

# SPSO NEWS

**August 2016**

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

Today we are laying 60 reports before the Scottish Parliament. Five of these are full investigation reports, one about a council and four about the NHS. This overview contains:

- key casework outcomes from today's reports
- our learning and improvement work, including how we plan to further the impact of our recommendations and where to access our annual letters online
- Complaints Standards Authority updates on local authority annual complaints reports; social work complaints procedures; and the NHS complaints procedure
- training events
- an update from our Scottish Welfare Fund team

## **Ombudsman's Overview**

Last month (in July), we received 390 complaints. We determined 376 complaints and of these we:

- gave advice on 186 complaints
- considered 129 complaints at our early resolution stage
- decided 61 complaints at our investigation stage

We made a total of 108 recommendations.

## **Key casework outcomes**

### **Housing matters**

#### Tied property

Case 201507645 was about the council's management of tied houses and their handling of repair works on a property. A woman lived in a property formerly tied to her husband's employment at a local school. After his retirement and subsequent death, the council failed to take steps to offer the woman a tenancy, meaning that she lived in the property for over six years without a written tenancy agreement. I found that the council's mismanagement amounted to a failure of duty of care. The council also failed in respect of ensuring that the property was acceptable

accommodation, and serious health and safety issues were outstanding for several months from the beginning of the tenancy. I am critical both of the time the council took to start repair works and of their poor communication. The council have now taken steps to effectively manage formerly tied properties, and so my recommendations are for redress in this individual case.

### **NHS matters**

The four reports about the NHS highlighted today concern a range of physical and mental health issues. The issue of consent, which I have repeatedly highlighted, features again, in a report (201508192) about a woman who had a procedure that led to a stroke and to her losing the use of her lower limbs. Our investigation found no evidence that all the risks and benefits of the procedure had been discussed with the patient, and we also found that the board's consent forms and printed information were inadequate.

In case 201508183, I am critical of a GP practice for failing to ensure that a man with terminal lung cancer consented to his wife administering pain relief to him. The main part of the complaint was about the practice's failure to make reasonable arrangements to manage the man's pain, and about their inadequate communication and record-keeping. In this case, I have taken the unusual step of writing to the General Medical Council to draw their attention to my concerns about the risks to patient safety arising from the lack of governance arrangements and documented patient consent.

One of the two mental health cases is about a lack of continuity of care for a woman with a history of low mood and self-harm who completed suicide a week after being discharged from the board's care. My investigation (201508849) found that the care and treatment of the woman, and the discharge and associated follow-up, were unreasonable. I made nine recommendations to ensure that the failings are addressed, including that the board review relevant policies and consider introducing a system whereby completion of the A&E mental health risk assessment form is mandatory for all mental health patients.

Case 201507664 is about a man who suffered from schizophrenia. He was admitted with a sore throat, a cough and a wheeze in his chest. He died two days later, and his mother complained that the board failed to provide a reasonable standard of care and failed to take into account his lack of capacity to understand how ill he was. My investigation found failings in the man's care, and also that the board failed to keep adequate records. I also found that the board gave inconsistent and unclear information about carrying out a significant event analysis (SEA). I have asked them to now undertake an SEA in view of what an independent adviser to the investigation describes as 'serious lessons to be learned from this case'.

To enable learning and improvement, we publish reports of investigations on our website. You can search these by authority, date, subject etc (eg consent) by visiting our website: [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings)

## Learning and Improvement

### Statement and annual letters

As I publicised in my June commentary, I am asking public authorities in the main sectors we receive complaints about to confirm that SPSO complaints are reviewed at a senior level (such as the appropriate scrutiny/governance/performance committees) by returning a learning and improvement statement to me. This builds on the model complaints handling procedures (CHPs) that set out the importance of authorities demonstrating how they 'systematically review complaints performance reports to improve service delivery'.

The learning and improvement statement is included in the annual letter we send to authorities each year. The letter contains statistics about 2015-16 complaints to SPSO about each organisation. This information is part of the detailed complaints picture that each organisation is responsible for gathering and publishing. You can read the annual letters online at [www.spsso.org.uk/statistics-2015-16](http://www.spsso.org.uk/statistics-2015-16)

### Recommendations

As I have advised previously, the aim of our new learning and improvement unit is to enhance the impact of our work by helping authorities improve public services through learning from complaints. One of the main areas we are focusing on is our recommendations. A key part of this work includes providing authorities with additional support and advice on how to meet our recommendations with a view to preventing repeat service failings and complaints. In addition to this extra support we are looking to adopt a tighter escalation process for the very few cases where our recommendations are not being implemented, with the potential to lead to a Special Report.

It is likely that, as part of this work, the way we make recommendations will evolve. As well as continuing to ensure that our recommendations address individual complainants' injustices, the onus will increasingly be on making recommendations that work to support authorities to identify and develop their own solutions for bringing about learning and lasting improvement. We are inviting authorities to be involved in this exciting new aspect of our work.

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

### **Local government**

Thank you to those councils that have already prepared and submitted their annual complaints reports. The reports of the 32 councils will be collated and analysed by the Improvement Service. We will soon be meeting with the chair of the local government complaints handlers' network and the Improvement Service to agree on the approach to this work, and the preparation of the sector's annual complaints performance report. We would request that any council that has not already done so sends a copy of their annual complaints report to us as soon as possible, to [csa@spsso.org.uk](mailto:csa@spsso.org.uk). Details of the next complaints handlers' network meeting will be circulated when available.

### **Social work complaints**

Preparations for our extended role in relation to social work complaints (which will apply to complaints made to local authorities on or after 1 April 2017) are progressing well. We are working closely with key stakeholders, including the Scottish Government, local authorities (including social work professionals), third sector organisations, advocacy groups and other key organisations to develop the new model CHP for social work complaints. We are also preparing for our new role in making decisions on the professional judgement exercised on behalf of the local authority.

Following the project steering group's first meeting in July, we set up a working group to help us develop the new social work CHP. We have since had our initial meeting with the working group. Members of the group are now developing parts of the new procedure in advance of the next steering group meeting, due to be held in late September. The steering group will have oversight of the working group's progress and will provide high level input and feedback on our preparations for our extended role.

We have also carried out fact finding visits in recent weeks and will attend scheduled Complaints Review Committees to build upon our existing knowledge of the typical issues raised in social work complaints. As this is an extension of our existing role, we have also been able to review internal SPSO social work cases to help ensure that we carry out the appropriate due diligence and are well prepared for this role.

### **NHS complaints procedure**

Work on preparing the new NHS model CHP is moving to the next stage. We will work with NHS Education for Scotland (NES) to develop a programme of activities to support NHS organisations as we move towards implementation. Options include, but are not limited to, updating the existing NHS e-learning modules to take account

of the revised procedure, developing and delivering podcasts and webinars, regional workshops and producing awareness-raising materials including leaflets and factsheets.

We are also working with specific NHS bodies to consider how best to trial parts of the CHP in advance of the procedure being implemented across NHS Scotland from April 2017.

For all previous updates, and for more information about CHPs, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

## SPSO Training Events

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

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

[www.valuingcomplaints.org.uk/training-centre/open-courses](http://www.valuingcomplaints.org.uk/training-centre/open-courses)

For general information, see our flyer: **SPSO Training 2016 (PDF, 40KB)**

For more information, and to book spaces, please contact [training@spsos.org.uk](mailto:training@spsos.org.uk)

## Scottish Welfare Fund

### Communications and engagement

While we already publish case summaries in this newsletter, we are keen to provide more information about our decisions in an easily accessible format. We have now built up a sufficient body of decisions to publish a dedicated case study section on our website. We will develop this over the coming months, providing illustrative examples of real cases and an overview of how we have arrived at each decision.

We are also holding both our local authority and third sector sounding boards next month, which will provide further opportunities to update our stakeholders, gather feedback and enhance learning.

## Reviews

In line with previous months, the number of applicants approaching SPSO for independent reviews continues to rise. In July we received 76 enquiries, which represents a 13% increase from the number received in June. We also determined 36 cases throughout the month, which was a 44% increase from the June figure. As noted in the June newsletter, the number of applicants contacting us prematurely remains high and we have taken further measures this month to address this including adjusting our phone message. We will continue to monitor these figures and consider additional actions as appropriate to help ensure applicants reach the right place first time round.

## Casework outcomes

One of the key themes this month has been around repeat applications for the same items. In one case, a woman made a community care grant application after moving into a new tenancy. She applied for flooring, beds and mattresses for children for whom she had kinship caring responsibilities. The council rejected the application on the basis that she had been awarded money for beds and mattresses from the council five months previously, and beds and mattresses from a different council the previous year. We asked the applicant why there was a further need for the same items in quick succession. She explained that damage was caused to the previous beds due to incontinence issues and that there was a need to leave some items behind in a previous property. One of the beds was also broken. We determined that while the SWF is a limited fund and it may initially appear unreasonable to award similar items on three occasions within 12 months, the full circumstances were not taken into account. We also considered that the guidance only sets out restrictions around repeat applications for the same goods and services within 28 days where there has been no relevant change in circumstances. In this case, we assessed that this restriction did not apply and awarded one bed and mattress but declined the other items on the basis of priority.

In another case, an applicant applied for carpets for a new property as she had left her previous tenancy following an assault. She was refused carpets as the council stated they normally only award this item once and she had received carpets previously. In this case we considered that a rule of thumb had been applied and the applicant's circumstances, which were very serious, had not been considered. We upheld the review request and awarded carpets on this basis.

## 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, 31 August 2016**

The compendium of reports can be found on our website: [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings)

For further information please contact:

**SPSO**

**4 Melville Street**

**Edinburgh EH3 7NS**

Emma Gray Tel: **0131 240 2974** Email: [emma.gray@spsso.gsi.gov.uk](mailto:emma.gray@spsso.gsi.gov.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 NHS, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water 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. Our complaints standards authority promotes good complaints handling in bodies under our jurisdiction.

Communications team: T 0131 240 2974

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)