
Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today. We also laid a report on 70 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in November), we received 452 complaints. In addition to the two reports we laid before Parliament, we determined 450 complaints and of these we:

- gave advice on 316 complaints
- handled 64 complaints in our early resolution team
- decided 70 complaints through detailed consideration
- made a total of 72 recommendations in decision letters.

Ombudsman's Overview



Investigation reports

I am publishing my first public investigation report about the water industry since this area came under our jurisdiction in August 2011. I am publishing this investigation in full, because the repeat failings in complaints handling at Business Stream need to be addressed. I am also publishing two other investigation reports, one about a mother who was not given the opportunity to consider birthing options, and one about delays in post programme reporting by the Scottish Prison Service.

Customer sounding board

Our customer sounding board, made up of representatives of different public service user groups, met for the first time in early December. It was a positive meeting and the board will be a useful forum for helping us with our current review of our customers' journey, ensuring that we continue to build clarity, transparency, timeliness and empathy into our service. Other areas of discussion were effective user feedback mechanisms, and raising awareness of our service with hard-to-reach groups. The sounding board also highlighted that trust in complaints processes comes from people seeing that complaining leads to change – a pertinent reminder that we need to bear in mind as we continue to review and improve how we report the impact of our work.

The current members are Citizens Advice Scotland, the Scottish Independent Advocacy Alliance, the Tenant Participation Advisory Service, Patient Opinion, Alliance Scotland, a prison visiting committee, Consumer Futures and Age Concern.

Evidence to Committees

Another way we share learning from the complaints we consider is through written and oral evidence to parliamentary committees. This month, I and members of my senior management team gave evidence to Holyrood's Local Government and Regeneration Committee about our 2012/13 annual report and local government complaints report. I also gave evidence to Westminster's Public Administration Select Committee (PASC) inquiry into Parliament's Ombudsman Service. This is one of PASC's two inquiries into complaints handling, and I was pleased to be invited to share Scotland's experience and practice, including the benefits of direct access to our service (with no requirement for the public to go through their member of Parliament) and simplification of the complaints landscape.

Our written evidence to the committees and transcripts of the sessions are available at <http://www.spsso.org.uk/consultations-and-inquiries>.

Further and higher education complaints reports

Since my last e-newsletter, we have published two more sectoral complaints reports, about the further and higher education complaints we considered in 2012/13. Like the other sectoral reports we have published, they contain:

- key complaints figures
- issues and themes arising from the complaints we see
- how we share learning and how we work with other organisations
- an overview of the relevant activities of our complaints standards authority
- our policy engagement.

Our final report, about Scottish Government and devolved administration complaints, will be published later this month.

To read the reports and access other sectoral information, visit <http://www.spsso.org.uk/sector-specific-information>.

To view our annual statistics, visit <http://www.spsso.org.uk/statistics>.

Investigation Reports



Investigation report ref: 201300283

Billing; complaints handling

Business Stream

Summary

Mr C complained on behalf of his client, Forestry Commission Scotland (FCS). He alleged that a secondary water meter had been installed on FCS's private water supply pipe and that water had been charged for twice. He also complained about the way in which his subsequent complaint was handled. I upheld both complaints, and made a number of recommendations for redress and improvement.

Mr C said that a number of years ago, with permission, FCS installed a water pipe to connect with Scottish Water's main supply. He explained that the pipe remained within FCS ownership although Business Stream charged for the water it supplied. However, Mr C said, without the permission of FCS, a meter had been attached to the supply pipe for premises at a property adjacent to FCS's water pipeline. This was despite the fact that a private arrangement for water already existed between FCS and the owner of the property.

Mr C supplied invoices for the property in support of his contention that water paid for by FCS was being paid for twice and that an unauthorised meter had been attached to FCS pipework. However, Business Stream understood this to mean that he wished to primarily concern himself with the property owner's account, even though Mr C had clarified his complaint and questioned the time being taken to deal with it. Business Stream responded saying that they could not discuss the matter with him because of data protection legislation and that they had gone back to Scottish Water to ask them to investigate the 'shared water supply'. This was despite the fact that it was already known that a meter had been fixed to the pipe without permission and that, throughout, Mr C had maintained that the water provided by the FCS pipe was paid for by them. I found that Mr C was still having to explain his complaint six months after he made it. As my report says, I can readily understand his frustration with the delay and obfuscation.

My investigation found that there was unnecessary and protracted correspondence about the matter, and that Business Stream did not provide Mr C with a clear answer to his concerns. Further, although it was undoubtedly FCS's decision to appoint Mr C to deal with this matter, I concluded that an apology on its own was an inadequate remedy for the complaint, given that this was essentially a straightforward matter. I recommended that Business Stream also reimburse FCS's fees (subject to proper invoices being presented) for the work Mr C carried out for them from July 2012 until November 2012 when it was known that there was a second meter attached to their water pipe.

I am also critical of Business Stream's responses to my office. Given the information available to them, it was insufficient for Business Stream to tell us that they knew nothing about the installation of the meter or whether permission had been sought to install it, when it was clear that a meter had been installed and they had billed on the basis of it.

Business Stream accepted that they had taken too long to deal with this complaint. They were unable to explain why, other than to say that it should have been dealt with once it was established that they should not have been charging the property owner for water. They also said that they had taken the matter further and were using a new system. However, I remain concerned that Business Stream failed to understand the nature of the complaint, despite Mr C's repeated efforts to explain that his concerns were on behalf of his client. While I note that they say new procedures have been put in place which should prevent a similar occurrence, no reference is made to the culture of the staff concerned and their relationship with the public. In this case there was a tendency not to listen to what Mr C was saying or to provide a clear and direct response to questions. This also applied to their responses to us, with a reliance on the use of internal jargon. I recommended that Business Stream conduct an independent audit of their complaints process and how it is applied. I also recommended that they formally apologise to Mr C for the delay in dealing with his complaint and for the confusion and inconvenience caused.

Investigation Reports



Investigation report ref: 201203251

Clinical treatment; communication; record-keeping

Highland NHS Board

Summary

This complaint concerned the care provided to a woman during her pregnancy and the delivery of her baby daughter. Ms A was admitted to Raigmore Hospital as her waters had broken. The next day labour was speeded up, but her baby was stillborn following shoulder dystocia (when the baby's shoulders become caught in the mother's pelvis).

The events leading to the complaint date back almost two years, and this has been a complex investigation involving obtaining independent advice from a number of specialists. My main criticism of the health board is the lack of discussion of birthing options with the mother, and in my report I acknowledge the trauma and loss that she has suffered. The complaint was brought on behalf of the mother by an advice worker, Miss C. I upheld it in full and made a number of recommendations.

Miss C complained to the board that Ms A had no extra scans or checks carried out during her pregnancy despite being on an amber pathway for maternity care and being told that her baby was big. The amber pathway relates to NHS guidelines, according to which women with potential medical/obstetric/social risk factors should be further assessed or referred to the appropriate health professional for further assessment and support. Miss C said that this, along with the size of Ms A's baby and her medical history, meant that Ms A felt that different birth plans should have been in place. In addition, Ms A felt that more checks should have been carried out when she was in hospital in a lot of pain. Ms A was also concerned that staff did not have her previous clinical notes and did not know about complications she had experienced during the birth of her first two children.

In investigating this complaint, I carefully considered the board's responses to the original complaint and to my further enquiries. I took independent advice from my midwifery adviser and from a consultant in obstetrics and gynaecology. I concluded that reasonable reviews were carried out after Ms A was admitted and that the emergency situation of shoulder dystocia was appropriately managed, in that reasonable manoeuvres were attempted after this was diagnosed at the time of delivery. Ms A's previous history of shoulder dystocia had been documented when she was admitted to the antenatal ward. However, I was concerned that there was no clear evidence to show that the midwife on the labour ward was clearly aware of Ms A's previous complications. It would have been good practice for the antenatal ward midwife to have noted this in the handover note to the labour ward midwife, who would thereafter be on alert to call for assistance if required. That being said, the advice I received was that it was unlikely to have changed the outcome as appropriate staff were called when shoulder dystocia was diagnosed.

On the baby's size, while I recognise that Ms A was concerned about being told that her baby was big, I accepted advice that the measurements documented showed that her baby's growth was within normal parameters and that the 20-week scan showed no abnormality. I, therefore, considered it was reasonable that staff did not consider further scans at that time. However, taking into account clinical guidelines and Ms A's previous history, I was not satisfied that a discussion in line with the guidelines took place with her about the risks of recurrent shoulder dystocia and the birthing options. Although it is not mandatory to recommend elective caesarean section routinely, there was no evidence to support that Ms A was given the opportunity to make an informed choice about birthing options. It is not possible for me to say what options Ms A would have considered had these discussions taken place. However, I am clear that she was not given the opportunity to make a considered choice in relation to birthing options and I am critical of this.

I made several recommendations, including that the board apologise to Ms A for the failings identified in my report; review their guidance to staff on the antenatal management of women to ensure that the risks of recurrent shoulder dystocia are discussed with expectant mothers together with birthing options; and draw to the attention of the antenatal midwife who looked after Ms A the importance of documenting previous history of shoulder dystocia in the handover note to the labour midwife.

Investigation Reports



Investigation report ref: 201202918

Policy/administration; complaints handling

Scottish Prison Service

Summary

Mr C, who was a prisoner, complained to the prison about the unreasonable delay in finalising his post programme report for the core sex offender treatment programme (SOTP). This is an offending behaviour programme delivered by the Scottish Prison Service (SPS) designed to provide treatment of specific risk factors in men who commit sexual offences. Mr C also complained that the prison failed to take appropriate steps to resolve his complaint. I did not uphold this complaint, as I found that the prison had taken steps to try to resolve Mr C's complaint, but I did uphold the first complaint and made a recommendation to the SPS.

Mr C completed the programme in March 2012. His post programme report was finalised eight months later, in November 2012. The SPS confirmed that the timescale for completion of such a report was 16 weeks – four months – from the date the prisoner finished the programme. In Mr C's case, there was a four month delay in completing his report.

When a prisoner completes a programme, their post programme report will be reviewed by the prison's programmes case management board who will decide whether the prisoner requires any further intervention. Prisoners are often keen to participate in any identified programmes within a reasonable time so that they can progress to less secure conditions before the parole board review their case. This increases their chance of being released and the SPS' risk management and progression guidance supports that process.

Mr C's parole qualifying date – the date he would be considered by the parole board – was August 2012. The parole board did not recommend his release at that time because it was likely that he required further intervention. Mr C's post programme report confirmed that this was the case. The parole board also recommended that Mr C be tested in less secure conditions.

Because Mr C's liberation date was less than 16 months from the date the parole board considered his case, there was then no further review. Mr C was automatically released from custody after serving two thirds of his sentence (this is known as his earliest date of liberation) in August 2013. He was released from closed prison conditions into the community to serve the remainder of his sentence on licence, without having had the opportunity to be tested in less secure open conditions.

In considering Mr C's complaint, I have taken account of what impact the delay in finalising his post programme report had on his progression. In particular, I am left questioning whether if the report had been completed within the relevant timescale, the circumstances, in that Mr C was released into the community from closed conditions without being given the opportunity to address his identified needs, might have been avoided.

I also question the SPS' explanation of why there was a delay in completing Mr C's report, and in particular, the impact that a change to the prison regime had on its psychology resources. It is of concern that sex offenders were transferred to the prison in October 2010 but that the prison was not adequately resourced to facilitate relevant treatment programmes for several months. In my opinion, this impacted negatively upon Mr C's potential to progress.

The recommendation that I made is that the SPS review the current resourcing and management of sex offender programmes to ensure appropriate steps can be taken to avoid unnecessary delays in completing post programme reports.

Complaints Standards Authority update



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

We have received confirmation of intention to implement the model complaints handling procedure (CHP) from almost all organisations in this sector as they work towards the deadline of 31 March 2014. We continue to receive contacts from a range of bodies in relation to implementation and our CSA team are happy to provide support and advice in the lead up to implementation in the new year.

Local government

As reported in last month's update we are undertaking a sample assessment of the accessibility of local authority CHPs and the quarterly publication of outcomes, trends and actions taken in line with CHP requirements. Given that we are approaching the end of quarter 3, we are keen to assess good practice in relation to local authorities' monitoring and reporting of complaints outcomes and learning from complaints. The outputs of our review and examples of best practice will be discussed with the local authority complaints handlers network at its next meeting.

The CHP requires local authorities to report outcomes, trends and actions taken on the complaints they have received. We expect this to contain details and information on a broad range of complaints received, rather than simply focused on a small number of case studies. What we are seeking is comparable, consistent and transferable learning on complaints which will help to focus on areas of improvement for the sector as a whole. We are keen to help the sector build on this and improve the mechanisms for sharing information on complaints across the sector.

Housing

We have completed our assessment across a random sample of registered social landlords (RSLs) in Scotland and have been greatly encouraged by the results. Assessment focused on compliance with the requirements of the model CHP, including the definition of a complaint, accessibility to the CHP via website and leaflets, timescales, stages and signposting to the SPSO. The outcomes of the assessment are positive with the vast majority compliant, subject to minor amendments which have been or are now being addressed. We are awaiting further information from these RSLs on their recording, reporting, learning and publicising of complaints, with evidence that they are meeting the reporting requirements of the CHP. We will report the outcomes of this assessment to the Scottish Housing Regulator.

NHS

In partnership with NHS Education for Scotland we are continuing to develop and roll out further training and awareness for NHS staff, recently delivering a number of training sessions for GP practice managers.

The Ombudsman completed a series of complaints and governance masterclasses for Executive and Non-Executive NHS board members, with the final session delivered in December in Edinburgh. As previously reported, the focus of the sessions was on the importance of complaints in good governance and their value as indicators of performance, service quality and risk, particularly for health boards in the light of the findings of the Francis report.

A video recording of this session will shortly be available on the NHS Education Scotland website.

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 December 2013

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

For further information please contact:

Emma Gray

Communications Team

Tel: **0131 240 2974**

Email: egray@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



CONTACT US

T **0800 377 7330**

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

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