

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid two investigation reports before the Scottish Parliament today. We also laid a report on 65 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 June), we received 368 complaints. In addition to the four reports we laid before Parliament, we determined 401 complaints and of these we:

- gave advice on 271 complaints
- handled 85 complaints in our early resolution team
- decided 41 complaints through detailed consideration
- made a total of 73 recommendations in decision letters.

Ombudsman's Overview



Investigating complaints

There has been a great deal of review, scrutiny and public discussion of complaints handling in the NHS in England over the past weeks and months. Understandably, this causes concern in Scotland as well, among patients, relatives, carers and healthcare professionals in the many environments where people are ill and cared for. It also highlights the role of all of us whose aim is to ensure that complaints are investigated robustly and transparently, that failings are addressed and learning from complaints is shared to prevent the problem happening again. Importantly, it also shows the need for assurance that the various organisations responsible for inspecting and improving services and dealing with complaints are talking to one another.

Our 2012/13 report on NHS complaints in Scotland is due to be published later this summer. As I have said in previous e-newsletters and elsewhere, we are taking a different approach to publishing information about our work this year. Our annual report will chart progress against our 2012/16 Strategic Plan and is devoted largely to corporate information. We will publish separate, more in-depth statistics, trends and analysis about each of the main areas under our remit over the rest of the summer and early autumn.

However, given the level of concern about NHS complaints, I want to make a number of points clear today. In 2012/13, we published the outcome of a total of 850 investigations – 806 decision reports and 44 full public reports (investigations that satisfied my public interest criteria and which we publish in detail). Of these, 330 decision reports and 34 detailed reports were about the NHS. We carry out more investigations into the health sector than any other area under our remit, in part because in health complaints we have greater powers, in that we can look at professional judgement.

We make all our reports publicly available on a regular basis, publishing around 30 decisions about the NHS each month, and drawing attention to specific issues or trends in this e-newsletter. Today, I am highlighting failings in the care of vulnerable adults in five published decision reports and one detailed investigation report.

The detailed investigation report helps me make my final point, which is about our relationship with inspectorates, regulators and others who work to improve public services. Our role is to seek redress for people at an individual level. However, if an investigation points to the possibility of a systemic issue, we can and do make broader recommendations as well as publicly alert the appropriate regulator to look into the matter. Today's investigation report is one such example, where I have drawn issues of concern to the attention of the Mental Welfare Commission for Scotland (MWCS). In a previous report (case 201003482) I looked at an issue on which the MWCS had already conducted a review, because I decided that the SPSO's approach of focusing on finding answers to an individual's experience would add value. As I said in my comments about our investigation report at the time, there can be insight and learning from the different approaches of organisations with different roles (to read my April overview see http://www.spsso.org.uk/files/webfm/Commentaries/2013/2013.04.24_SPSO_Commentary.pdf).

What is essential is that organisations share information and concerns, within the legal limits under which they operate, especially where there may be any risk to the public. Our arrangements with professional regulatory bodies, regulators and others are set out in a series of protocols and Memoranda of Understanding, which are published on our website at <http://www.spsso.org.uk/freedom-information/spsso-publications-list/about-spsso>.

Vulnerable adults

A key theme of some of the reports I am publishing today is the care of vulnerable adults. I have raised this issue several times in previous e-newsletters and annual reports, highlighting a lack of awareness or misunderstanding of the Adults with Incapacity (Scotland) Act 2000. This has led to problems such as failing to assess a person's capacity to make decisions for him/herself on admission to hospital, or to recognise a carer or family member's role when making decisions about the treatment of a vulnerable adult.

All of the cases I highlight today came about from an overwhelming sense of frustration on the part of the family, carer or advocate as they, unsuccessfully, tried to get their concerns heard and taken into account. One complaint (case 201104966) was brought to us by an independent advocate and was about the care of a woman (Miss A) who had Down's Syndrome, a learning difficulty and severe dementia. She had no family and no welfare guardian. The advocacy worker had been appointed to ensure that Miss A's rights were enforced and protected.

The advocacy worker complained to us after Miss A's death about two aspects of her care – decisions taken by staff about artificial feeding, and lack of consultation with the advocacy worker about a decision taken in advance not to resuscitate Miss A if she had a cardiac arrest. I upheld Ms C's complaints, and a further complaint about an inaccuracy in the board's response to her complaint. While I recognise that the board have made a number of positive changes since the time of the circumstances that gave rise to this complaint, I am critical of the quality of decision-making, consideration of capacity issues and recording of these issues with respect to a most vulnerable member of society. I have also referred this case to the Mental Welfare Commission for Scotland who have an oversight role in this area.

Five decision reports published today also concern the care of vulnerable people. Like the detailed investigation report I describe above, we make these reports available on our website at www.spsso.org.uk/decision-reports, to raise awareness of our findings as a tool for learning and improvement.

One of the reports (case 201104503) is about an elderly woman with Alzheimer's disease, who was taken to hospital after she broke her hip in a fall at her care home. After she was discharged she fell again and broke her arm. She did not recover, and died in hospital. Her capacity was not assessed while she was there and there was failure to communicate with her daughter who held welfare power of attorney. We also highlighted our finding about a Healthcare Inspectorate report. The board had said in their response to the original complaint that this report found that they were delivering a high standard of care to elderly patients with cognitive impairment. However, our investigation found that it had, in fact, highlighted the need for improvements in the areas of assessment and care planning. We made several recommendations as a result of this investigation, which can be read in the decision report on our website.

A second complaint (case 201200935) was about a man with dementia, for whom a brother had welfare and continuing power of attorney. The man's capacity was not fully assessed in hospital and communication needs were not met. A further complaint (case 201103345) was from the son and daughter of a man who died in hospital several weeks after being admitted with a urinary tract infection. The man's daughter was unhappy that during an earlier hospital admission, no senior member of staff contacted her to discuss her father's care, even though she held a power of attorney for her father. In particular, she was concerned about the hospital's decision to withdraw life supporting medication during the first admission and, while we did not uphold the complaints about her father's clinical treatment, we made a recommendation to ensure that when changes in medicines are made for patients with diminished capacity, such changes should be discussed with their carers.

Another complaint (case 201200873) concerned a woman with dementia whose sister was welfare guardian. We upheld the sister's complaint that she was not consulted, as she should have been, by the GP about a prescription for a drug given to the woman. In a further investigation (case 201200060), we did not uphold the complaint but we made recommendations about a very unwell man with learning difficulties, who developed dementia and died in hospital.

All of these cases occurred in the health sector, but this is not the only area where this is an issue. In last year's annual report I said *'For the protection of both patients and staff, it remains vital that authorities across Scotland properly understand and implement this legislation.'* I again urge all relevant authorities to ensure that they and their staff are fully aware of the provisions of the Adults with Incapacity Act. They should also ensure that their procedures and processes take the Act into account, particularly around communication about the needs and care of the individual. Person-centred care should be at the heart of all such processes and too often the evidence in some of the complaints we see shows that it is not.

Investigation Reports



Investigation report ref: 201104966

Artificial feeding; do not resuscitate decisions; adults with incapacity

Lanarkshire NHS Board

Summary

Ms C was acting as an independent advocate for a 55-year old woman (Miss A). After Miss A's death, she complained to us about the board's decisions about Miss A's hospital care and about an inaccuracy in the complaint response she received from them.

Miss A had Down's Syndrome, a learning disability and severe dementia. She needed help with all aspects of daily life and her day-to-day care was arranged by the local authority and provided by a national charity. She had no family and no welfare guardian. Ms C was her advocacy worker, and her role was to ensure that Miss A's rights were enforced and protected.

Ms C complained that the decision to remove a nasogastric tube by which Miss A was being artificially fed was flawed. After considering the medical notes, the board's responses, the relevant legislation and taking independent medical advice, I upheld this complaint. Ms C also raised a concern about a lack of consultation with her about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision. It was not within the scope of the complaint for me to consider whether or not such a decision was appropriate for Miss A. What I considered was whether the decision should have been discussed with Ms C. I concluded that there was a duty on the clinical team to ascertain, if possible, Miss A's prior wishes through either her carers or advocate. However, this did not happen. When Miss A was discharged from hospital, there was also a requirement on the DNACPR form to discuss the decision and again, this did not happen. I therefore upheld this complaint. I highlight in the report that:

'...these complaints raise serious concerns about the quality of decision making, consideration of capacity issues and recording of these issues with respect to a most vulnerable member of society, namely an adult with life-long learning difficulties and dementia. There are a number of legal safeguards which should have been in place for Miss A precisely because of her degree of vulnerability, and it is of considerable concern that there were significant delays in enacting these.'

I also upheld Ms C's complaint that a response from the board contained an inaccuracy. I made two recommendations to the board. These were that they use the circumstances of Miss A's case to review their practice in respect of patients with learning difficulties and/or suspected dementia, with particular focus on a review of the quality of decision making, the recording of decision making and the quality of record-keeping on admission and about DNACPR decisions; and that they review their procedures for investigating complaints to ensure that responses are accurate and can be justified.

Investigation report ref: 201105266

Governance; complaints handling

Public Standards Commissioner*

Summary

Mr C complained about the Commissioner's handling of Mr C's complaint about the actions of a councillor. Specifically, he complained that the Commissioner had failed to investigate his complaint adequately and that there were errors in his Note of Decision that remained uncorrected. I upheld the aspect relating to the Note of Decision, and made a recommendation to address this failing. I did not uphold any of the other aspects of Mr C's complaint.

* From 1 July 2013, the Commission for Ethical Standards in Public Life in Scotland and two existing members – the Commissioner for Public Appointments and the Public Standards Commissioner – were restructured to establish one new office of the Commissioner for Ethical Standards in Public Life in Scotland.

Complaints Standards Authority update

Further and higher education – compliance statements and self-assessments

By the required deadline of 28 June, the vast majority of colleges and universities had provided us with a statement that they had complied with the new model complaints handling procedure (CHP) and their self-assessment. Early indications confirm that significant progress has been made in both areas towards full implementation of their CHPs by the required date of 30 August. We are working through the information provided and will respond directly to each institution advising of the outcome of our assessment.

Further and higher education – e-learning courses

We have been working with representatives from the FE and HE sectors to finalise a complaints handling e-learning programme. This will be made available to all colleges and universities in Scotland through our virtual learning portal.

The e-learning training modules have been developed to help with the introduction of the model CHPs for each sector. They provide an opportunity for staff to think about complaints and how they handle them. They include real life scenarios so learners are able to practice new knowledge and skills in a safe environment and they also demonstrate how complaints can be used to improve services. We are grateful to our sector partners for their help in developing these products.

To register and gain immediate access to the e-learning modules visit the SPSO Training Centre at www.spsotraining.org.uk. For further information about our training unit, including the direct delivery courses we offer, contact Kerry Barker, Training Coordinator at kbarker@spsso.org.uk.

Further education – online complaints handling tool

We are pleased to report that Cumbernauld College, supported and guided by the Quality Development Network and College Development Network, have developed a complaints handling tool that will be available for use by all colleges, permitting a consistency of recording and reporting across the sector. Throughout the development process, Cumbernauld College worked closely with the CSA to ensure that its work complied with the requirements of the model CHP. The launch of the college's 'Online complaints handling tool' is due on 12 August and we commend the sector for its progress in this important area.

Local authority complaints handlers network

The local authority complaints handlers network continues to convene regularly, with the most recent meeting being hosted by Glasgow City Council in June. It was attended by over 30 complaints handlers from across the sector. A full agenda included the further development of a performance management framework; sharing learning about assessing customer satisfaction; and a complaints surgery where attendees helpfully shared knowledge, experiences and their learning from complaints.

The next meeting of the network is on 20 September, and will again be hosted by Glasgow City Council. If you are interested in joining the network please contact CSA@spsso.org.uk and we will provide your details to North Lanarkshire Council, who co-ordinate the network.

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

As a reminder, each organisation is required to comply with the model CHP by the end of March 2014. However, by 30 September each organisation should provide the SPSO with a compliance statement, and a self-assessment of compliance to confirm that their CHP complies with the published model CHP, or will comply by the end of March.

The model CHP and associated documents are available on the CSA website:

www.valuingcomplaints.org.uk. Please contact csa@spsso.org.uk if you have any questions about the model CHP, or your obligation to implement.

SPSO training – investigation skills open course

We will be running an open course in investigation skills (Stage 2 of the model CHP) on 4 September in Edinburgh. The course will be open to all sectors. We will use a variety of case studies and while examples will be mainly drawn from housing and local authority areas, delegates from other areas will have an opportunity to discuss their specific issues.

We have a maximum number of 20 for the course and will allocate places on a first come first served basis (although should there be demand for more we may be able to run a second open course).

For more details about the course including about booking please visit

www.valuingcomplaints.org.uk/training-centre/open-courses or contact us at training@spsso.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, 24 July 2013

The compendium of reports can be found on our website: <http://www.spsso.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.



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