SPSO NEWS

MAY 2015

Monthly news from the Scottish Public Services Ombudsman

This month we are laying four reports before the Scottish Parliament, all about the NHS. We are also laying a report on 85 decisions about all of the sectors under our remit. These can be read on our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in April), we received 449 complaints. We determined 471 and of these we:

- gave advice on 256 complaints
- considered 168 complaints at our early resolution stage
- decided 47 complaints at our investigation stage.

We made a total of 120 recommendations.

Ombudsman's Overview

I highlight the following matters this month:

- the investigation reports we are publishing
- highlighting best practice
- our 2014 – 15 statistics

Complaint investigation reports

The four reports that I am laying before Parliament are all health cases. Whilst on the face of it they present a disparate range of issues, at the heart of all of them lie concerns about communication. In the first case, 201305516, the failure in communication was between a patient and hospital staff in relation to her suitability for surgery. In this instance the level of communication was poor enough to lead the complainant to take steps to arrange her own treatment privately where we found it was likely that it was unnecessary to do so. In the other three cases, 201305814, 201306190 and 201400643, it was family members who we found had not been communicated with effectively. In case 201305814, where the parents of a man who had lost his life due to suicide complained to us, we concluded that decisions about his treatment plan were made without their involvement, and there was no evidence to show that they or his partner had been provided with any advice on what to look out for or what to do in an emergency. Case 201306190 relates to the treatment of a patient with dementia where we identified a number of significant shortcomings in the care provided but we note that these failings were exacerbated by significant shortcomings in communication. And in case 201400643, where we found that there was no coherent diagnosis and treatment plan in place for a patient who was at the end of his life, we identified a particular concern where the patient's wife and his family should have been directly involved in the consent decision-making process, in line with the Adults with Incapacity (Scotland) Act 2000, and were not.

I have no doubt that failures in communication in all of these cases have played a significant part in why these patients and families felt compelled to invest the time and energy required to pursue their complaints to this office. These cases illustrate why good health care can only ever be delivered where there is full and effective communication with patients and their families.

Highlighting best practice

As well as highlighting what has gone wrong, importantly our case summaries and reports also identify where organisations have taken steps to resolve complaints and demonstrated good practice. These examples include where we have spotted good complaints handling and there is as much to learn from these cases as there are from those cases where we have identified concerns and failings. For example, in case 201304171, we highlight that whilst the handling of the complaint took longer than the normal 20 days set out in the Patient Rights Act framework, we noted that the complainant had been kept well informed and there were no unreasonable delays.

2014–15 statistics

We have published our 2014–15 statistics and **these are available to view on our website**. This year has again seen an increase in the number of complaints we received, with an increase of 10% on last year's figures.

Investigation Reports

Investigation report ref: 201305516

Clinical treatment; communication; complaints handling

Grampian NHS Board

SUMMARY

Mrs C was suffering from abdominal pain, and was seen at a gynaecology out-patient clinic following referral by her GP Practice in November 2012. She was diagnosed with uterine fibroids in January 2013. Mrs C was admitted to a ward at her local hospital (in another NHS board area) due to the pain. In February 2013, Mrs C's GP contacted the consultant gynaecologist (Consultant 1) in charge of the out-patient clinic, requesting that she be placed on the list for surgery due to the impact her condition was having on her life. Consultant 1 replied to say further discussion was required within the multi-disciplinary team; Mrs C was offered another appointment at the clinic on 2 April 2013. Mrs C decided to seek private treatment, and had successful private surgery on 4 April 2013.

Mrs C made a complaint in June 2013 about the care and treatment she received, as well as communicative difficulties she had had when trying to contact Consultant 1. She received a reply in August 2013, apologising for the administrative backlog that caused delay with her care and treatment. The Board also said it was unlikely Mrs C would have been seen earlier than 2 April 2013 due to the gynaecology service's waiting times overall. Mrs C complained again and the Board issued a final response in February 2014. At this time, Mrs C was told that, in February 2013, Consultant 1 had made a decision that she should be referred for surgery. An appointment for 4 April 2013 was to be offered; a telephone call was made by the Board to her GP Practice on 4 March 2013. Consultant 1 told us that this had been left with the GP to discuss with Mrs C.

My investigation found that more prompt action should have been taken by the Board given Mrs C's worsening condition, and that there was a lack of urgency which meant Mrs C's care plan was not re-assessed. I concluded that to expect Mrs C to wait for a further clinic appointment in April 2013 was not reasonable. In addition, it was not reasonable that Consultant 1 had only contacted the GP Practice by telephone to advise of the offer of surgery; contact should have been made in writing to ensure Mrs C was aware of her options. It was not reasonable to expect the GP Practice to pass on a message about the offer of surgery. In my view, it was likely Mrs C would not have sought private treatment had she known the same procedure would have been available via the NHS at the same time. I also found that the Board's responses to Mrs C's complaints were delayed, having been received well outwith the timeframes within the Board's complaints handling procedure.

Investigation Reports

Investigation report ref: 201305814

Clinical treatment; follow-up care; communication

Fife NHS Board

SUMMARY

Mr A suffered from anxiety, depression and panic attacks for many years; he attended his GP regularly and was prescribed Citalopram and, on occasion, diazepam. In March 2013, Mr A saw an out-of-hours GP, describing worsening symptoms and feeling suicidal. He was prescribed lorazepam and told to see his GP the next day; Mr A attended the out-of-hours GP again the next day and reported suicidal feelings again; he was then seen by a Duty Psychiatrist and discharged with a plan to refer for a medication review. Two days later, Mr A attended the Accident and Emergency Department at the Victoria Hospital after taking an overdose. He was discharged, and his parents (Mr and Mrs C) contacted his GP to say they felt they could not leave him alone due to his state. The following day, Mr A took his own life.

Mr and Mrs C complained to the Board and, along with Mr A's partner, met with Board staff. The Board said that, because Mr A's suicidal thoughts had been fleeting and intermittent, a decision was made that he could be treated safely in the community. He had also been declined further medication, which he had requested, due to the risk of overdose. A Significant Events Analysis was then carried out, where it was identified that benzodiazepine withdrawal may have been a factor in Mr A's mental health deterioration. It concluded that, in hindsight, Mr A's level of risk to himself had not been anticipated. A number of recommendations were made.

My investigation was mindful that we were reviewing what happened with the benefit of hindsight; nevertheless, I found that although the initial assessment by the out-of-hours GP was reasonable, the Duty Psychiatrist's assessment did not detail suicide risk factors and there was no evidence that Mr A's partner, who had attended with him, was included in discussions. Mr A was not told what to do should his condition deteriorate further. When Mr A attended A&E, staff did not know that he had already presented twice to NHS services with suicidal feelings, which he was now acting upon. Had staff known this, they would have been able to see that Mr A's condition was developing, and different, more urgent action may have been taken. I upheld Mr C's complaint that the Board failed to provide Mr A with appropriate care, support and treatment following his visits to hospital in April 2013.

Mr C also complained that the Board unreasonably failed to provide Mr C's family with sufficient information about Mr A's health to allow them to support him, and I upheld this complaint too. The Board's SEA had already recommended that, in cases where suicide plans have been expressed and hospital admission is not taking place, it would be best practice to agree with patients that partners, family or carers are fully informed to help prevent harm. We found that Mr A's partner, who had attended all the hospital assessments, did not appear to have been involved in decisions about treatment. In addition, neither Mr A's partner nor Mr and Mrs C appeared to have been given any advice about how to deal with the on-going situation.

Investigation Reports

Investigation report ref: 201306190

Care of the elderly; adults with incapacity; nursing care; clinical treatment; communication

Borders NHS Board

SUMMARY

Mrs C complained about the way her late mother Mrs A had been treated while in hospital. Mrs A, who had dementia, was admitted to Borders General Hospital on 20 November and discharged on 4 December 2012. She was readmitted on 6 December and then discharged again on 17 December 2012. Mrs C was concerned about aspects of her mother's treatment while in hospital and that she was discharged too soon. She felt that Mrs A had been treated poorly because of her cognitive impairment. I sought independent expert advice from a nursing adviser and a medical adviser. I did not find that Mrs C had been deliberately discriminated against because of her dementia. However, my investigation identified a significant number of failings in her care, many of which related to a failure to provide appropriate care and support to someone with cognitive impairment or to follow the legislation that provides protection for someone with cognitive impairment who requires medical treatment. As a result of these failings, it is likely that, taken together, the failings were such that Mrs A's rights as an NHS patient and a dementia patient were infringed.

Care seemed to be poorly led and coordinated. There was no evidence of a full care plan and, despite the fact that she had been admitted to the hospital because of a fall and had five falls during her stay, there was no completed falls assessments in the clinical records or any evidence of a falls prevention plan. There was limited evidence of the involvement of medical staff and communication with the family was sporadic and poor. Pain and nutritional assessments were inadequate. There was also a specific incident of which I am critical when Mrs A required but was not provided with adequate pain relief and this meant her journey to the care home on 4 December was very uncomfortable. While the report identifies a number of medical and nursing failures, I did not uphold a complaint about physiotherapy and occupational therapy. There was evidence in the records of appropriate physiotherapy involvement and while I am critical that an occupational therapy assessment was only carried out after prompting by the care home, I found that overall care in these areas had been reasonable.

Investigation Reports

Investigation report ref: 201400643

Clinical treatment; adults with incapacity; policy/administration

Lanarkshire NHS Board

SUMMARY

Mrs C complained about the care and treatment provided to her late husband Mr A. Mr A was admitted to Wishaw General Hospital on 24 February 2014 and died there on 6 March 2014. Mr A had been unwell for some time prior to admission and cared for by family members at home. In the days leading up to his admission his condition had deteriorated and he had been hallucinating and unable to swallow. Mrs C complained about a number of the aspects of care provided to Mr A. In their response to her complaint, the board accepted some failings and apologised. Mrs C remained unhappy and asked the SPSO to investigate. I took independent advice from a consultant physician and a nursing adviser.

My investigation found that although her complaint had been upheld, the complaints process had only looked at Mr A's care in a superficial manner. Not all the clinical staff involved in the case had commented and may have been left unaware of the outcome of the board's investigation. I also found a number of significant failings. There was a lack of any overall plan for Mr A's care and treatment, and the treatment he did receive fell well below a level that Mr A should have expected on a number of points. There was no specific assessment of his swallowing difficulties or monitoring of the dehydration that he presented with on admission. Significantly, there was evidence of confusion between staff about whether Mr A was being provided with active or end of life care. Mr A was being proposed for referrals and investigations just two days before palliative care and a possible transfer to a hospice was considered although there was no apparent change in his condition. One doctor noted on file that Mrs C wrongly believed Mr A was dying. However, there is also evidence that other staff did think Mr A was dying and the board acknowledged in their investigation that end of life care would have been more appropriate throughout this admission. Mrs C told us she received conflicting information about his condition and received a call from occupational therapy about physical aids she may need to care for him at home when it should have been clear he would not be discharged. Alongside the failings in the treatment and the confusion around this, I was also critical that there was no evidence Mr A's family were appropriately involved in decision-making. On the day he died, Mr A had a gastroscopy to investigate some of his symptoms. We found that there had been no clear assessment of the risks of such a procedure and further, that, at the time, Mr A did not have the capacity to consent to such a procedure. A certificate of incapacity was in place that allowed medical staff to provide general treatment as Mr A could not legally consent to this. It did not provide for this specific procedure which would normally require additional consent and Mrs C and her family should have been involved in this decision. This means that Mr A was denied safeguards put in place by legislation to protect adults with incapacity when the decision whether or not to go ahead with the gastroscopy was made. Mr A did not recover well from this procedure and, while there was some treatment following his return to the ward, there was little evidence this deterioration was properly assessed.

Investigation Reports

Investigation report ref: 201400643

Clinical treatment; adults with incapacity; policy/administration

Lanarkshire NHS Board

SUMMARY CONTINUED

I found there were also failings around the very sensitive issue of when Mr A had died and who should be informed of his death. The records indicate Mr A died around 13.40 to 13.50. However the death certificate recorded the time as 15.13. This difference happened because it was not until then that a doctor confirmed the death. However, advice by the Chief Medical Officer makes it clear that this approach is wrong and that doctors should seek to put on the certificate as accurate an actual time as possible based on the available information and not simply the time they confirm the death. Following Mr A's death, the decision was made not to notify the procurator fiscal. This assessment was made using a standard checklist. I found no problems with the checklist but it had been wrongly completed and said there were no reasons for Mr A's death to be reported. In fact, Mr A potentially met two criteria – deaths which were clinically unexplained and which may be due to an anaesthetic. Mr A died from unknown causes on the day he had had an invasive procedure and there was evidence he had deteriorated following that procedure. I made a number of recommendations as a result of my investigation. They reflect that some action had been taken by the board prior to my investigation and the significant changes to the procedures around certification of death introduced on 13 May 2015.

Complaints Standards Authority (CSA)

NHS

Our work continues in planning for changes to the NHS complaints handling arrangements and engaging with the sector. This includes liaising closely with the Scottish Government in respect of legislative change, and engaging with NHS Boards, health service providers and key agencies. Our key aim is the development of a model complaints handling procedure (CHP) for the NHS, which takes account of the framework of the Patient Rights (Scotland) Act 2011 whilst prioritising the early resolution of complaints and better quality learning to inform service improvements.

We will provide further information on this to NHS stakeholders shortly.

Local government

The next meeting of the network will be held on 12 June 2015, where key considerations will be 2014/15 performance reporting process and how to further develop and refine the performance indicators, with particular focus on the demonstrating organisations' learning from complaints. We are continuing to engage with key sector partners – including COSLA, SOLACE, Improvement Service, Audit Scotland and the Accounts Commission – on ensuring the best possible approach to using the local authority complaints performance information.

Housing

As previously reported, the Housing Complaints Handlers Network considered at its last meeting how operating within a performance culture helps to drive effective complaints handling, and provides opportunities to benchmark for improvement. We agreed that, at future Housing Complaints Handlers Network meetings, we would consider the quarterly performance information of members against the requirements of **the SPSO complaints self-assessment indicators for the housing sector (PDF, 188KB)**. This will allow us to progress the benchmarking process towards learning and improving. The next meeting of the network will be held in early July, and we would encourage members to collate their complaints performance information from the first quarter of 2015/16 in advance of the meeting.

Interest in this network continues to grow. If you would like your organisation to be represented at future meetings of the network, please email **anne.fitzsimons@tollcross-ha.org.uk** to confirm.

Complaints Standards Authority (CSA)

Further education

The Further Education Complaints Advisory Group hosted a successful benchmarking workshop for all colleges on 6 May 2015. The event focused on the annual complaints reports from all college members which had been provided in advance of the workshop to allow for a high level analysis of performance across the sector, and identified opportunities for colleges to learn from each other. Initial feedback on the value of the event is extremely positive with all attendees agreeing the workshop was helpful and would have a positive impact on their future management of complaints. Comments included *'excellent event. Would like it to be regular seminar e.g. every six months; extremely useful discussions which will help inform and enhance our practice'* and *'helpful, great to share practice and best practice learning'.*

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

Higher education

We were pleased to attend the most recent meeting of the higher education complaints forum held on 23 April 2015 at the Paisley Campus of the University of the West of Scotland. Our regular attendance at this network allows us to promote the complaints performance culture that is growing across the public sector, update members of the work of the Ombudsman and of the Complaints Standards Authority and to respond to any specific queries on complaints, or the SPSO, from network members.

We encourage all higher education institutions to contact us directly at csa@spso.org.uk for advice on performance reporting, the compliance requirements of The Scottish Higher Education Model Complaints Handling Procedure or for generalist advice on complaints handling.

For all previous updates, and for more information about CHPs, visit our dedicated website **www.valuingcomplaints.org.uk**. You can also contact the CSA directly at **CSA@spso.org.uk**

SPSO Training Events

Bookings are now open 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 SPSO, 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@spso.org.uk

Booking now:
Managing Difficult Behaviour: 1 day open course

Monday 22 June 2015, central Edinburgh

This course, new for 2015, is open to staff who might receive negative feedback from the public or other stakeholders. Participants will be given an opportunity to assess their own conflict styles and develop ways of managing their own personal 'triggers'. We will consider a number of different theories and tools that can be helpful in managing conflict. The session will include a number of opportunities to put theory into practice and participants will be able to discuss their own particular concerns. **Full course details are available on the SPSO Training Unit website**.

Price: £180 pp

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, 20 May 2015

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

For further information please contact:

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