

# SPSO NEWS

**December 2016**

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

Today we are laying 56 reports before the Scottish Parliament, including two full investigation reports about the NHS. This overview contains:

- ensuring learning from complaints
- 'Making the most of complaints', our forthcoming conference
- Complaints Standards Authority news including the new social work CHP
- an update from our Scottish Welfare Fund team

## **Ombudsman's Overview**

### **Ensuring learning from complaints**

Today's two public interest reports underscore how vital it is that boards ensure that their complaints investigations lead to learning. As is regularly the case, significant organisational learning leading to change and improvement should have taken place when the authorities concerned first handled the complaint.

In each set of events described in today's reports, the patients' treatment put them at increased risk and resulted in prolonged distress and suffering for them and their families. In the first case ([201507831](#)), a child's brain tumour was not diagnosed when it should have been, leaving them requiring additional treatment with significant risks and with neurological defects. In the second case ([201508264](#)), the board initially failed to provide a correct diagnosis for a man's head injuries. He was subsequently found to have suffered a brain haemorrhage and underwent emergency surgery.

Our role in such cases is to provide individual redress, as far as possible, and to make recommendations to boards to prevent future failings. For individuals, the investigations provide the patients and their relatives, who often have questions after

such traumatic events, with explanations as to what went wrong, as well as a recommendation that appropriate apologies are made.

On organisational learning, our recommendations in these two cases are typical in that we ask each board to ensure that health professionals are aware of the correct relevant guidance and follow it. In the second report, I criticise the board's investigation and make a number of other recommendations. As the report states, I would have expected them to identify the failures to follow national and hospital guidelines and to suggest suitable steps to address these mistakes. I also consider that the repeated failures by multiple staff to follow the procedures in place, or sufficiently document the care and treatment provided, constitute a systemic failure. I therefore ask the board to carry out an audit of a sample of recent cases of this kind, to ensure they are being dealt with appropriately; and carry out a root cause analysis to identify why the medical and nursing staff on duty did not follow the systems in place.

One of the aims of our new Learning and Improvement Unit is to work with individual public authorities to support them in doing this better, and to provide further guidance and tools for authorities more generally. We already provide every organisation with a complaints handling self-assessment reflective learning form, which they are required to fill out at the start of SPSO's enquiries to them about a complaint. We have been pleased with the positive response to this. We are in the process of further developing our Complaints Improvement Framework, which helps authorities self-assess the effectiveness of their overall complaints handling arrangements at a strategic level across six areas of good practice. [Read about the Complaints Improvement Framework](#). We are also developing other tools to support specific improvements in quality, learning and root cause analysis.

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

## **SPSO Learning Event Conference**

### **Making the most of complaints: Using learning to improve public services**

**15 March 2017, Central Hall, Edinburgh**

This event will use a mixture of presentations, hands-on workshops and good practice examples from public authorities that use learning from complaints effectively to make their services better. It will provide ideas and tools to help increase the positive benefits of complaints to enable authorities to prevent repeat failings more effectively and bring about change by making the most of the learning.

We will focus on three key themes:

#### **1. Using complaints to drive improvements**

- How do you use complaints data and other sources of management information to identify themes and trends?
- How are networks used to benchmark, as sounding boards and to proactively prevent complaints?

#### **2. Impactful outcomes**

- Risk assessing – how likely is the mistake to recur?
- What level of intervention is required?
- How do you measure the success of the action taken?

#### **3. Improve your complaint handling**

- How do you use quality assurance and self-reflective learning forms and how do you develop a standard and work to it?
- How do you use a complaints investigation as a 'critical friend' and develop independence of mind?
- How do you know that you have investigated 'enough'?

[Read further information about the event and download a booking form](#)

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

### **Social work complaints procedure**

The Social Work Model Complaints Handling Procedure (CHP) was published on 15 December 2016. It brings social work complaints handling in line with the new NHS model CHP that will be introduced from 1 April 2017 and sets out how complaints about social work services must be handled from 1 April 2017. It will apply to all organisations that deliver social work functions, including both local authorities and health and social care partnerships. We formally notified the chief executives of Scotland's local authorities and health boards, in addition to the chief officers of all health and social care partnerships, of the publication of the new CHP.

The new procedure was developed by a working group that included representatives from local authorities, health and social care partnerships, the Scottish Government and the third sector, together with other key partners from the public sector including the Care Inspectorate and the Scottish Social Services Council. We would like to thank all those involved for their invaluable help in producing the new CHP and associated documents, which are available on the Valuing Complaints website.

[Read about the forthcoming changes to social work complaints processes](#)

### **NHS complaints procedure**

We are continuing to work closely with NHS Education for Scotland to update the existing NHS feedback and complaints e-learning modules to reflect the changes in the new procedure. We are also working to develop a programme of education and awareness sessions and will provide further information in future updates.

### **Complaints handling networks**

#### **Local Government**

The local government complaints handlers network met in November and the next meeting will be in March 2017. The network has introduced a working group to consider options for a more effective approach to reporting the annual complaints

performance of councils. The CSA is pleased to be part of this working group, which will meet early in 2017 and report its findings to the next meeting of the full network.

### **Further Education**

The next complaints handling advisory group meeting will take place in February 2017 at the College Development Network in Stirling. The meeting will consider its approach to planning for this year's annual complaints event.

### **Housing**

The next meeting of the housing complaints handlers network will be held in January 2017.

For all previous updates, and for more information about the networks and the CSA, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk) or email [csa@spsso.org.uk](mailto:csa@spsso.org.uk).

## **Scottish Welfare Fund (SWF)**

### **Communications and engagement**

This month we welcomed 13 councils to our Local Authority Sounding Board where we gathered useful feedback about the service and trends being observed by SWF decision makers across the country. One key discussion topic was factors that can be taken into account when considering the qualifying criteria relating to the risk of going into a care institution.

### **Statistics and reporting**

We have responded to 479 enquiries and made 224 decisions (109 on Crisis Grants and 115 on Community Care Grants) since the scheme began on 1 April 2016 to the end of November 2016. November was our busiest month to date, with 49 cases being determined, representing a 36% increase on our previous busiest month.

### **Casework outcomes**

In recent weeks we have determined several cases where applicants have been experiencing issues or delays with their benefits. In one such case, an applicant had

applied for a crisis grant after separating from his partner and being held by the police for several days. When he returned to the property there was no money, gas or electricity and he was not due to receive his payment of Universal Credit for another five days. The council declined the application on the basis that he had received a short-term benefit advance a month previously and had a few tins of food available, therefore they considered that he was not in crisis. We disagreed with this assessment and upheld the review request, awarding a payment for five days which totalled £31.33.

In another case, an applicant had applied for a crisis grant for living expenses after being sanctioned. The applicant was in receipt of hardship payments and noted that he had enough food and electricity to last him for at least three days. The council made reference to not being able to undermine a DWP (Department for Work and Pensions) sanction. We assessed that this reference was incorrect as it had been included in an earlier version of the interim SWF guidance but is not included in the current statutory guidance. Overall, they assessed that the applicant did not meet the qualifying criteria as he was not in a circumstance of pressing need that required immediate action and there was no risk to his health and safety. We agreed with the council's assessment that the applicant did not meet the qualifying criteria therefore did not uphold the review request.

## **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 December 2016**

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