SPSO NEWS

MARCH 2015

Monthly news from the Scottish Public Services Ombudsman

This month we are laying four reports before the Scottish Parliament – three about the NHS and one about Scottish Water. We are also laying a report on 61 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 February), we received 467 complaints. We determined 437 and of these we:

- gave advice on 259 complaints
- considered 126 complaints at our early resolution stage
- decided 52 complaints at our investigation stage.

We made a total of 126 recommendations.

Ombudsman's Overview

I highlight the following matters this month:

- the investigation reports we are publishing
- the alternative dispute resolution provision available under the Education (Additional Support for Learning) (Scotland) Act 2004

Complaint investigation reports

This month I am drawing attention to a case about Scottish Water (case 201302982). It involves a long-running saga about a pumping station built near houses, the construction of which caused concern to local residents. There was significant disruption over almost a decade, and there was damage to some homes during the construction phase. Scottish Water had, however, assured residents that once the building work was complete the disruption they had experienced would be over. Residents, however, have told me that this is not the case and that since the station became operational they have suffered for a number of years from vibration related to it. In my report, I say that I consider that Scottish Water have not done enough to address residents' outstanding concerns about the impact of this development on the value of their properties. Nor have they done enough to address the distress and inconvenience of nine years of disruption on a community of elderly residents, some of whom suffer from serious health conditions. I recommended that Scottish Water assess any impact of the station on relevant property values and compensate residents for any loss of value; the first time I have made a recommendation of this nature. Although after interviewing a number of residents I found that their views on a solution differed, I have made recommendations to try to address the main concerns, and I have been careful to say that the steps that Scottish Water should take only apply where a resident wishes it.

We are also publishing three cases about NHS boards, each very different, but each involving issues of communication. In one, a woman with gynaecological problems did not undergo the procedure she thought she was to have (case 201302900). Although she had given consent for a particular procedure, her surgeon was unavailable so a locum carried out her operation, and did not obtain her consent for the full procedure she had expected. They then gave her inaccurate information about what they had done. In another an elderly man died after being admitted to hospital (case 201304738). Although he had significant ongoing medical problems, he was not properly assessed after falling in hospital and his fractured hip was not diagnosed early enough. And in the third case, a man recently released from prison was not allowed to see a GP at a medical practice, although his mother had made efforts to enable him to do so (case 201305288). Neither he nor his mother was told in advance that his registration with the practice had been cancelled. He died shortly afterwards from pneumonia, and his mother was concerned that he should have been able to see a GP. I agreed that he should and was critical that he was prevented from doing so. I was also very critical of the practice's handling of later correspondence after they first responded to the complaint, and of their failure to provide information to me during my investigation. As ever, I urge health boards and GP practices to read these cases, and ensure that they do everything possible to avoid similar errors in their own procedures and practices.

Rights under additional support for learning legislation

I also wish to draw attention to the issue of additional support needs, which is the subject in one of our published decision reports this month (case 201302996). In this case I upheld a mother's complaint about her child's additional support needs, and I want to remind providers that staff should advise about alternative dispute resolution in such cases. The Education (Additional Support for Learning) (Scotland) Act 2004 makes provision for this.

In such cases, a parent has a right to access independent mediation and adjudication, and has the option of appealing to the Additional Support Needs Tribunal for Scotland. The provider should always make a member of the public aware of this where there is a dispute about support, but in this case, the mother was not told about her rights under the legislation.

All providers should satisfy themselves that staff dealing with this are aware of the need to make members of the public aware of these rights, and of the alternative dispute resolution avenue, and to do so early in the process.

Investigation Reports

Investigation report ref: 201302982

Communication, customer service

Scottish Water

SUMMARY

Mr C was unhappy with a sewage pumping station that Scottish Water built near his home. The station was much larger than the existing facility and discharged the sewage differently, with the aim of reducing discharge levels. There was a lot of work involved in building the new station, and strong local objections were raised during the planning process. Construction began in 2006. There was significant disruption and damage during the building work, and after the station began operating there was further disruption due to repeated pump failures.

I upheld Mr C's complaints that Scottish Water had not taken appropriate action on the issue of vibration and had not provided a permanent solution. I made a number of recommendations, which can be read in full in my report. These include providing annual structural surveys for residents for the next five years, carrying out required work on any relevant issues the surveys identify, assessing any impact of the station on relevant property values and compensating residents for any loss of value.

Mr C complained that since then vibrations from the new station have damaged his and his neighbours' properties, and that Scottish Water have not provided a permanent solution. He said that during a public consultation in 2005, Scottish Water assured residents that once the station was built they would have no further disruption. Mr C said, however, that he and his neighbours have continued to suffer disruption since, causing distress and inconvenience, as well as structural damage to some properties. Residents still experience noise and vibration and believe that the value of their properties has been affected.

Scottish Water said that they accepted there was significant customer impact during the construction phase, which was to be expected with a project like this, and had fixed damage caused at that time. They did not, however, believe that there was a link between these earlier issues and the later issues. Since the station was put into operation, they had commissioned various reports into its operation and issues of vibration because of the complaints received. They were of the view that they had taken action where appropriate.

My report into this complaint contains a significant amount of background and technical information. I took independent advice from one of my advisers – a chartered civil engineer with considerable experience of the water industry. There have been continuing problems with the operation of the new station, and various reports and investigations have been carried out into residents' concerns. Indeed, this matter was first brought to me a number of years ago, and I ended my involvement with it then on the understanding that Scottish Water had an action plan in place that would resolve the outstanding complaints. However, the complaint was brought to me again as residents say the station is still not working in the way that they say they were told it would. During my investigation, I saw no evidence that Scottish Water have fully addressed residents' ongoing concerns about vibration and structural damage, or that they have assessed the possible impact on the value of properties. I am of the view that they should have done so, particularly in view of the initial assurances they gave. In my report I say that I do not consider that this can be considered resolved until the issue of both short and long-term impact on the structural integrity of local properties has been definitively resolved.

Mr C had also complained that Scottish Water had not set a date by which they would decide whether to move the station. Although I appreciate that this will be disappointing for some residents, I found that it was not unreasonable for Scottish Water to reach this decision and that in doing so they took material considerations into account. I did not uphold this element of the complaint, although I made further recommendations about future monitoring.

Investigation Reports

Investigation report ref: 201302900

Consent, clinical treatment, communication

Western Isles NHS Board

SUMMARY

Mrs C had a long history of gynaecological problems and needed a major operation to help with these. Although she at first had concerns about having her ovaries removed, after discussing the options with her consultant she consented to an operation to remove all but the neck of her womb (a sub-total hysterectomy) and her ovaries. By the time she had the surgery, her consultant was unexpectedly unavailable, and the board arranged for a locum consultant (the locum) to operate instead.

The locum met Mrs C the day before, discussed the operation and obtained her consent. Immediately after the procedure, Mrs C needed a blood transfusion because of complications, and was transferred to the High Dependency Unit (HDU). A few days later, the locum told her that he had done the sub-total hysterectomy, removed all of one ovary and part of the other. Some five months after the operation, however, Mrs C was referred back to her original consultant as she was in pain, and learned that in fact her ovaries had not been removed. When she complained to the board, they told her that the locum said that Mrs C initially did not want her ovaries removed, but changed her mind in the operating theatre. He said that during the operation he found that scarring from previous operations meant that it was unsafe to do so. He thought he might have given Mrs C wrong information because he confused her with someone else. The board accepted this might have happened, but said it was not deliberate. They also said that Mrs C was transferred to the HDU because of low blood pressure, and that when she was assessed there she had a scan that excluded internal bleeding as a problem.

Mrs C complained to me that the locum did not carry out the full procedure she expected, and gave her inaccurate information, and that the board did not adequately explain the complications to her. The scarring means she cannot now have further surgery to complete the procedure, and she continues to be in pain.

I took independent advice from one of my medical advisers, a gynaecology specialist. He told me that the consent form Mrs C signed for the locum was not in line with board guidance, and was only for a sub-total hysterectomy, with no mention of removal of the ovaries. The adviser found nothing in Mrs C's notes to show that she changed her mind or that the locum decided not to remove her ovaries. He said that had either of these things happened they should have been recorded. My adviser was also concerned that the locum might not have had the skills needed for such a complex operation, and that his explanation about a mix-up was unacceptable. The locum should have had Mrs C's notes before him when speaking to her, especially as she was not known to him. The board's response to Mrs C's concerns about the complications also seemed to demonstrate a lack of understanding of what actually happened. My adviser said she had clearly suffered internal bleeding, but that there was little evidence of this having been considered in detail, and it was not recorded as a significant adverse event as it should have been.

I upheld all Mrs C's complaints. I found serious failings on the part of the locum and the board both before and after the operation. I made a number of recommendations, including that the board bring my adviser's comments to the attention of relevant staff, review their locum cover procedures and significant adverse event guidance, and ensure they have a clear policy for transferring responsibility for care between consultants.

Investigation Reports

Investigation report ref: 201304738

Diagnosis, care of the elderly, adults with incapacity, resuscitation, complaints handling

Greater Glasgow and Clyde NHS Board

SUMMARY

Mr A, an 88-year-old man, had a blood disorder for which he needed frequent blood transfusions, and which left him very vulnerable to infection. He was admitted to Glasgow Royal Infirmary suffering from sepsis (a life threatening blood infection). Before this, he had become increasingly frail. He had fallen several times and had diminished cognitive ability (the ability to understand, think and reason). He then fell in hospital, fracturing his hip and pelvis. Although staff assessed him after the fall, his hip was not x-rayed for some days. By the time the fracture was picked up, Mr A had deteriorated. It was considered too late and too dangerous to operate, and after discussion with his family he was provided only with palliative care (care to relieve suffering). He died just over a month after being admitted to hospital. His daughter (Mrs C) complained about her father's care and treatment, the board's communication with the family and their response to her complaints.

Mrs C was unhappy about a number of issues, including the delay in diagnosing Mr A's hip injury. She said that the family were put in an impossible position – by the time they knew an operation might be necessary, they were also told that Mr A might not survive the procedure. She also said that they felt ignored when looking for information and were not given clear answers about Mr A's prognosis when discussing the possibility of surgery.

The board said that when Mr A was admitted, he had a complex medical condition. After he fell, it was thought that his knee was injured, which was x-rayed. When he developed further pain in his hip this was also x-rayed, and the fracture was diagnosed. They accepted there were delays, but said there was no immediate suggestion of a hip fracture, and that Mr A's medical condition meant that he would not have been able to have surgery. They apologised and said they had reviewed the relevant protocols and reminded staff about keeping families informed.

I took independent advice, which I accepted and which is detailed in my report, from a consultant in geriatric medicine. Among a number of other failings, my adviser said that the medical records showed classic signs of a hip fracture. The delay in x-raying Mr A's hip was unacceptable and denied him the possibility of surgery, which might, in fact, have been appropriate had the fracture been diagnosed earlier. I was very concerned that, given Mr A's history and condition, there was no evidence of any assessment of his mental capacity for decision-making, and no discussion about whether he should be resuscitated should his heart or breathing stop. Ultimately, at the end of his life Mr A was subjected to an extended resuscitation attempt, which my adviser said was futile, and compromised Mr A's dignity. I criticised the lack of consultant-led engagement, as discussion was largely left to junior members of the medical team who, although they did their best, could not always answer all the family's questions. This also delayed the decision-making process. Finally, I criticised the board's complaints handling. Their investigation did not identify some significant failings in Mr A's care and treatment, and they did not show me that they had fully addressed the failings they did identify.

I made six recommendations, which can be read in full in my report. They include that the board carry out a morbidity and mortality review of Mr A's case, which examines some very specific areas of his care, and that the outcome of that review is included in the appraisal of the consultant involved in Mr A's care.

Investigation Reports

Investigation report ref: 201305288

Clinical treatment, communication, complaints handling

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

SUMMARY

Mr B was in prison but was due for release. His mother had filled in registration forms for him at the GP practice and made him an appointment for the day of his release. She did this so that he could get medication to help him with methadone withdrawal. She confirmed the appointment two days before his release, but meanwhile the board's registration service contacted the practice saying that they could not register Mr B until he was released. The practice manager cancelled his registration and told staff members to let him and his mother know about this, but they did not do so. When Mr B was released, he went for his appointment but was told his registration had been cancelled and the appointment cancelled, and he would need to complete forms to re-register. He was upset about this and demanded to be seen, as he urgently needed medication. The practice manager told him that a GP would not be able to prescribe in the circumstances, and gave him contact details for other organisations, including NHS 24. Mr B eventually left without having seen a GP. He died from pneumonia three days later.

Mr B's mother said that, as well as needing the medication, her son had complained of lung pain. She felt that had he been seen his condition might have been diagnosed and treated. After complaining to the practice, she came to me, through an advice worker, with the complaint that her son was unreasonably refused access to a GP, and that the practice did not respond to further letters about the complaint. The practice manager responded to the initial complaint by saying that although she acknowledged and was dealing with the communication failures, she had given Mr B the best possible advice in the circumstances. In later correspondence with me, she acknowledged that there were unacceptable delays in responding to the later letters, which she ascribed in part to changes within the practice.

This was a case in which there were significant delays during the complaints process, which took almost a year before I became involved. Even I had great and unusual difficulty in getting information from the practice. Ultimately, I had to involve the NHS board with which the practice is contracted. When I eventually received a response, I took advice from one of my medical advisers, an experienced GP. My adviser said that the practice could have registered Mr B when he went there. Although Mr B's request was a difficult one, his health needs were not assessed as they should have been, to see if he needed immediate treatment. The practice manager should have asked him to wait until a GP could see and assess him, and should not have told him to contact NHS 24 – the practice's contract with the board required them to see and assess him that day.

I upheld the complaints as, although I could not say whether seeing a GP would have had a different outcome for Mr B, it was clear that he should have been seen when he went to the practice. I also found that although the original complaint was handled reasonably quickly, there was then a complete failure to acknowledge or address further enquiries. I noted that GPs at the practice were not involved in these events. I also noted that since then, having becoming aware of this through my investigation, they have taken significant action to learn from what happened. They are working with NHS agencies on this and on improving their complaints handling. In the circumstances, however, I made a number of further recommendations, which can be read in full in my report. These included apologising, providing me with copies of their analyses of these events and ensuring that all practice staff are fully trained on registration and complaints handling procedures.

Complaints Standards Authority (CSA)

NHS model complaints handling procedure

We have previously reported on changes to the NHS complaints handling arrangements, with the Scottish Government committing to align the current NHS complaints arrangements with those in place in other sectors. The Complaints Standards Authority will work with boards and other stakeholders to develop a model complaints handling procedure (CHP) for the NHS, which is in line with the framework of the Patient Rights (Scotland) Act 2011 and takes account of the 'Can I help you? guidance for handling and learning from feedback, comments, concerns or complaints.

The revised procedure will encourage more early local resolution of NHS complaints wherever this is possible. In line with other model CHPs in operation across the public sector in Scotland, there will be two stages to the revised procedure – a distinct, five working day stage for early, local resolution of complaints, ahead of a 20 working day investigation stage. These changes are intended to support NHS providers to improve outcomes for people using their services, by helping them to resolve more complaints quickly at the early stages, and improve performance in meeting the subsequent 20-day target.

We are currently engaging with the sector with a view to developing the NHS model CHP over 2015/16. Working together with NHS Education for Scotland, we are currently working through a program of 'Master Class' events for NHS Middle Managers as part of our engagement with complaints practitioners within the NHS sector. Events have been held in Edinburgh and Glasgow, with further events scheduled for Aberdeen and Inverness.

Local government

The local authority complaints handlers network met most recently in March. Members considered a presentation on 'Actively Managing Complaints' as well as further analysis of the 2013/14 annual complaints reports, and held a complaints surgery, a standing item at each network meeting. They also considered the key performance indicators and options for continuing to improve the way complaints performance information and learning is analysed and benchmarked across the sector.

Housing

The housing complaints handlers network will meet in Glasgow at the end of March, and will reflect on how the CHP has worked in practice and how registered social landlords can continue to improve their performance reporting and develop a performance and learning culture. The network will also hold a complaints surgery to facilitate sharing of learning and common issues and challenges and allow members to share good practice in complaints handling.

The network is run by the sector for the sector, and aims to identify, evaluate and share good practice in complaints handling. It also seeks to compare and contrast complaints handling performance with a view to benchmarking and sharing the learning from complaints handling.

If you would like to attend future meetings of the housing complaints handlers network, please, in the first instance drop us an email to confirm to **csa@spso.org.uk.** We will pass your details to the lead housing officers for the network.

Complaints Standards Authority (CSA)

Further education

The further education complaints advisory group will host a workshop in May for benchmarking complaints performance in the sector. They will provide further details by early April. The advisory group has agreed that, to allow for a meaningful baseline of annual complaints data, colleges will be asked to provide their data in a consistent format in advance of the workshop. Again, further details will be provided by early April.

Higher education

The next meeting of the higher education complaints forum will take place on 23 April 2015 at the Paisley Campus of the University of the West of Scotland.

As a reminder, we ask that higher education institutions that have not already done so to please provide us with their annual complaints report, or a link to their published annual complaints report online, by contacting us at **csa@spso.org.uk**

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

Managing Difficult Behaviour: 1 day open course
Wednesday 15 April 2015, in 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 To apply for the course, please email **training@spso.org.uk**

Complaint investigation skills (stage 2 of the model CHP): 1 day open course
Wednesday 27 May 2015, central Edinburgh

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Wednesday 27 May 2015 in 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@spso.org.uk**

For more SPSO course information, please visit the SPSO Training Unit website:
www.valuingcomplaints.org.uk/training-centre/

Save the date:
SPSO Conference, Thursday 8 October 2015

With a range of keynote speakers, interactive workshops and cross-sector networking opportunities, our one-day conference will focus on helping you implement improvements to your complaints handling, quality assure your complaints responses, and maximise learning from complaints using root cause analysis.

Location: **COSLA conference centre, Edinburgh (near Haymarket train station)**

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

Spaces will be limited, but to register your early interest or for more information, please contact training@spso.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, 18 March 2015

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

For further information please contact:

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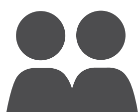
The Scottish Public Services Ombudsman

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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