SCOTTISH PUBLIC SERVICES OMBUDSMAN

News

October 2019

In this month's e-newsletter:

- Our findings this month:
  - Complaints, and
  - Scottish Welfare Fund reviews
- SPSO Complaints Improvement Conference
- Infected Blood Inquiry

Our findings

Complaints

This month we:

- published one full investigation report available here
- published 40 decision reports available here
- upheld 29 complaints in full or part
- made 78 recommendations for learning and improvement.

The recurring themes were from health related complaints, as summarised below:

- It is important that clinical staff keep clear, accurate, and legible medical records, which are recorded in line with the appropriate standards and guidance on record-keeping.

- The medical consent process should start earlier than the day of surgery. A shared decision-making approach should be followed, and the patient given information about the associated risks and benefits, and treatment options discussed.

- Those delivering health care should follow board policy and/or relevant professional standards and guidance in healthcare.

In our full investigation report: 201805931 Mr C complained about Grampian Health Board's failure to assess and treat him for adult ADHD (a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness). We found that the board had unreasonably failed to assess him. The report highlights failings in the board's overall approach to adult ADHD assessments and how this led to a service gap in diagnosis and treatment over an extensive period of time. We made three recommendations directly in relation to these findings, which the board have accepted. We asked the board to apologise to Mr C, carry out an urgent ADHD assessment (if he still wished for this) and ensure that future patients are assessed appropriately in line with relevant clinical guidance.

Learning points

A key learning point this month was the need to keep appropriate, accurate records, in line with policy and professional standards. These cases highlight this across a number of sectors.

- 201805015 – a patient complained about the diagnosis and treatment of a ruptured Achilles tendon. While we considered this aspect of their care to be reasonable, we found that there was no record of any detailed discussion about risks or benefits of proposed operations with the patient, the alternatives to surgery or the possibility that the condition could be made worse. The board also had a document for recording fasting and insulin instructions for diabetic patients but this was not completed. We asked the board to apologise and ensure that all future patients are given full information, with all discussions and instructions documented.

- 201810244 – we found that the Scottish Prison Service (SPS) failed to investigate a complaint about staff behaviour appropriately. They did not take statements from the officers present at the time of the alleged incident and failed to maintain a proper record of the evidence gathered as part of their investigation. We asked the SPS to consider whether CCTV footage should be retained when complainants allege inappropriate behaviour and to ensure our findings and decision is communicated to relevant staff.

- 201701825 we found that a university failed to provide evidence that their mitigation process had been followed appropriately in respect of a decision to remove a student from a course. We found that the university's records in relation to this decision were inadequate; with no evidence that the supervisor's view on their progress had been sought. We asked the university to obtain a written statement from the supervisor about the student's progress and ensure that they are able to demonstrate administratively through clear records that their decisions are made appropriately.

Scottish Welfare Fund (SWF) Reviews

During September we:

- responded to 76 enquiries
- made 61 decisions
    - 18 community care grants
    - 43 crisis grants

- changed the council's decision on 10 (56%) community care grants and 5 (12%) crisis grants
- signposted an additional 47 applicants to alternative sources of assistance, including 40 to their local council.

Did you know we now have a searchable directory of SWF case studies available on our website?

SPSO Complaints Improvement Conference

Tuesday 25 February 2020, Tynecastle Park
Our next Complaints Improvement conference is now available to book! This is not a public event, rather it is designed for public sector staff, advice agencies and academics for whom learning from complaints to improve services is a key part of their work or research. Specifically, it will be of interest to:

- those with lead responsibility for monitoring and improving organisational performance
- managers responsible for organisational learning from complaints
- quality assurance managers
- complaints and customer service managers, including staff who handle and investigate complaints
- organisations with an interest in consumer redress.

The conference will focus on the recent review of the Model Complaints Handling Procedure and best practice in complaint handling – especially learning from complaints. There will be a mixture of presentations and workshops around the following themes:

- supporting staff who are the subject of a complaint
- resolution skills
- encouraging positive behaviour (including the use of social media).

Download a booking form here. Further information will be available in next month's newsletter!

Infected Blood Inquiry

The Infected Blood Inquiry was set up to examine why men, women and children in the UK were given infected blood and/or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; questions of consent; and whether there was a cover-up. The Inquiry has been in contact with SPSO and we have agreed to share some information relevant to their work. They are keen to hear from anyone who may hold evidence or have experience relevant to their work.

More details can be found on their website: www.infectedbloodinquiry.org.uk

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