

SPSO NEWS

April 2017

Monthly news from the Scottish Public Services Ombudsman

Today we are laying 56 reports before the Scottish Parliament, including seven full investigation reports about the NHS. In this overview, we highlight:

- key points from our investigations
- changing how we present our recommendations
- refreshing our Valuing Complaints website
- training course dates
- Complaints Standards Authority news including the social work and NHS complaints procedures
- an update from our Scottish Welfare Fund team.

Key points from our investigations

While complaints about any public service sector matter to the people who make them, complaints about the NHS usually have the most serious consequences. Today's reports detail failings in treatment, care, communication and complaints handling, and the impact of these on patients and their families. They contain a total of 35 recommendations for health boards, to support them in using the learning from complaints to ensure that the failings are not repeated.

In one case ([201507556](#)), the cause of a woman's head and neck pain had not been reasonably investigated. While we could not say that the woman's life would definitely have been saved if the relevant tests had been carried out, independent advice that we obtained said that it was probable that her condition was treatable.

In another case ([201603057](#)), a man complained that his sister's neck injury was incorrectly diagnosed. We found that despite the fact that the woman had serious and profound learning difficulties which were detailed in documentation that accompanied her to hospital, these were not properly taken into account. We also found that a senior opinion was not obtained nor were available objective

assessment tools used, and we were critical that the man's opinions were not sought to establish whether he could input into the findings of his sister's examination.

Case [201507587](#) concerned a young boy who suffered a head injury at nursery. He had hydrocephalus and had a shunt fitted soon after his birth to relieve the pressure caused by fluid accumulation. His mother said that because of this, her son should have been given a precautionary CT scan as well as the usual checks and examination. This did not happen. A CT scan taken several weeks later after he fell ill showed that the child's shunt had become dislodged and he had suffered a bleed.

In case [201602345](#), a woman complained that her husband did not receive treatment for a very rare type of cancer until four years after the initial diagnosis, by which point it had progressed considerably. We found that the delay in his receiving treatment was largely due to a failure to review a scan and make further appointments to monitor his condition. However, we also found that there was a failure to discuss his case at a multi-disciplinary meeting when he was first diagnosed, and to discuss his case with a specialist unit. We further found that there was a failure of the responsible consultant to communicate with the man and his GP about the diagnosis. In this case, we also found a large number of basic and fundamental complaints handling failings.

In case [201601541](#), a woman complained about the care and treatment her son received following a road traffic accident. She said the original surgery had damaged a nerve in her son's arm and that he had developed a life-threatening infection. We found that the board had failed to provide a reasonable standard of care and treatment and we were highly critical of their failure to acknowledge that the surgery had not been carried out correctly. We also found that their handling of the complaint was inadequate as it did not properly acknowledge the failures in care, despite the board being aware of these at the time. They also failed to handle the complaint in an open and transparent manner and failed to address the concerns of the family properly.

In case [201508324](#), a woman complained about the care and treatment her late husband received at hospital after he attended by ambulance. Despite her husband

being initially diagnosed with a chest infection, his condition deteriorated suddenly and he died the following day. She questioned whether he was given appropriate treatment and complained that staff did not properly communicate with her. We found significant failings in relation to the treatment he received in the emergency department, including the fact that the board's investigation of the complaint did not pick these up. While we found that the care provided in the Intensive Treatment Unit was of a reasonable standard, we were critical of the communication with the woman about her husband's continuing deterioration.

In cases ([201600216](#), [201600283](#) and [201600284](#)), a woman complained about the treatment she received when she saw a dentist after a bridge that replaced some of her teeth had come off. We found that there had been a lack of care and no evidence that the woman had been adequately advised of her options for replacing the original bridge. There were also failings in record-keeping and complaints handling.

To enable learning and improvement, we publish reports of investigations on our website. You can search these by reference number, organisation, date, subject etc by visiting [our website](#).

Changing how we present recommendations

As we highlighted in our last e-newsletter (and have also communicated directly to authorities), we began presenting our recommendations in a new way from April 2017. The key aim is to further enhance the impact of our recommendations by more directly linking the failing we identify with the improvement we want, and being more explicit about the evidence we will require and by when. The changes are based on the research and analysis we carried out earlier in the year, which included input from authorities through a survey. We also obtained feedback from our customer sounding board and customer forum on the final drafts of the products.

We would also like to take this opportunity to remind authorities that once they have accepted a recommendation, they must comply with it - and supply relevant

evidence to us by the deadline we have indicated. Any concerns about the practical implication of a recommendation should be brought to our attention straight away.

Refreshing our Valuing Complaints website

We have updated our complaints handling good practice website. It aims to help organisations to value complaints at all levels by providing tools for handling complaints (including the model complaints handling procedures); resources and techniques for learning and improving as a result of complaints; and clarifies the need to embed complaints (and complaints data) as a vital part of the overall governance arrangements within organisations. All of the resources from our recent conference are now available to download from our site. More generally, the new site includes:

- [A new bank of tools for handling complaints](#): This includes our guidance on apology, investigation plan template and decision-making tool.
- [Best practice resources for learning and improvement within organisations](#): This includes our self-assessment tool (the Complaints Improvement Framework) and the Quality Assurance tool.
- Details of our [training courses and e-learning](#).

Training course dates

We are holding open courses in complaint investigation skills in Edinburgh on 5 September and 28 November. Please see our Valuing Complaints website for [further details and booking information](#).

Complaints Standards Authority (CSA)

Social work complaints

The [model complaints handling procedure \(CHP\) for social work](#) was introduced on 1 April 2017. From that date, each local authority was required to ensure that their procedure fully complied with the model CHP. Our [Guide to Implementation](#) required all councils to undertake a self-assessment of compliance and submit this together

with confirmation that they had adopted the model CHP across all social work services from 1 April.

At the time of writing, 21 councils had met this requirement and we are now reviewing the assessments and the respective CHPs in detail. We will be providing feedback to each authority over the coming weeks. We would ask the councils that have still to submit their documentation to do so as a matter of urgency.

Some health and social care partnerships (HSCPs) have chosen to have their own social work CHP, alongside the local authority's procedure. It is for each authority and HSCP to determine whether they take this approach; our key concern is to ensure that all social work services are covered by an appropriate procedure.

NHS complaints

The [NHS Scotland model CHP](#) also came into effect on 1 April 2017. This applies to all providers of NHS services in Scotland. From that date, boards and primary care providers were required to ensure that their organisations had implemented the new procedure.

Boards have been asked to provide confirmation to the Scottish Government that they are operating the model CHP and the public-facing CHP across all services. At the time of writing, 14 boards had met this requirement. We are working closely with the government to assess the submissions to ensure that they are fully compliant. We would urge those boards that have still to submit their documentation to do so as a matter of urgency.

Complaints Handling Networks

Local Government

Items discussed at the April meeting included annual performance reporting, the introduction of the social work CHP and priorities for the network over the next 12 months. We were particularly encouraged by the findings of the Annual Complaints Performance Sub-Group and the subsequent agreement of network members to a revised process of reporting which will see the network family group members

receiving annual benchmarking data by the second week of May. This will allow the June meeting of the network to be solely dedicated to benchmarking.

The network welcomed guests from the Scottish Prison Service and the Public Services Ombudsman for Wales. Both reported positively on the meeting and said they would share the learning with their own organisations. Network members also reflected that the external visitors had made a valuable contribution to the meeting.

The College Sector

The complaints handling advisory group met in April. Plans for the 'Learning from Complaints' annual event, to be held on 18 May 2017, are well under way. The event is likely to include an overview of sector complaints received in the previous year, lessons learned, quality assuring complaints handling, developing complaints categories, the journey of a complaint through the SPSO and decision-making.

We would encourage any college sector staff who handle complaints, manage the complaints procedure, have responsibility and/or accountability for complaints performance or have an interest in quality or performance reporting to attend the event. Full details are available from the [College Development Network](#).

The University Sector

We were pleased to attend the university sector's April complaints network meeting. We provided an update on SPSO's recent activities and an overview of the university sector complaints we received during 2016-17. We explained the types of information we would request from a university when considering a complaint, and we outlined the journey of a complaint through SPSO from receipt to closure.

We responded to several questions about the SPSO process and listened carefully to the experience of those university representatives who have had dealings with SPSO over the last year, and undertook to share this feedback with our colleagues. We will continue to liaise closely with the chair of the network, and we look forward to attending future meetings of the network.

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

Scottish Welfare Fund

Communications and Engagement

Raising awareness of the independent review function continues to be a priority as we begin our second year of delivering the service. As such, we recently presented at the Welfare Rights Officer's Forum and are due to speak at the Scottish Social Security Consortium next month. We are also continuing our visits to local authority SWF teams to meet staff, explain our role and discuss some of our findings.

Statistics and Reporting

We have responded to 768 enquiries and made 437 decisions (207 on crisis grants and 230 on community care grants) between 1 April 2016 and the end of March 2017. During March, we determined 67 cases including 33 crisis grants and 34 community care grants. In the coming weeks, we plan to publish a more detailed account of our casework from the first year in our SWF Annual Report.

Casework Outcomes

During recent weeks we have considered a number of cases where applicants have been transitioning between benefits and employment. In one such case, an applicant applied for a crisis grant as he had recently started a new job but had missed the payroll deadline. This meant that he was not due to receive his first wage until several weeks later, and his employer was unable to provide an advance on his wages. The council declined the application as they considered that it was medium priority, and they were only awarding awards at high priority at the time they made their decision. After taking into account all the relevant information, we did not agree with the council that Mr C's application was medium priority. We placed particular weight on the length of time until his first wage and the impact that it could have on his ability to sustain his new job. We concluded that the application was high priority and instructed the council to award a crisis grant for the 34 day period until he was due to receive his first wage.

In another case, an applicant had just started work after a period of unemployment and had only received a partial wage due to the date he started his new job. We assessed that although he had not received a full month's wages, he had still been paid a considerable amount more than the equivalent level of means tested benefit. We therefore assessed that he could not be considered to be on a low income. Additionally, his bank statement showed that he had £50 savings at the time of his application which was subsequently transferred out of the account. Taking the above information into account, we concluded that the applicant did not meet the criteria to be awarded a crisis grant.

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, 26 April 2017

The compendium of reports can be found on [our website](#).

For further information please contact: SPSO, 4 Melville Street, Edinburgh, EH3 7NS
Emma Gray: 0131 240 2974 Email: 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: 0131 240 2974

SPSO website: www.spsso.org.uk

Valuing Complaints website: www.valuingcomplaints.org.uk

Contact us: 0800 377 7330 www.spsso.org.uk/contact-us