented to the Quality Development Network Steering Group. The advisory group will also consider the priority areas for the sector and the key deliverables they can work towards over the next year.

Again, the FE complaints handling advisory group is run by the sector for the sector, and we encourage representatives who are keen to join or to learn more about the group to contact the CSA team directly at **csa@spso.org.uk**.

Model CHP for the Scottish Government, Scottish Parliament and associated public authorities in Scotland

All organisations in this sector should now have implemented, and be fully compliant with, the model CHP for the Scottish Government and associated public authorities sector. Our engagement with organisations continues to be positive as we provide advice and respond to operational queries arising during the initial phases of operating the model CHP.

We have taken assurance of compliance with the model CHP from the self-assessment and compliance returns from organisations. We will monitor compliance both through the complaints that we are asked to consider and through our CSA activities. Where appropriate and where required we will liaise with organisations directly to support them in addressing any areas of non-compliance.

We continue to be available to all organisations in this sector for advice, and to respond to operational queries. If and where there is a need for additional support we encourage organisations to contact the CSA directly at **csa@spso.org.uk**.

NHS

The Scottish Health Council's report *'Listening and Learning – How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland'* recommended that the CSA should lead on the development of a more succinctly modelled, standardised and person-centred complaints process for NHS Scotland. We are considering the report and the way in which this and other SPSO-related recommendations can best be taken forward. We will liaise directly with NHS stakeholders as we look to develop the next steps in relation to this work.

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, 21 May 2014

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