SPSO NEWS

JUNE 2015

Monthly news from the Scottish Public Services Ombudsman

This month we are laying two reports before the Scottish Parliament, both about the NHS. We are also laying a report on 68 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 May), we received 444 complaints. We determined 444 and of these we:

- gave advice on 238 complaints
- considered 144 complaints at our early resolution stage
- decided 62 complaints at our investigation stage.

We made a total of 144 recommendations.

Ombudsman's Overview

I highlight the following matters:

- how SPSO reports are being used to inform parliamentary debate
- this month's ombudsman reports

Parliamentary committees

This month SPSO were invited to give evidence at four different parliamentary committee sessions on a range of issues.

The first session was on Tuesday 2 June with the Health and Sport Committee where we were able to highlight the case relating to palliative care that we **published in our May compendium** about the need to be clear whether or not someone is receiving active treatment or palliative care. As well as noting this case, **our written evidence (PDF, 554KB)** and **our oral evidence** both highlighted the low numbers of palliative care cases that we see, in particular in relation to hospices. We did, though, note our wider experience of end of life care for elderly patients in acute settings. We particularly highlighted the need to involve more the people who have most information about patients, their carers and families, in discussions and decisions around end of life care – especially where there are capacity issues. Most importantly, we recognised the communication skills and the support required by NHS staff to be able to communicate early and well with families about end of life care and also to help families have these difficult conversations in a society where we find it hard to talk openly about death and dying.

On Tuesday 9 June, **we spoke in front of the Justice Committee** in relation to the draft Apologies (Scotland) Bill. We highlighted from the cases that we see that saying sorry is what many people want most, and the power an apology can have if done well to repair relationships. We recognised the special importance of being able to do this when there are ongoing relationships and there isn't 'choice' about where to go to receive services. Paul McFadden, Head of CSA, noted:

'From a very early point in the journey of many of the complaints that we see, it is clear that, if a simple, timely and human or empathetic apology had been given, the complaint would not have escalated. The failure to make that apology results in a breakdown of the relationship between the individual citizen and the public body, which then escalates, builds and exacerbates the situation – it grows arms and legs.'

For this reason, we offered our broad support for the Bill. In our experience, there continues to be a common misconception that saying sorry is automatically an expression of negligence. We know from speaking to staff and delivering our training on apology that there continues to be a culture of fear around apologising. The proposed legislation has the potential to help create a safe space for public bodies to say sorry. **Our written evidence for this session is also available on the Scottish Parliament website (PDF, 174KB).**

On Wednesday 10 June we attended the Education and Culture Committee in relation to the complaints process for complaints about additional support needs. On the same day we also gave evidence to the Local Government and Regeneration Committee regarding the health and social care integration agenda and the range of complaints routes that a service user might have to pursue depending on what aspect of their care they were raising concerns about.

In both sessions we highlighted the need to ensure that complaints processes are as streamlined as possible to ensure the best access possible. In his evidence to the Education and Culture Committee, **which can be read in full on the Committee's webpage**, Jim Martin said:

'The direction of travel in Scotland is to reduce complexity and to make it as easy as possible for people using the system to complain and to have their complaint resolved as quickly and as well as possible.

If we present people with a complex landscape, they will go to the wrong place, go round in circles, get tired, drop out and not pursue their rights.'

In summary, these evidence sessions gave us a strong platform to highlight three of our core messages – the need for good communication in order to deliver good care, the benefits that flow from having the capacity and support to be able to apologise early and do it well, and finally the need for easily accessible complaints processes where the barriers to complaining are removed.

Investigation Reports

Investigation report ref: 201304732
Hospital transfer, care of the elderly
Highland NHS Board

SUMMARY

Mr C was an older man with multiple health problems; in July 2013 he suffered a fall at home and fractured his hip. He was taken to his local hospital, with the intention being he should be transferred to Raigmore Hospital for surgery. Mr C was not transferred until two days after the fall, and surgery was performed three days after the fall. He spent time recovering in another hospital after the surgery, and was discharged in August 2013. Mr C died in May 2014.

Mr C's wife (Mrs C) complained to Highland NHS Board (the Board) about the length of time taken to transfer Mr C to Raigmore Hospital, particularly taking into account the amount of pain relief that he was being given at the local hospital. She felt he should have had surgery within one day, given his multiple health problems, and that the delay and use of pain relief had contributed to his poor recovery and subsequent decline in health. The Board apologised for the distress caused and said that due to bed pressures it had not been possible to transfer Mr C earlier, but that appropriate care was being given by the local hospital and that there had been no detrimental effect on Mr C. I obtained further information about the other hip operations being performed over the relevant period. The Board said those operated on earlier had been admitted to Raigmore Hospital directly, and that Mr C's transfer had been delayed further by a lack of available orthopaedic receiving beds.

My investigation found that whilst the standard of care provided at the local hospital was reasonable, the delayed transfer meant Mr C received a large quantity of morphine, which has potential side effects which Mr C went on to suffer. In addition, the local hospital did not have the facilities required to provide the type of care outlined within the relevant national guidelines for patients with hip fractures. I found that Mr C was an emergency trauma patient and that, despite the Board's position that such patients would be prioritised over routine and elective patients, he was not prioritised appropriately. The information provided about the other procedures performed over the relevant period indicated there were no issues with theatre or surgical team availability. Mr C had to wait on the basis that he was admitted to a local hospital rather than Raigmore Hospital directly. The importance of the timing of such surgery, in terms of the outcome, is also highlighted in the relevant national guidelines. I was critical of the Board's actions, particularly given the adverse outcome for Mr C.

I made a number of recommendations to the Board including addressing the issues of prioritisation of clinical need for emergency patients requiring transfer and bed management, as well as apologising to Mrs C for the failures my investigation identified – all of which can be read in full in my report.

Investigation Reports

Investigation report ref: 201401527

Consent, record-keeping

Greater Glasgow and Clyde NHS Board – Acute Services Division

SUMMARY

Mr C had an abdominal tumour, and saw a consultant who recommended that the tumour should be surgically removed. The consultant started Mr C on medication that helps to prevent dangerous rises in blood pressure related to the surgery he was due to undergo. In January 2013 Mr C completed a consent form agreeing to undergo surgery to remove the tumour. The form did not specify any potential risks of the operation that the surgeon performing the procedure had discussed with Mr C, or that any discussion had taken place around any extra procedures which may become necessary. Surgery took place the next day.

Mr C was then reviewed the following month by the surgeon who wrote to Mr C's GP to say that Mr C had reported difficulty with ejaculation but had experienced problems with this in the past. Mr C was seen by a urology doctor (specialising in problems of the urinary tract and reproductive organs) in November 2013, where Mr C said he was still having problems with ejaculation. Tests confirmed that Mr C had retrograde ejaculation (where semen enters the bladder rather than coming out of the penis). Mr C had further follow-up appointments with the consultant who had recommended the surgery, and the surgeon who had carried it out. Mr C complained to the Board about the lack of information he was given about retrograde ejaculation before the planned surgery, and that the surgeon had told him that he did not foresee any complications arising.

In the Board's response to Mr C's complaint, they did not clearly respond to Mr C's complaint about the information he was provided with during the consent process. Instead, they focused on the reasons why they felt it was unlikely that Mr C's operation was the cause of the retrograde ejaculation, and said that this was a problem Mr C suffered from in the past, which Mr C disputed. Mr C then complained to my office.

In considering Mr C's complaint, I took independent medical advice from a consultant urological surgeon who specialises in sexual dysfunction, who said that whilst the medication Mr C had been prescribed prior to the surgery (to regulate blood pressure) does have a side effect of causing retrograde ejaculation, this would only last for the short time the drug was prescribed and administered. My Adviser said that the surgical procedure Mr C had was not very common, and, therefore, it is logical to refer to data for similar and more common operations which take place in the same region of the body but for different conditions. For operations of a similar nature, my Adviser said that retrograde ejaculation is a rare but recognised side effect and this should have been discussed with Mr C when consent was obtained for the procedure. The Adviser also noted that there are other potentially very serious risks to major arteries and veins when undertaking surgery in this area.

Whether or not Mr C previously reported problems with retrograde ejaculation prior to surgery, I found this was only documented in the post-surgery notes taken a month after the surgery was carried out. There was nothing in the notes leading up to the surgery about this. In relation to the information Mr C was given, I consider that the surgeon should have warned Mr C about the possible risks or complications. Whilst the risk of this side effect occurring is very small, General Medical Council guidance says that patients must be told about recognised serious adverse outcomes, even if they are rare. There is no clear evidence to demonstrate this was done or indeed that discussion took place about other major structures close to the operative area being at risk of injury with possible significant consequences.

I recommended that the Board apologise to Mr C, and ensure that their consent policy includes guidance on the importance of accurately recording conversations with patients regarding risks and complications as part of the consent process.

Complaints Standards Authority (CSA)

Local Government

The Local Government Complaints Handlers Network met most recently on 12 June 2015. Issues considered by the network included good practice in dealing with complainants who have mental health issues, learning from complaints, the peer review of annual complaints reports and solutions to complaints handling issues through the complaints surgery.

Building on the positive outcomes of annual complaints reporting for 2013/14 which produced the first ever baseline of complaints performance information for the sector, the network will soon be looking at performance in the year 2014/15. This information will be compared with the baseline data and will be used to benchmark for improved performance across the sector.

NHS

Our work continues towards bringing forward changes to the NHS complaints handling arrangements. This includes liaising closely with key stakeholders to examine the present arrangements and to consider opportunities for improvement. For example, we recently met with Tayside NHS to consider the issue of how complaints from prisoners are handled within a prison heath centre. We will continue to work closely with our NHS partners as we work towards developing a model complaints handling procedure (CHP) for the NHS, which takes account of the framework of the Patient Rights (Scotland) Act 2011, is based on the current guidance while prioritising the early resolution of complaints, and places a requirement on service providers to learn from complaints. More information will be provided in our following updates.

Housing

The next meeting of the Housing Complaints Handlers Network will be held in July. We would like to remind all attendees that as part of the meeting we will consider the quarterly performance information of members against the requirements of the **SPSO complaints self-assessment indicators for the housing sector (PDF, 184KB)**. We ask that attendees prepare their complaints performance information from the first quarter of 2015/16 in advance of the meeting so that we may move quickly towards benchmarking performance within the network.

We are encouraged that interest in this network continues to grow. Further information on the role of the network, including details of how you may join can be obtained from **anne.fitzsimons@tollcross-ha.org.uk**

Complaints Standards Authority (CSA)

Further education

The Further Education Complaints Advisory Group is making excellent progress as it works towards driving up the standards of complaints handling and learning from complaints across the sector. It met most recently on 8 June 2015 when the issues discussed included the use of the 'online complaints handling tool', a review of the successful workshop event held in May, complaints categories and key performance indicators, measuring customer satisfaction with the complaints process and the impact of complaints on the quality of learning, teaching and support services across the sector. A small working group will consider the current categories of complaints used across the sector in more detail with a view to identifying opportunities to standardise across the sector. The group will also review the current approach to measuring satisfaction with the complaints procedure with a view to identifying and sharing good practice across the sector.

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 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:
Complaint investigation skills (stage 2 of the model CHP):
1 day open course

Wednesday 9 September 2015, central Edinburgh

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Wednesday 9 September 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**

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, 17 June 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.