

Monthly news from the Scottish Public Services Ombudsman

This month we are laying three investigation reports about the health sector before the Scottish Parliament, and 97 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 July), we received 534 complaints. We determined 496 complaints and of these we:

- gave advice on 304 complaints
- considered 150 complaints at our early resolution stage
- decided 42 complaints at our investigation stage.

We made a total of 95 recommendations.

Ombudsman Overview



Of the reports published this month, there is one health case in particular that I highlight here as being useful for wider review and learning, and I would encourage all health boards to give it careful consideration. The case (reference 201402644) raises concerns about the process for obtaining consent for surgery from a patient with capacity to decide. In this case, we conclude that there was no evidence of a comprehensive explanation (of the procedure) given to the patient or his family sufficiently in advance of his operation.

The need to improve the process for obtaining informed consent has been highlighted in previous commentaries. In 2013-14 we laid one public report relating to this issue (**201105263**). More recently, we have highlighted a number of public report cases and decisions. In June 2014 (case **201300380**) we underlined how important it is to provide sufficient specific detail to allow people to make informed decisions and to record those discussions. Every patient has the right to make an informed choice and in this case we found that the explanations were not tailored to meet the individual's needs and understanding. In February 2015 we reported a case where a man was given the impression he was consenting to a procedure that would not result in a scar, but which subsequently did (case **201304866**). A variety of things went wrong in getting consent and, although we found the board had taken steps to improve their procedures, I felt that they had not gone far enough, and I made recommendations for further improvement. And finally, in June 2015 we highlighted the importance of informing patients of recognised serious adverse outcomes, even where the risk of the side effect occurring is very small (case **201401527**). In this case, I highlighted the need to ensure that consent policies include guidance on the importance of accurately recording conversations with patients regarding risks and complications as part of the consent process.



These are views supported by the General Medical Council, who stated in June 2015 that *‘Fundamental to the doctor and patient relationship is the requirement that a patient with capacity to decide should be informed about the treatment options open to him or her; the risks and benefits of each option; and be supported to make their choice about which treatment best meets their needs.’*¹

In a second health report published this month (reference 201304283), I have been required to take the unusual step of reporting a case against a medical centre who have failed to handle a complaint in line with the NHS ‘Can I help you?’ guidance, and where I have extreme concerns about the medical centre’s resistance to accept the failings in complaints handling that have been identified. In these unusual circumstances, I have recommended that the relevant health board become involved by giving consideration to a referral to the GMC and to the current contract with the concerned medical centre.

The SPSO regularly responds to consultations and calls for evidence. **Our responses to consultations can be found on our website.** This month we responded to a call for evidence of the proposals for a legislative Duty Of Candour as set out in the proposed Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill. **Our response to the call for evidence (PDF, 182KB)** highlighted two key concerns. The first is that the new legislation works well alongside other existing processes such as the National Framework for Learning from Adverse Events. The second is the need to ensure that the new legislation is enabling in the sense that it supports giving an apology in all circumstances, rather than unintentionally encouraging apologies to be given only when a need arises to fulfil the duty of candour obligation.

As well as our usual **Complaints Standards Authority update**, there is information below about a major **SPSO Conference** and forthcoming **training events**.

¹ General Medical Council. June 2015, Hot Topic: Consent, Making decisions with an adult who has capacity to decide, <http://www.gmc-uk.org/guidance/27164.asp>

Investigation Reports



Investigation report ref: 201402644

Consent, communication, follow-up care, referrals, policy/admin, discharge planning

Greater Glasgow and Clyde NHS Board

SUMMARY

Mr A was referred by his GP to the ear, nose and throat (ENT) clinic at his local hospital (in another NHS board area) in January 2014 with a swelling below his left ear. This was found to be cancerous and Mr A was referred to the board for surgery. The surgery, which resulted in extensive facial disfigurement, was carried out on 11 March 2014 and Mr A was discharged on 27 March 2014.

Mr A's daughter (Mrs C) complained to the board that they failed to explain the extent of Mr A's surgery and the possible impact on him. Mrs C also complained about delays following surgery in arranging onward referrals for Mr A to various specialists.

The board noted that the process for obtaining consent for complex procedures such as this takes place over multiple visits, with information being given by different medical professionals. This is to ensure that patients fully understand the information being given to them. They said that Mr A appeared to understand the proposed procedure. They also noted that Mr A was found to be competent and, therefore, able to give consent himself. They said that staff always try to involve patients' families with this process though there was no formal obligation to do so. They were sorry that Mr A's family felt they were not adequately involved.

I took independent medical advice from a consultant maxillofacial surgeon (doctor specialising in the treatment of diseases affecting the mouth, jaws, face and neck). My adviser said that, before such a major procedure, it is important that the patient has all the relevant information, and enough time to discuss it with family and friends, to make an informed decision. He confirmed that a family presence during discussions is not a legal necessity but said it would be recommended by most doctors. My adviser also explained that, although Mr A was diagnosed in another NHS board area, it was the board's responsibility to explain the procedure and get consent. He said that there was a lack of evidence in Mr A's medical notes to show that this was done as it should have been.

In addition, my adviser informed me that most patients who have been diagnosed with head and neck cancer will be seen by a head and neck cancer nurse specialist (CNS), who can help reinforce the issues that have been discussed.

I upheld Mrs C's complaint. It is crucial that patients are given enough information about planned procedures to allow them to make an informed decision. They should also be given enough time to make a decision. The advice I have received, which I fully accept, indicates that Mr A should have been seen earlier by the consultant who performed the surgery, preferably in an out-patient setting with his family and the CNS present. There is no evidence of any involvement by the CNS, or of relevant patient information literature having been provided. This may potentially have been provided by the CNS in Mr A's local NHS board area, but I can see no evidence of the board's CNS having taken action to confirm this. There need to be clearer lines of responsibility when a patient is being referred from one health board to another.

Regarding the complaint about the delays in referrals, my adviser noted that records showed that all the relevant referrals were made within a few weeks of Mr A being discharged from hospital. However, this was not done by the time of discharge. This appears to have been as a result of confusion as to which health board was responsible. I consider that the board ought to have taken steps to clarify this and ensure it was specified in the discharge plan, so I also upheld Mrs C's complaint about the support given to Mr A following his discharge.

Investigation Reports



Investigation report ref: 201304283

Complaints handling

A Medical Practice in the Greater Glasgow and Clyde NHS Board area

SUMMARY

Mr A had concerns about the care and treatment he received from his medical practice in diagnosing his kidney condition. An advice worker (Ms C) complained to the practice on his behalf in April 2013. When she had not received a response to her complaint, despite chasing a response and resubmitting her complaint, she complained to my office. Ms C noted that the only contact she had with the practice was a reply from them asking her to pay £50 to release Mr A's medical records, which was not what she had asked for. She was also concerned that the practice was operating outwith the NHS complaints procedure, as her complaint should have been acknowledged within three days and responded to within 20 working days. My complaint reviewer considered the evidence available, upheld Ms C's complaint and made recommendations to the practice, which were to issue a response to Ms C's original complaint, apologise to Mr A and review their complaints handling procedure. We published our decision on this case in March 2014.

There then followed several attempts from my office to ensure that the practice had complied with our recommendations. The correspondence we received from the doctor at the practice noted that the practice had no idea what their mistake was or what they were to apologise for. Eventually, after making several attempts to correspond with the practice, I wrote to the chief executive of the board to make them aware of the matter. The chief executive noted that many of the statements made by the practice to my office during our investigation were inaccurate. In particular, the chief executive confirmed that the mail system within the building in which the practice was located was not dysfunctional (the practice had said that the mail system had led to them not receiving Ms C's initial complaint).

I took independent advice from one of my clinical advisers who is a GP. He noted that whilst Ms C presented a credible history, the practice appeared to contradict themselves and were less credible with the explanations and information they had provided to us. My adviser commented that the practice did not appear to have correct and proper systems in place to ensure the safe running of the practice. In addition, he said the chaotic way in which the practice dealt with Ms C's complaint including treating it as a request for copies of medical records and requesting a payment for £50 was worrying. My adviser highlighted a number of sections of the General Medical Council (GMC)'s Good Medical Practice guidance, and noted where the practice appear to have failed to demonstrate their compliance with this guidance, including their failure to operate a credible complaints system.

The advice I have received, and accepted, is that the practice had deliberately complicated the issues around Mr A's complaint with the aim of not answering it, which was compounded by the poor systems they had in place for handling complaints. The practice's failure to engage with the board to allow mediation and assistance to improve their situation led to the injustice of Mr A not having his complaint answered.

Finally, my adviser commented that the actions, and lack of action, taken by the practice were serious enough to threaten the reputation of the medical profession because they had repeatedly failed in the duties expected of them by the GMC. The evidence available indicates that they failed to handle Ms C's complaint appropriately in line with the NHS 'Can I Help You?' guidance. In addition, I have extreme concerns about the practice's resistance to accept that they failed to handle the complaint properly. Their refusal to comply with my recommendations has resulted in my office having to issue this report when the complaint should have been finalised following the decision issued by my complaints reviewer over a year ago. In light of my serious concerns, I have not only made further recommendations to the practice, but also recommended that the board consider the contract held with the practice, and consider whether to refer the practice to the GMC.

Investigation Reports



Investigation report ref: 201402113

Clinical treatment, nursing care

Greater Glasgow and Clyde NHS Board – Acute Services Division

SUMMARY

Mrs C was admitted to Glasgow Royal Infirmary in January 2013 to get treatment for a skin infection in her left leg. Mrs C has spina bifida (a condition where the spine does not develop properly, leaving a gap in the spine) and lymphoedema (a build-up of fluid which causes swelling in an area of the body) which means that she has problems moving around. She developed pressure ulcers on her left heel and calf, which were still there when she was discharged. When she got home, Mrs C also found that a pressure ulcer had developed on her buttock. She was readmitted to the hospital in February 2013 as one of the pressure ulcers was infected, and discharged a few weeks later. She was again admitted in December 2013.

Mrs C felt that, each time she was admitted to the hospital, her risk of pressure ulcers was not properly assessed and that, due to her existing medical conditions, she should have been placed in the 'very high risk' category. She said that the pressure ulcers developed because of the incorrect assessment and due to a lack of appropriate care. She said that she had suffered a great deal of pain and discomfort, as well as scarring, which continued to cause her distress. With the help of an advice worker, Mrs C complained to the board.

The board apologised that Mrs C felt that her pre-existing medical conditions were not taken into account. They set out the timeline of events across her three admissions to hospital, stating that she had been assessed as requiring a low level of support. When she had needed a pressure-relieving mattress when she left hospital on the second occasion, they said that this had been provided.

They said that she was assessed by a district nurse at home and continued to receive treatment for a pressure ulcer at the base of her spine until the end of July 2013. The board said that the readmission notes for Mrs C's third admission to hospital state that her skin was healthy and, although she had previously developed pressure ulcers when she was unwell, she did not require pressure-relieving equipment because she was assessed as being able to adjust her own weight whilst in bed. The board said it was documented that Mrs C's husband (Mr C) had insisted that a pressure-relieving mattress was ordered for Mrs C, and he had been extremely unhappy that one had not been provided. Finally, they said that staff had carefully considered Mrs C's condition and treatment, and they were sorry that she had been dissatisfied with her care in the hospital.

Mrs C was dissatisfied with the board's response to her complaint and contacted my office, with the help of an advice worker. I took independent advice from a nursing adviser who considered that, as Mrs C has spina bifida, she was at very high risk of developing pressure ulcers during her admissions to hospital. The adviser found no evidence that the nursing staff took Mrs C's pre-existing conditions into account or put steps in place to prevent pressure ulcers occurring. In particular, the Waterlow risk assessment charts (a pressure ulcer risk assessment tool) completed for each hospital admission were not marked properly. The adviser said that, as Mrs C has reduced sensation below the waist (because of spina bifida), she should have had five extra points added to her Waterlow score. This would have put her into the 'high risk' category. During the second hospital admission, the adviser considered that the delay of several days for a tissue viability nurse to provide advice on Mrs C's care, and for a pressure-relieving mattress to be arranged, was unacceptable. The adviser also noted that the nursing staff involved in an incident when Mr C was very angry about Mrs C's treatment and the delays experienced may benefit from education and training in front-line resolution. The adviser also found it 'shocking' that the board had not determined and admitted their failings in Mrs C's care and treatment when they investigated her complaint.

The advice I have received is that nursing staff failed to take into account Mrs C's specific needs due to her spina bifida and, as a result, failed to appropriately assess and manage her pressure areas on each of her admissions to the hospital. There was also a failure by the board to acknowledge these failings while carrying out their investigation of Mrs C's complaint. I am critical of these failings and uphold the complaint.

Complaints Standards Authority (CSA)



Local government

Since our last update, agreement has been reached with the Improvement Service to provide support to the Complaints Handlers Network in analysing complaints handling performance across the sector against the requirements of the SPSO performance indicators.

Each member of the network has been asked to provide their council's 2014/15 annual data for each of the indicators in a standardised way. The Improvement Service will use this information to produce a report, with headline findings, in time for the next network meeting in October 2015, when the development of guidance to support the learning from complaints will be a feature of the meeting.

NHS

The Scottish Government issued an invitation to Health Boards for expressions of interest to form a working group on the development of a model complaints handling procedure (CHP) for the NHS. Members have now been identified and the working group will hold its first meeting in September 2015. The aim of the group will be to work with the CSA to develop a standardised model CHP for the NHS within the framework of other model CHPs developed and introduced across the public sector in Scotland, and also to consider issues around implementation. It will take account of appropriate amendments to the regulations and directions associated with the Patient Rights (Scotland) Act 2011 and to the Scottish Government's 'Can I help you?' guidance. Further information will be provided to working group members in advance of the meeting.

Complaints Standards Authority (CSA)



Housing

The most recent meeting of the Housing Complaints Handlers Network was held in August at NG Homes, Glasgow. The theme of the meeting was complaints handling performance during the year 2014/15 and in the first quarter of 2015. Full performance information was provided by 14 Registered Social Landlords against the requirements of the SPSO performance indicators for the housing sector.

The key findings of the data analysis included that:

- 88% of complaints were closed at stage 1 of the complaints procedure;
- 64% of complaints were upheld at stage 1;
- 54% of complaints were upheld at stage 2.

The data also showed that, on average, complaints were closed in 4.4 days at stage 1 and 15.2 days at stage 2.

The full data analysis will be provided to network members to allow for comparisons across the sector and to enable learning from one another.

The meeting was also updated on the Scottish Housing Regulator's thematic inspection in relation to complaints. The inspection is looking at 12 landlords and considering how these landlords: make tenants and customers aware of their right to complain; promote their complaints handling procedures; monitor complaints performance; learn from complaints; and report performance and good practice. The inspection will also look at how landlords use the SPSO self-assessment indicators to understand and improve their performance. The regulator's report is due to be published towards the end of the year.

Further information on the role of the network, including details of how you may join, can be obtained from anne.fitzsimons@tollcross-ha.org.uk.

Further education

The next Complaints Handling Advisory Group Meeting will take place on Wednesday 9 September 2015, in Stirling. The group will consider progress around complaints categories and the approach to measuring customer satisfaction.

We would encourage any colleges that wish to join the Further Education Complaints Advisory Group to contact us at CSA@spsso.org.uk, and we will pass your details on to the Chair of the group.

For all previous updates, and for more information about CHPs, visit our dedicated website www.valuingcomplaints.org.uk.

SPSO Training Events

Spaces still available for the first ever SPSO Conference

Thursday 8 October 2015, COSLA conference centre, Edinburgh

Complaints processes generally concentrate on 'putting it right' for the consumer. Using the intelligence that can be derived from complaints, how can we ensure we 'get it right' next time for everyone else? How do we ensure that our complaints processes and responses are fit for purpose and allow us to identify where there is learning and meet the needs of the consumer?

Keynote speakers from the SPSO and public and private sector organisations will talk about their real-world challenges in changing organisational culture, embedding potential learning and improving future practice. A series of workshops and ample networking opportunities will enable delegates to meet with colleagues across the public sector and beyond.

Who should attend?

- **Those with lead responsibility for monitoring and improving organisational performance**
- **Managers with responsibility for organisational learning from complaints and feedback**
- **Quality Assurance Managers**
- **Complaints and customer service managers**
- **Organisations with an interest in consumer redress**

Where and when?

9am – 4pm, COSLA conference centre, Edinburgh (near Haymarket train station)

Price: delegate rate £150 pp, including refreshments and conference materials

For further information or to request a booking form, please contact us at training@spsso.org.uk

Booking now:

Complaint investigation skills (stage 2 of the model CHP): 1-day open course

Next course with spaces available: Wednesday 11 November, central Edinburgh

This is open to staff from all sectors under the SPSO's jurisdiction. Full course details are available on the **SPSO Training Unit website**.

For more information and to book spaces, please contact training@spsso.org.uk

We have more information about courses that we can offer to organisations in our new flyer:

SPSO Training 2015 (PDF, 40KB)

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, 26 August 2015

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

For further information please contact:

Alison Bennett
Communications Team
Tel: **0131 240 8849**
Email: abennett@spsso.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.



COMMUNICATIONS TEAM
T 0131 240 8849



SPSO WEBSITE
W www.spsso.org.uk



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W www.spsso.org.uk/contact-us

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