SPSO NEWS

FEBRUARY 2013

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today, about complaints about three different health boards. We also laid a report on 54 decisions about most of the sectors under our remit. All of the reports can be read on the 'Our findings' section of our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in January 2013) in addition to the two investigation reports we laid before Parliament, we determined 366 complaints and handled 43 enquiries. Taking complaints alone, we:

- gave advice on 234 complaints
- resolved 81 in our early resolution team
- resolved 51 by detailed consideration
- made a total of 83 recommendations in decision letters.

Ombudsman's Overview

In last month's overview, I reported on my evidence session to the Parliament's Health and Sport Committee about the regulation of the care of older people in acute settings. Soon after, the media spotlight fell on the findings of the public inquiry into failings at the Mid-Staffordshire NHS Foundation Trust. The Francis Report made for distressing and all too familiar reading, and underlines once again the traumatic consequences of poor nursing and failings in clinical treatment. I appreciate that these issues are very much in people's minds at present, and this makes us redouble our efforts to bring about change.

When we investigate concerns brought to us by the public, and if we find that things have gone wrong, we try to ensure that the same things do not happen again to someone else. We do this through our recommendations. We may recommend, for example, that a health board should review or change their practices or policies, or carry out training or awareness raising. Very often, we recommend that they make a full and meaningful apology to the people who have brought the complaint. As two of the reports I lay today make clear, the significance of handling complaints well cannot be understated. When something goes wrong, people need to have full explanations that they can understand, delivered in a timely and empathetic way. This is particularly important where they have been suddenly bereaved.

Handling complaints well is something that we as an organisation also take very seriously. I was questioned about customer service and the quality of our service at the second of the evidence sessions I attended last month. I explained to the Local Government and Regeneration Committee how we survey users of our service, carry out quality assurance, and seek external validation of our process. The wealth of information we seek from these and other sources helps shape improvements we make to our service through, for example, staff training. We recently asked the Samaritans to run courses for our complaints reviewers about effective communication with people who are severely distressed or angry. We recognise that the softer skills of understanding and listening can be just as important as expertise in technical jurisdictional matters, and that we have a duty to support staff and complainants in dealing with the sometimes harrowing stories that we investigate.

Complaints Standards Authority Update

Local authority complaints handling procedures (CHPs)

We are pleased to report that most local authorities have either implemented, or are nearing the point of implementation of, the model CHP with many rolling out full programmes of staff training ahead of implementation. We have received a majority of draft CHPs from those local authorities required to provide these by 30 January 2013 and will shortly respond with our assessment of compliance. Local authorities who have still to provide these drafts should do so soon.

Local authority complaints performance indicators

The local authority complaints handling network met on 25 January 2013. The primary focus was on monitoring and reporting complaints performance including developing performance indicators. The network agreed to further develop the detail of the SPSO indicators, previously outlined in the CHP *Guide to Implementation*, which will be a requirement for local authorities to report against from 2013/14. Further detail on these indicators has been circulated to the network for comment ahead of publication by the end of March 2013, although the list of indicators remains similar to those previously published.

Please contact the CSA (**csa@spso.org.uk**) if you would like to contribute to the local authority complaints handling network's discussions on the performance indicators.

NHS e-learning

We are currently developing, with NHS Education Scotland (NES), a set of e-learning modules for NHS staff to provide training and guidance on feedback, comments, concerns and complaints as outlined in the NHS *Can I Help You* guidance published in 2012. This is part of a two-year project to develop wider education and training across all levels of the NHS to help improve the handling of, and learning from, feedback, comments, concerns and complaints.

The modules will be piloted shortly and will be available in the coming months.

Further and higher education

Following publication of the model CHPs for further and higher education in December 2012 we are planning further engagement with both sectors. We are planning a stakeholder event for universities in March/April for representatives to discuss the requirements of the HE model CHP and discuss issues and challenges around implementation.

For colleges we have planned further engagement with Scotland's Colleges following an event with college representatives in November 2012. This will aim to develop the model CHP into a single CHP to be adopted in its entirety by the sector.

Further details will be provided when available, including through the Valuing Complaints forum (see **www.valuingcomplaints.org.uk/forum**)

We are, of course, happy to provide specific advice or support to colleges and universities in relation to their implementation of the CHP by August 2013. Please address any questions about the model CHP, or the requirement to implement, to the CSA at **csa@spso.org.uk**

Scottish Government, Scottish Parliament, agencies, NDPBs and associated bodies

We are currently developing the model CHP for this sector which will include all agencies, NDPBs and associated bodies under the SPSO's jurisdiction, as well as the Scottish Parliament and Scottish Government departments. This will be available in the coming months along with details of the requirement to implement in 2013/14. The CHP will be broadly in line with those developed for other sectors so far. Any enquiries relating to this CHP should be directed to **csa@spso.org.uk**

Training and Valuing Complaints forum

Our e-learning training modules on frontline resolution are available at **www.spsotraining.org.uk**. These have been developed to help with the introduction of the model CHPs for each sector. The training is available to all public sector staff and is currently free.

We would also encourage all complaints handlers to log on and join the discussions on the online complaints handling forum at **www.valuingcomplaints.org.uk/forum**. If you have any questions on implementation, put them up on the forum and you will get a response from the CSA team or from other complaints handlers.

Fair and Equal: How does the Equality Act 2010 affect complaints handling in Scotland?

As we have highlighted in previous updates, we have published an article on our Valuing Complaints website which explains that for people working in the public sector, including in complaints handling, there are many implications of the Equality Act.

We would encourage you to read this article which can be found **here**. We would ask anyone working in complaints handling in the public sector in Scotland who has already begun to work on equality and complaints handling, developed good practice policies and procedures or indeed is struggling with a particular area of the Equality Act, to provide comments on the article or ask questions through the Valuing Complaints forum or by contacting the CSA team.

See the CSA's website for more information: **www.valuingcomplaints.org.uk**

Investigation Reports

Investigation report ref: 201103310

Delay in sending ambulance; complaints handling

Scottish Ambulance Service

Summary

Mrs C raised concerns about the length of time it took for an ambulance to attend an emergency at home when her husband (Mr C) became gravely unwell. After Mrs C phoned 999, the ambulance took 24 minutes after mobilisation to arrive at her house, even though it is located only a couple of minutes from where the ambulance was dispatched. Mrs C's husband died that day. Mrs C also complained about how the Scottish Ambulance Service handled her complaint. I upheld both complaints, noted that action has already been taken to rectify some of the failings, and made a number of recommendations.

The service attributed the delay to failures in the system and by the call taker. It is clear that a combination of factors meant that the crew had difficulty in finding Mrs C's address. Although my investigation found that the resulting delay was not reasonable, the advice I accepted was that the delay would not have changed the outcome for Mr C. However, the failures by the service led to a significant personal injustice to Mrs C in that the delay exacerbated what was already a very traumatic experience for her.

On the complaints handling issue, it was clear that the service attempted to explain what was a complex problem. However, their response was overly technical and they failed to apologise for the significant shortcomings they had identified that led to an unreasonable delay in the ambulance's arrival. They also failed to acknowledge and apologise for the significant distress that this caused Mrs C. I found and criticised a significant delay in their complaints handling as, overall, it took nearly a year for the service to issue their formal response. This is unacceptable and insensitive, as was the delay in investigating. My report concludes that, given the nature of the complaint, the service should have investigated as a priority to ensure that any systems failures in the emergency callout service were rectified.

Investigation report ref: 201102952

Care of the elderly; clinical treatment; diagnosis; communication; record-keeping

Highland NHS Board

Summary

Mr C raised a number of concerns about his late father (Mr A)'s care and treatment in hospital, where he died four days after admission. Mr A was 92 years old, and was admitted with constipation. He was treated with a powerful laxative and subsequently suffered acute respiratory distress, which Mr C complained was not taken seriously nor treated effectively. Mr C also complained that he had not, as the nursing notes stated, had a discussion in which he had agreed that his father should not be resuscitated should he suffer a cardiac arrest. He said that neither he nor his father (who, although elderly, was fully mentally competent) had been given the opportunity to prepare for his death.

In the course of this investigation I took independent medical advice from a consultant in acute medicine for older people. After considering this advice, I found no evidence that the laxative treatment was unreasonable. However, I did establish that several clinical management failings occurred when Mr A started to vomit two days after admission. I found that at this time and for the next 36 hours there was a failure to ensure appropriate investigation, assessment or management of Mr A. I was also critical that the first documented medical review of Mr A's changed condition took place the evening before he died and happened after Mr C expressed concern to a nurse about Mr A's condition. Furthermore, the doctor who reviewed Mr A may not have been aware of Mr A's condition, as there was no documentation of the events of the early hours of the previous day, no record in the medical notes, and the examination carried out was solely based on findings. While I accepted that, had the hospital taken different action, it was perfectly possible that the outcome would have been the same, given Mr A's age and the description of him as physically frail, this is no reason for the impact of these failures to be diminished.

The adviser also found that there was no documentation of Mr A's cognitive function or capacity to participate in decision making. When Mr A first attended the hospital he was not acutely unwell and there was no evidence of established sinister, malignant or life-limiting disease that would justify a palliative approach to an unexpected acute illness. The adviser was unable to locate any medical documentation of the resuscitation discussion or decision, or any Do Not Resuscitate Form. These failings in such important aspects of end-of-life care fell below an acceptable standard and I therefore upheld the complaint about the lack of effective communication with Mr A, and with Mr C and his wife.

I made ten recommendations for redress and improvement, which can be read in full in the report.

Investigation report ref: 201201464

Clinical treatment; diagnosis; hospital discharge

Borders NHS Board

Summary

Mr C was a 70-year old man who was admitted to the Accident and Emergency (A&E) department of a hospital after losing consciousness at home. He was examined by a doctor who concluded that Mr C had cystitis (a urinary tract infection). Mr C was sent home with antibiotics and painkillers and his family were told that if they were anxious at any time they should bring him straight back to A&E. Shortly after returning home, Mr C experienced more pain and started to lose consciousness again. His family called an emergency ambulance and he was readmitted to A&E. After a scan it became evident that Mr C had an abdominal aortic aneurysm (a ballooning of part of the large blood vessel in the abdomen), which had ruptured. Mr C died early the next day. His wife (Mrs C) questioned the care and treatment given to her late husband after he was admitted on the first occasion. She complained to me that staff failed to thoroughly assess and treat her husband, and then unreasonably discharged him home.

In response to the complaint, among other things, the board said that the type of aneurysm that Mr C suffered was rare and not easily spotted. Although Mrs C thought that her husband should have been scanned earlier, they said it was not routine to scan all patients who had abdominal pain. The decision on whether to do so would be a matter of clinical judgement, based on the patient's symptoms and the doctor's clinical findings

In investigating the complaint, I carefully considered all the information from Mrs C and the board, and obtained an independent clinical opinion from an emergency medicine specialist adviser. The adviser said that, in his view, the symptoms with which Mr C presented meant that he was in the 'immediate' (red) category. This meant that he should have been immediately referred to and assessed by a doctor. The adviser said that Mr C's clinical notes did not show an appropriately detailed history and examination note, or any obvious attempt to rule out certain, potentially serious, reasons for Mr C's condition. The documented history, therefore, fell short of what could have been expected, as did the documented examination. Given Mr C's age and condition, intravenous fluids should have been administered and an urgent ultrasound scan taken. The adviser said that this would not necessarily have meant that the outcome would have been different, but it might have improved the possibility of survival. He also took the view that Mr C should not have been discharged after his first admission.

I noted that the board had learned from the events in this case and had put in place a number of changes so I made no recommendations relating to the care and treatment provided. I recommended that they apologise to Mrs C for the failures of care and treatment identified in my report, and for unreasonably discharging Mr C from hospital.

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 February 2013

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.