

# SPSO NEWS

**March 2016**

## **Monthly news from the Scottish Public Services Ombudsman**

This month we are laying four investigation reports about the NHS and one about a water provider before the Scottish Parliament, along with 55 decisions about most of the sectors under our remit. These can be read on our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

## **Case numbers**

Last month (in February), we received 421 complaints. We determined 445 complaints and of these we:

- gave advice on 224 complaints
- considered 144 complaints at our early resolution stage
- decided 77 complaints at our investigation stage

We made a total of 162 recommendations.

## **Ombudsman Overview**

### **NHS casework outcomes**

For the second month in a row I am highlighting the issue of consent. It is the subject of several of the investigations outlined briefly below. Clearly, under General Medical Council guidelines, health professionals have an obligation to ensure that patients are able to give informed consent, and the frequency with which people are bringing us complaints about this issue is increasingly concerning.

One investigation (201406646) concerned a man who died a week after an operation to remove his lung. I found a number of serious failings including that a consultant anaesthetist failed to provide a reasonable level of care before and during surgery. I found that post-operative communication with the family was not of a reasonable standard and that the pre-operative assessment was not appropriate. I made nine wide-ranging recommendations, three of which related to the anaesthetist's practice. Other recommendations require the board to review the pre-operative assessment procedures for appropriate patients, and review how families are advised of adverse incidents that require admission to intensive care. On consent, I asked the board to review their consent procedure for lung cancer surgery to ensure that it informs the patient what level of risk the operation will incur for them.

The second investigation (201406803) was about a woman who suffered severe nerve damage following an operation on her ankle. While the risk of permanent nerve damage is a very rare side-effect, it is a clearly a serious one and I considered it a failing that she was not warned about it. I was concerned that this failing may have arisen due to the pressures on the service and recommended that the board conduct a review to ensure staff have sufficient time to spend with patients before procedures to obtain and document consent properly.

The third investigation (201407899) was also about post-operative complications and consent. In this case, a woman found that she was incontinent after having surgery. As a result she had to undergo a colostomy procedure, which has had a significant impact on her. Incontinence is a well-recognised side-effect of the procedure the woman had and she said that she would never have consented to it had she been made aware of this risk. I found that it was unreasonable that this was not discussed with her and documented prior to surgery, and that the consent form that she signed did not mention this as a possible risk. In this report, my recommendation was that the board review the relevant consent forms and ensure they accurately reflect the potential complications.

The fourth investigation (201407748) concerned a delay in the diagnosis of a child with Hodgkin's Lymphoma (a cancer that develops in the lymphatic system). I found that the GPs who saw the child should have been aware of the significance of the lump the child presented with and referred more urgently. I made recommendations to address this gap in clinical knowledge. I was also concerned that there was a lack of a robust system for following up referrals or test results. As a result of the complaint the practice have changed their process, and I agreed with advice I received that the new system would adequately address the issue that arose in this case.

### **Other sector casework outcomes:**

**Water:** today's investigation report (201407663) highlights the consequences of a failure to take meter readings according to a provider's policy. Other water decisions we are laying today include a finding that there was a lack of communication and delay in taking action after a leak was identified (201501401) and about the lack of a clear explanation to a customer about his responsibility for maintaining a supply pipe (201407224).

**Planning:** we upheld a complaint (201405656) that stemmed from the lack of stability of a steep banking that resulted from a developer's activity. We found that the council had not given sufficient consideration to stability and that this should have been a material consideration in their planning report. We made a recommendation that they consider how they could assist the complainant whose

garden was affected or offer redress if this was not possible. In another investigation (201405676), we found that a council could have done more to ensure an owner's privacy was protected in line with the planning consent that had been granted. We were also critical of their handling of her complaints and their failure to respond to relevant information she presented to them. We made four recommendations for redress and improvement.

**Prisons:** today's reports are about subjects prisoners bring us on a regular basis: in one investigation about progression to less secure conditions (201407466) we did not uphold a complaint about delay, while in another (201503738) we upheld the complaint about the level of detail the Scottish Prison Service (SPS) provided to explain their decision about whether or not to progress a prisoner. We also upheld a complaint (201502431) about the information held on a prisoner's record, which was relevant to the prison risk management team's consideration of his parole. We upheld aspects relating to the SPS' complaints handling (201502253) and also in relation to their handling of a disciplinary hearing (201503747).

### **Learning resource for senior nurses and midwives**

We are very pleased to publicise a DVD that we developed with NHS Education for Scotland (NES) to support senior nurses and midwives. The resource is a filmed interview with two sisters who complained to the SPSO about the treatment and care their mother received in hospital. What makes the material powerful is that the complainants are also nurses, and therefore very well placed to comment on the care and communication issues that they and their mother experienced. Their story is introduced through a short opening interview with the Ombudsman.

As well as promoting the material on their website, NES have been disseminating the publication through their network of Leading Better Care facilitators and through a series of roadshows on promoting person-centred care. You can download the workbook at: <http://www.leadingbettercare.scot.nhs.uk/media/5079/nes-spso-resource.pdf>. There is also a webinar on the topic (webinar 2) which can be viewed here: <http://www.leadingbettercare.scot.nhs.uk/development-resources/generic-leadership/webinars/>

### **SPSO Strategic Plan**

We laid our 2016-2020 Strategic Plan before Parliament last week. We posted it on our website, along with our analysis of the responses we received to our consultation on a draft strategic plan. Overall, the responses were positive, particularly in relation to our proposal to set up a learning and improvement unit. The analysis contains an SPSO response to the feedback we received, and you can read this along with the individual responses themselves at <http://www.spsso.org.uk/spsso-draft-strategic-plan->

2016-2020-consultation. The finalised strategic plan is available at <http://www.spsso.org.uk/strategic-plan>

## **Scottish Welfare Fund**

Our SWF team have continued to make preparations for taking on our new role as independent reviewer from 1 April. We are grateful for the input we have received at visits to learn about councils' decision-making and first tier reviews, and also from our two SWF sounding boards (local authorities and third sector). We are finalising our new review guidance and process, as well as leaflets, an online form and dedicated website information.

If you have any questions, please contact Paul Smith, SWF project lead, at [paul.smith@spsso.gsi.gov.uk](mailto:paul.smith@spsso.gsi.gov.uk) or 0131 240 2969.

## **Complaints Standards Authority (CSA)**

### **NHS**

We are continuing to make progress in developing a revised NHS model complaints handling procedure (CHP). A draft procedure and public information has been developed and will be presented to the steering group in April. Specifications in respect of the recording and reporting requirements of the procedure have been identified and the working group responsible for this area of work will update the steering group at the April meeting. In partnership with NHS Education for Scotland, we have participated in a programme of workshops to raise awareness of the new procedure across Scotland, including a strong focus on the importance of early resolution.

We intend the model CHP to be published during 2016, with implementation by NHS Scotland being introduced from April 2017.

### **Social work complaints**

The Parliament recently approved the Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016. It will abolish the existing social work complaints process. It also contains provisions to allow the SPSO to consider the professional judgement of social work staff and allow the sharing of information between the SPSO, Care Inspectorate and the Scottish Social Services Council when appropriate.

The abolition of the current system means that the SPSO will be able to use its existing complaints standards role to develop a process for social work complaints that will align with the current modern procedures in use across the Scottish public sector. The order comes into force on 1 April 2017 and we will be working closely with the Scottish Government, local authorities (including social work professionals), third sector, advocacy groups and other key stakeholders both in developing the new process and preparing for our new role.

### **Health and social care integration**

The Scottish Government have committed to help ensure a standard approach to complaints in this area across Scotland. Integration Joint Boards (IJBs) are now under the SPSO's remit.

### **The named person and child's plan**

The Parliament also recently passed the Children and Young People (Scotland) Act 2014 (Part 4 and Part 5 Complaints) Order 2016. This order will give the SPSO the

ability to consider the merits of decisions when dealing with complaints made under parts 4 and 5 which deal with the named person and child's plan. The order will come into force on 31 August 2016. There will be more detail on our new role and our approach to this in future commentaries.

## **Local Government**

The local government complaints handlers network continues to meet and share good practice regularly. At the most recent network meeting in March items discussed included service requests and the need for further clarity on differentiating these from complaints; supporting staff through the CHP and a 'complaints surgery' that provided members the opportunity to share experiences and learn from one another. SPSO sought feedback on the introduction of a reflective learning form for bodies under our jurisdiction in relation to complaints received about them by SPSO, and outlined plans for progressing changes to social work complaints and how this will be managed at a local level.

## **Further Education**

The advisory group's annual complaints event will be held in April, where the work on standardised categories will be presented along with the annual complaints handling performance for all colleges for 2014-15 and in the year to date. Other sessions will include the approach to assessing customer satisfaction with the complaints procedure, and how to quality assure your complaints handling performance by using the SPSO complaints performance assessment tool.

The advisory group provides a forum to identify and share good practice, and look at ways in which learning from complaints can be used to improve the services that colleges deliver. The meeting will also consider hosting an event in April or May to give colleges the opportunity to benchmark their complaints performance.

## **Housing**

The housing complaints handlers network met in February. A presentation was provided, detailing members' complaints handling performance in quarters 2 and 3 of 2015/2016. This allowed members to consider their own performance in relation to other similar organisations, and to look at opportunities to learn and improve.

A representative of the Further Education complaints advisory group attended the housing network to talk about the FE sector's approach to standardising complaints categories. Based on the experience in education, the housing complaints network will now consider the best way to take forward a similar piece of work for housing complaints. Finally, the complaints surgery presented an opportunity for members to identify and share best practice in handling complaints.

## Training Events

### Upcoming courses (all based in central Edinburgh)

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

Thursday 23 June

Tuesday 29 November

**Managing Difficult Behaviour:** Wednesday 28 September

These are 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](mailto:training@spsso.org.uk)

We have more information about courses that we can offer to organisations in our flyer: **SPSO Training 2016 (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, 23 March 2016**

The compendium of reports can be found on our website:

<http://www.spsso.org.uk/our-findings>

For further information please contact:

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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: T 0131 240 8849

SPSO website: [www.spsso.org.uk](http://www.spsso.org.uk)

Valuing Complaints website: [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

Contact us: T 0800 377 7330 [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)