
Monthly news from the Scottish Public Services Ombudsman

This month we are laying three investigation reports about the health sector before the Scottish Parliament, and 66 decisions about all of the sectors under our remit. These can be read on our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in September), we received 462 complaints. We determined 441 complaints and of these we:

- gave advice on 259 complaints
- considered 104 complaints at our early resolution stage
- decided 78 complaints at our investigation stage.

We made a total of 120 recommendations.

Ombudsman Overview



One of today's reports concerns the distressing subject of suicide. There is learning for the organisation involved in how they can improve their care of people who are in extreme anxiety, depression or crisis. The investigation (case 201403377) was about the way a woman's phone call was handled – she needed immediate help but instead a three hour call back was arranged, and she was offered another telephone service meanwhile. My report concludes that the case raises concerns about how effectively the organisation manages mental health crises. I state: *'The initial call handling is geared towards physical problems and gathering personal information. However, the advice I have received highlighted that, for people experiencing mental health difficulties, this is ineffective and can exacerbate their symptoms. More needs to be done to ensure that mental health is not treated with any less urgency than physical health...'* I made a total of 13 recommendations, some individual to the case and others to address my wider concerns.

There is also learning in the two other reports laid today. In one (case 201403146), I am critical of the standard of nursing care provided to an elderly man in hospital. He had several serious health problems, including dementia. My investigation found that there was a lack of care plans for his personal care and communication difficulties, and that record-keeping was inadequate. There was also a significant failure to monitor his glucose levels appropriately, and a failure to adequately monitor his nutritional intake.



The final report (ref 201406017 and 201503127) investigates delays and confusion in the treatment of a woman who had mouth cancer. The surgery she eventually received significantly reduced her quality of life and gave her a low chance of surviving her cancer. In addition to failings in planning and communication in relation to the woman's surgery, I outline significant concerns about the way in which both boards involved in her treatment provided information during my investigation. One board failed to provide a key piece of evidence relating to the complaint until after my investigation was concluded. The other board also provided new evidence at a late stage, which directly contradicted information they had previously given during the investigation. This caused unnecessary difficulties and delays in completing the investigation, and undoubtedly added to the woman's distress. I also raise concerns at the lack of appreciation both boards have shown of the impact these events have had on the woman, and of the value of her complaint. I am disappointed that the boards were not more proactive about acknowledging that her experience was unacceptable, and acting to prevent a recurrence.

SPSO Draft Strategic Plan consultation

We launched this consultation on October 9. It lays out the key challenges and opportunities we foresee over the next four years and how we are preparing for them. We make three proposals about measures we will consider if the trend in rising complaints numbers and complexity continues and there is no increase in our investigations resource. We also highlight our new role in reviewing Scottish Welfare Fund decisions, and changes in relation to complaints arrangements under the Scottish Government's health and social care integration programme.

The full consultation can be found on our website, and we invite comments about all aspects of the plan. The consultation is open until 18 December.

Scottish Welfare Funds review consultation

We launched this SPSO consultation last month. It will help inform the way we will approach and manage reviews about welfare fund decisions. This is a new and different role for SPSO in relation to local authorities. It sets out a draft statement of practice, explaining how we will approach decision-making. We are also consulting on draft rules for oral hearings, and on our approach to undertaking an Equalities and Human Rights Assessment of our new role.

The full consultation can be found on our website, and it is open until 27 November.

As well as our usual **Complaints Standards Authority** update, there is an update on our recently-held **SPSO Conference** and a forthcoming **training event**.

Investigation Reports



Investigation report ref: 201403377

Out-of-hours Services & NHS 24; clinical treatment; diagnosis

NHS 24

SUMMARY

Mrs C complained about her late mother (Ms A)'s interaction with NHS 24, in particular their main out-of-hours telephone service, the Unscheduled Care Service (UCS), and Breathing Space, which is a confidential telephone service for people experiencing low mood, anxiety or depression, and also part of NHS 24.

Ms A suffered from anxiety and depression. One week after attempting suicide, she telephoned Mrs C and told her she needed help as she could not cope. Mrs C called NHS 24, describing Ms A as a risk to herself, and an NHS 24 call handler rang Ms A directly. Ms A was extremely distressed during the call. She told the call handler that she might harm herself again and that she wanted to be taken away under mental health legislation. The call was initially classified as 'serious and urgent' but, when no nurse was available to speak to Ms A, a senior nurse advised the call handler to downgrade the call, which set a three hour call back from a nurse practitioner. They also offered Ms A assistance from Breathing Space whilst she waited for the call back, which she accepted. The Breathing Space adviser (the BSA) spoke and did breathing exercises with Ms A, but she was still tearful when the call ended. A nurse practitioner called Ms A around two hours later but there was no answer and the call was closed. Mrs C called the police a few days later as she had been unable to contact Ms A. They forced entry to Ms A's home and found that she had completed suicide. It is understood that she died from an overdose of medication.

In investigating Mrs C's complaints, I took independent advice from a nursing adviser, a mental health adviser and a GP adviser with experience of NHS 24 and out-of-hours work.

Mrs C said that the classification of Ms A's call meant that a suicidal woman needing immediate help instead received a three hour call back. NHS 24's own investigation report noted that it was unclear why the call was downgraded, and that there seemed to have been a disregard of mental health concerns by the senior nurse. They also found that following the transfer to Breathing Space, the call should have been closed down within the UCS. The advice I received was that, given the information taken by the call handler, contact with Ms A should not have been broken. Allocating a three hour call back and leaving the call open after transferring to Breathing Space was not reasonable and, therefore, I upheld this complaint.

Mrs C complained that the BSA had not used Applied Suicide Intervention Skills Training (ASIST) during the call with Ms A and took no action to help her. NHS 24 said that ASIST techniques were not used as the BSA knew that a nurse practitioner would be calling Ms A to make a full clinical assessment of her symptoms. My mental health adviser said that this explanation was not reasonable as the BSA knew about Ms A's suicide attempt yet did not explore sufficiently the risk of suicide during the call. My adviser said that the support offered by the BSA was ineffective. The call recording showed that Ms A became increasingly distressed and my adviser commented that they would have expected the BSA to continue speaking with Ms A until her distress had reduced, instead of ending the call. I found that Breathing Space did not offer a reasonable service to Ms A so I upheld this complaint and made several recommendations.

CONTINUES

Investigation Reports



Investigation report ref: 201403377

Out-of-hours Services & NHS 24; clinical treatment; diagnosis

NHS 24

SUMMARY CONTINUED

Mrs C also complained that there was only one attempt to call Ms A back before closing the call, and that NHS 24 did not contact Ms A's GP. My investigation found that NHS 24's procedure is to attempt to call patients up to two times before closing the call, unless there is a particular clinical concern. However, there was enough evidence from Ms A's call to indicate a 'particular clinical concern' and I considered that further action should have been taken, including sharing information with Ms A's GP. Therefore, I upheld this complaint.

This significant case has raised concerns about how effectively mental health crises are managed by the UCS. The initial call handling is geared towards physical problems and gathering personal information. However, the advice I have received highlighted that, for people experiencing mental health difficulties, this is ineffective and can exacerbate their symptoms. More needs to be done to ensure that mental health is not treated with any less urgency than physical health, so I made a number of additional recommendations to address my wider concerns.

Investigation Reports



Investigation report ref: 201403146

Hospitals; clinical treatment; diagnosis

Lothian NHS Board

SUMMARY

Mr A was elderly and had several serious health problems, including a form of dementia. He was admitted to the Royal Edinburgh Hospital from his nursing home due to worsening behavioural problems, including agitation and aggression. His mental health assessment showed that he lacked awareness and insight into his problems, and had trouble with communication. This, plus his aggression, meant that he was a risk to himself and other people.

Mr A was mobile with the help of a walking stick when he was admitted to hospital. He fell two days later and suffered bruising, then fell again a few days later, and broke his hip. He was transferred for surgery but died two days after the operation.

His daughter (Mrs C) believed that Mr A's fall risk had been poorly assessed when he was admitted, and that he was not properly cared for after the first fall so the second fall was not prevented. She was concerned that he was over-sedated and not eating or drinking enough, and that the management of his diabetes was inadequate. She also felt Mr A's aggression had not been handled well and that he was blamed for his behaviour, when it was actually the result of his illness.

I obtained independent advice from a nursing adviser, who noted that the board's policy is to complete a falls risk assessment for all elderly patients and to review the patient's falls care plan if they fall. The board's complaint investigation report said that this was all done, but my adviser found no evidence to support this and considered that the standard of record-keeping and falls prevention practice was poor overall. I agreed with this view and, therefore, upheld the complaint and made recommendations.

Regarding Mrs C's complaint about sedation, my adviser said that the appropriate medication and dosage was prescribed and that quick action was taken when adverse effects were noted. My adviser also considered that the board's response letter was balanced and did not blame Mr A for his behaviour.

However, the advice I received was critical overall of the standard of nursing provided to Mr A. The record-keeping was inadequate and did not include care plans for Mr A's personal care or communication difficulties. There was also a significant failure to monitor Mr A's blood glucose levels appropriately and a failure to adequately monitor his nutritional intake. I noted that the board's complaint response states that blood glucose levels were not monitored following Mr A's admission and I was critical of their failure to act on this. I upheld the complaint and made several recommendations.

Investigation Reports



Investigation report ref: 201406017 and 201503127

Hospitals; clinical treatment; diagnosis

Lanarkshire NHS Board and Greater Glasgow and Clyde NHS Board

SUMMARY

Mrs C had previously suffered from mouth cancer and was treated at Monklands Hospital. After finding an ulcer in her cheek, she contacted the consultant previously in charge of her care, and was seen at Monklands Hospital again, where the ulcer was found to be cancerous. Mrs C's case was discussed at the multi-disciplinary team (MDT) meeting, who decided to refer Mrs C to the Southern General Hospital for treatment.

However, this was not done until a week later. The referral was by email from the consultant to his colleagues with details of Mrs C's (and other patients') cases, rather than a formal referral by letter. It is not clear whether the email was received. Around this time the head and neck / maxillofacial (the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck) consultants at the Southern General Hospital decided that, due to lack of capacity, they would no longer accept referrals of patients they considered could be treated locally (such as Mrs C). It is unclear whether the management team instructed the consultants to do this, or whether the Southern General Hospital was required to accept Mrs C's referral under the existing funding arrangements. Mrs C was not told that there was a problem with her referral.

Mrs C grew increasingly concerned about the delay, and phoned the consultant at Monklands Hospital several times over the next few weeks to follow this up. Finally, about a month after the MDT, Mrs C emailed the consultant, outlining her strong concerns, and the consultant phoned the Southern General Hospital and arranged an urgent appointment for Mrs C. Mrs C said that her treatment from Southern General Hospital staff was excellent from that point on.

Mrs C complained about the delay in the scan and the MDT meeting, as well as the delay in referring her to the Southern General Hospital. Mrs C was concerned that the delay may have worsened her outcome, as she was initially told that surgery would be performed with the aim of providing a cure. However, the surgery that she subsequently received significantly reduced her quality of life and gave her a low chance of surviving her cancer. Mrs C also complained about the lack of communication from Monklands Hospital staff about what was happening.

My investigation found that the delay in arranging Mrs C's surgery was unreasonable, and outwith the national HEAT (Hospital Efficiency and Access Targets) standards. I found it was unreasonable for the Monklands Hospital consultant to wait one week before referring Mrs C, and also that the email sent by the consultant was not an adequate referral. I also found that there was a breakdown in the referral process between Monklands Hospital and the Southern General Hospital, which meant that no plans were made for Mrs C's surgery at either hospital until she followed this up repeatedly. I am concerned that an important decision (not to accept certain referrals) could be made and implemented at NHS Greater Glasgow and Clyde without clear, recorded management approval. I am also strongly critical of the poor communication between the consultants at both health boards, as they apparently discussed Mrs C's case without clearly agreeing who would be responsible for her treatment (both hospitals appeared to think the other would be responsible). It was only through Mrs C's courage and perseverance in following up her own appointment that this matter was resolved.

CONTINUES

Investigation Reports



Investigation report ref: 201406017 and 201503127

Hospitals; clinical treatment; diagnosis

Lanarkshire NHS Board and Greater Glasgow and Clyde NHS Board

SUMMARY CONTINUED

I also found that Monklands Hospital staff failed to communicate reasonably with Mrs C about her treatment. Staff did not return her calls on at least one occasion and, although the consultant phoned the Southern General Hospital to follow up the referral and offered to perform the surgery himself, no-one contacted Mrs C to explain what was being done or to check that the appointment had come through.

In reporting on this complaint, I outlined significant concerns about the way in which both boards provided information during my investigation. NHS Lanarkshire failed to provide a key piece of evidence relating to this complaint until after my investigation was concluded. NHS Greater Glasgow and Clyde also provided new evidence at a late stage, which directly contradicted information they had previously given during the investigation. This caused unnecessary difficulties and delays in completing the investigation, and undoubtedly added to Mrs C's distress. I also raised concerns at the lack of appreciation both boards have shown of the impact these events have had on Mrs C, and of the value of her complaint. This case involves a patient who was left without any plans for her cancer surgery for several weeks, as the boards were unable to effectively communicate about, and resolve, an administrative disagreement over who was responsible for the surgery. In this context, I am disappointed that the boards were not more proactive about acknowledging that Mrs C's experience was unacceptable, and acting to prevent a recurrence.

Complaints Standards Authority (CSA)



NHS

We have worked closely with the Scottish Government group on further developing the methodology for a revised NHS model complaints handling procedure (CHP). We have continued to engage with stakeholders to update on the progress of this work, having met with the NHS Chief Operating Officers and the NHS Complaints Personnel Association Scotland since our last update. We also plan to meet with Patient Advisers through the Patient Advice and Support Service in early November.

The Scottish Government have now communicated the schedule of the next NHS CHP working group meetings which will take the working group to February 2016. In discussion with the government, we are also proposing further sub-groups to take forward more detailed work on the model CHP, recording and reporting, and education and training. This will be discussed and agreed with NHS partners at the next meeting.

Integration of Health and Social Care

Related to the work on an NHS CHP, we continue to have positive discussions with the government on the work required to progress changes in respect of arrangements for health and social care complaints.

We provided evidence to a second session of the Scottish Parliament's Local Government and Regeneration Committee on health and social care complaints, following the first session in June. The Scottish Government outlined its plans for progressing changes in this area. For more information, **the transcript of the committee evidence is available.**

The proposed changes include legislative changes around SPSO's role in social work complaints, in line with the recommendations of a Scottish Government working group from 2013. The government have launched a consultation seeking views on a draft order to amend the Scottish Public Services Ombudsman Act 2002. This would allow the SPSO to investigate complaints in relation to the substance of social work decisions. The draft order also amends the Public Services Reform (Scotland) Act 2010 in relation to the sharing of information between the Care Inspectorate and the SPSO. Additionally, it amends the Social Work (Scotland) Act 1968 to abolish the existing system of local authority social work complaints (including Complaints Review Committees) and allow a model CHP prepared by the SPSO to be introduced. The consultation runs until 14 December and **is available on the government's website.**

In addition, given that changes to the NHS and the social work procedures will take time to implement, the Scottish Government has committed to developing guidance for Integration Joint Boards as they progress with implementing their complaints arrangements. This will help ensure a standard approach across Scotland that is in line with the proposed changes and moves to adopt the model CHP in these areas.

Complaints Standards Authority (CSA)



Local Government

The local authority complaints handlers network will meet on 30 October in Glasgow. The main theme of the day will be 'learning from complaints'. The network will also consider the output of the SPSO Conference held earlier this month.

The network will also consider the emerging findings from the Improvement Service's analysis of councils' annual complaints performance reports for 2014/15, in line with SPSO indicators, and consider benchmarking of this information.

Further Education

The further education complaints handling advisory group are currently working to consider the development of standardised complaints categories. The output of this work will be shared at the annual event planned for later this year, which will also consider the annual complaints performance for colleges for 2014/15. This will enable benchmarking of performance across the sector and facilitate the sharing of learning from complaints in terms of wider good practice initiatives performed by colleges.

Housing

The next meeting of the housing complaints handlers network will be held in November. Dates and venue will be communicated by the network in due course. 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.

For all previous updates, and for more information about CHPs, visit our dedicated website www.valuingcomplaints.org.uk.

SPSO Training Events

SPSO Conference

Our thanks to all those who presented, facilitated, scribed and attended the recent Conference and made it such a successful event. We have posted speaker presentations and workshop materials on our **Valuing Complaints website**. The workshop information includes the toolkits that were demonstrated on the day and some further reading.

The speakers and subjects were:

- Dr Nikki Maran, NHS Lothian, Human factors
- Douglas Clydesdale, financial services, Learning from complaints
- Mark McEwen, General Manager, Scottish Water, Learning from customers

The workshop themes were:

- Human factors/Learning from complaints
- Quality assuring your complaints process
- Quality assuring your responses

Booking now:

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

Next course with spaces available: Wednesday 11 November, 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@spsso.org.uk

We have more information about courses that we can offer to organisations in our 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, 21 October 2015

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.



COMMUNICATIONS TEAM

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VALUING COMPLAINTS WEBSITE

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