SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201706689, Glasgow City Health and Social Care Partnership
Sector: Joint Health and Social Care
Subject: HSCP - Social Work / Complaints handling (incl Social Work complaints procedures)

Summary
Ms C complained about the way that the Glasgow City Health and Social Care Partnership (the HSCP) handled her complaint.

Ms C made a complaint on 16 October 2017 expressing her dissatisfaction with the HSCP's response to her complaint at Stage 1. When she then did not receive a response to her complaint of 16 October 2017, she contacted my office. We queried with the HSCP whether Ms C's complaint of 16 October 2017 had been responded to which the HSCP were unable to tell us. We found that this was unreasonable because complaint responses should be appropriately tracked and recorded under the model Complaints Handling Procedure and the NHS Greater Glasgow and Clyde Complaints Handling Procedure (NHSGGC CHP).

We asked the HSCP on four occasions to review Ms C's complaint of 16 October 2017 and provide her with a response to her complaint as we did not consider all the points raised by Ms C had been addressed by the HSCP. On each occasion we were given assurances that a further response would be sent to Ms C. The HSCP did not send a response to Ms C until more than a year after her complaint of 16 October 2017.

Following the HSCP's response to Ms C's complaint of 16 October 2017, she brought her complaint to this office.

We found that it was not made clear to Ms C why her complaint to Greater Glasgow and Clyde NHS Board was being responded to by the HSCP. Ms C's complaint was also not acknowledged in writing within three working days.

We noted that there was a significant delay in Ms C receiving a complaint response even after we referred the matter back to the HSCP. Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale.

We found that substantially different reasons were provided to Ms C and to this office about the delay, and there was a lack of openness and accountability as to why the significant delay occurred.

We also found that the tone and language used in the HSCP's complaint responses was, at times, inappropriate.

The public are entitled to expect openness and accountability in the way in which their complaint is handled by a public body. These principles were established a number of years ago by the Committee on Standards in Public Life and enshrined in the “Nolan Principles” designed to improve standards of behaviour in public organisations. In this case, we found that the HSCP failed to live up to these principles in the handling of Ms C's complaint and the way in which they have responded to us.

In view of these failings, we upheld Ms C's complaint that the HSCP did not handle her complaint reasonably.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the HSCP to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	It was not made clear to Ms C why her complaint to Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP. Ms C's complaint of 16 October 2017 was not acknowledged in writing within three working days. There was a significant delay in Ms C receiving a complaint response after my office referred the matter back to the HSCP. Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale.	Apologise to Ms C for not making it clear to her at the earliest opportunity why her complaint to Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP; for not acknowledging her complaint of 16 October 2017; for the significant delay in sending her a final complaint response; for not keeping her updated about the reasons for the delay or providing a revised timescale; for the lack of openness and accountability as to why the significant delay occurred and for the tone and language used in the complaint responses. The apology should meet the standards set out in the SPSO	A copy or record of the apology By: 18 September 2019

	Substantially different reasons were provided to Ms C and to this office about the delay and there was a lack of openness and accountability as to why the significant delay occurred. The tone and language used in the HSCP's complaint responses was, at times, inappropriate	guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	

We are asking the HSCP to improve their complaints handling:

Complaint number	What we found	What should change	What we need to see
(a)	It was not made clear to Ms C why her complaint to the Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP. Ms C's complaint of 16 October 2017 was not acknowledged in writing within three working days. In January 2018, the HSCP were not able to tell my office whether Ms C's complaint of 16 October 2017 had been responded to. There was a significant delay in Ms C receiving a complaint response after my office referred the matter back to the HSCP. Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale.	The necessary systems should be in place to ensure that complaints are handled in line with the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure and that all staff responsible for dealing with complaints should be aware of their responsibilities in this respect. The tone and language used in complaint responses should be professional and empathetic	Evidence that training has been carried out with relevant staff involved in this complaint to remind them, in a supportive way, of the principles underpinning the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure. Evidence that the HSCP's systems demonstrate senior level/governance responsibility for complaint handling. Evidence of an audit of a sample of complaint responses since September 2017 to ensure that complaints are being handled in accordance with the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure

	Substantially different reasons were provided to Ms C and to this office about the delay and there was a lack of openness and accountability as to why the significant delay occurred. The tone and language used in the HSCP's complaint responses was, at times, inappropriate		and that the tone and language used is professional and empathetic By: 21 November 2019

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, 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. Our service is independent, impartial and free. 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.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to me about the way in which Glasgow City Health and Social Care Partnership (the HSCP) handled her complaint. The complaint I have investigated is that:

(a) The HSCP failed to handle Ms C's complaint reasonably (upheld).

Investigation

2. With my complaints reviewer, I have carefully considered all the information provided by Ms C and the HSCP, including:

- the complaints correspondence;
- the NHS Greater Glasgow and Clyde Complaints Handling Procedure (the NHSGGC CHP); and
- the NHS Scotland Complaints Handling Procedure (the model CHP).

3. I have decided to issue a public report on Ms C's complaint due to the significant failings my investigation has identified in the HSCP's handling of this complaint and the personal injustice suffered by Ms C as a result. I also consider there may be wider learning available to other bodies who are handling complaints.

4. In particular, I have found that there was an unreasonable and unjust delay in sending Ms C a full response to her complaint, following a request to do so by my office. In addition, the HSCP responses to both Ms C and to my office provided different explanations for the delay; lacked openness and accountability and were not what I would expect from a public body. Ms C was entitled to receive a timely response to her complaint and a reasonable standard of complaint handling as set out by the model CHP. Unfortunately this did not happen.

5. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but I confirm that all the information available during the investigation has been reviewed. Ms C and the HSCP were both given an opportunity to comment on a draft of this report.

Background

6. I have provided below a timeline of Ms C's complaints correspondence and the responses she received, and some details of the issues raised by Ms C, where it has been necessary to do so, to explain the reasons for my decision.

7. In September 2017, Ms C received correspondence from the HSCP offering an appointment with the Community Mental Health Service and a meeting with social work.

8. On 26 September 2017, Ms C submitted a complaint to Greater Glasgow and Clyde NHS Board about being offered an appointment with the Community Mental Health Service without explanation.

9. On 3 October 2017, the HSCP responded to Ms C's complaint about the letter she received from the Community Mental Health Service at Stage 1 of their complaints procedure. In this letter they explained the reasons why Ms C had been offered the appointment and meeting without any explanation or prior contact. Reference was made to contact with the police and Ms C's General Practitioner (GP). They advised that the template letter offering the appointment should have been adapted to suit the circumstances of the referral to the Community Mental Health Service and apologised for this.

10. On 16 October 2017, Ms C wrote to Greater Glasgow and Clyde NHS Board expressing her dissatisfaction with the Stage 1 response she received. In this letter Ms C also raised concerns about the contact from the police and her GP.

11. On 18 October 2017, Ms C submitted a complaint to the Head of Social Work at Glasgow City Council about the contact from social work services. Ms C's complaint was acknowledged by the HSCP on the same day.

12. On 31 October 2017, the HSCP responded to Ms C's complaint of 18 October 2017. This response referred to historical complaints raised by Ms C from 2010 onwards and confirmed the HSCP's view that Ms C's current complaint about their services was without any foundation or rational basis and was not upheld.

13. On 3 November 2017, Ms C submitted a complaint to the HSCP reiterating her concerns about the police and her GP and advising that she would be referring her complaint to my office.

14. On 6 November 2017, the HSCP acknowledged this complaint and referred Ms C to their previous response of 31 October 2017 as to their position on these matters.

15. On 21 December 2017, Ms C referred her complaint to my office.

16. On 23 January 2018, my office contacted the HSCP to query whether Ms C's letter of 16 October 2017 had been responded to.

17. On 1 February 2018, **my office asked the HSCP to review Ms C's letter of 16 October 2017 and provide her with a response to her complaint as we did not consider all the points raised by Ms C had been addressed by the HSCP**.

18. On 19 February 2018 and 6 March 2018, following contact from Ms C advising she had not received a response from the HSCP, my office contacted the HSCP. We were given assurances that a complaint response would be sent.

19. On 2 November 2018, Ms C contacted my office again to make us aware that she had not received a complaint response from the HSCP.

20. On 5 November 2018, my office contacted the HSCP to ask if they had sent a complaint response to Ms C. **The HSCP responded to Ms C's complaint on 15 November 2018**.

21. Ms C remained unhappy with the way the HSCP handled her complaint and she brought her concerns to us on 21 November 2018.

(a) The HSCP failed to handle Ms C's complaint reasonably

Concerns raised by Ms C

22. Ms C is concerned that:

- her letter of complaint dated 16 October 2017 was made to Greater Glasgow and Clyde NHS Board and not to the HSCP. Ms C said that she was not informed that her complaint had been redirected to the HSCP.
- the HSCP did not respond to the points raised in her complaint of 16 October 2017 until 15 November 2018.
- the HSCP's complaint response of 15 November 2018 referred to a separate complaint she made on behalf of her sibling. Ms C said that this should not have been mentioned because it was not relevant to the complaint she made on her own behalf.
- the HSCP's complaint response of 15 November 2018 infers that she is unable to perceive her own mental health problems.
- the HSCP's complaint response of 15 November 2018 said that should she complain in the future about social workers or community based health workers, there would likely be no grounds for complaint.

Glasgow City Health and Social Care Partnership's response

23. In January 2018, in response to enquiries from my office, the HSCP was unable to confirm whether they had responded to Ms C's complaint letter of 16 October 2017.

24. On 1 February 2018, the HSCP said that a final response may have been sent to Ms C's complaint of 16 October 2017. They said they were sourcing all of their internal paperwork to establish what had happened. They stated that if a response had not been sent, they would be happy to write to Ms C to conclude the matter. As noted above, on the same day my office asked the HSCP to review Ms C's complaint of 16 October 2017 and send her a full response given we did not consider they had addressed all the issues raised.

25. My office then contacted the HSCP between February and November 2018 as Ms C had not received a response. On each occasion my office was advised that a complaint response would be sent. A response to Ms C's complaint was subsequently sent by the HSCP on 15 November 2018.

26. In this letter, the HSCP:

- confirmed that their response of 31 October 2017 was their final response to all the complaints Ms C had submitted up until that point. The HSCP apologised if this was not clear and they accepted it would have been helpful if they had explicitly referred to her letter of 16 October 2017 in their response of 31 October 2017. The HSCP acknowledged that it would have been helpful if they had explained at the time that Ms C's complaint about her GP was a matter that she would need to raise directly with her GP.
- apologised to Ms C for not resolving the matter before now and stated that there had been severe workload and resource issues and they did not prioritise the matter, considering it to be non-urgent and had been substantively addressed in all important respects. The HSCP acknowledged that they should have made the time to confirm this to Ms C and apologised that they did not do so.
- said that the services Ms C complained about, including social work services and the community mental health team, are both delivered by the HSCP.
- said that they had asked the community mental health team not to correspond separately with Ms C because this might confuse matters, particularly as Ms C had a separate ongoing complaint with the adult learning disability team in respect of her sibling.

- acknowledged that Ms C does not accept she has any mental health problems and explained that they have a statutory duty to intervene to support people, including individuals who both do and do not have insight into their own mental health.
- said that were Ms C to complain about that type of contact again, regardless of whether the complaint is about social workers or community based health workers, there will most likely be no valid grounds for complaint.

27. As noted above, Ms C remained concerned with the response received and complained to my office on 21 November 2018. On 8 March 2019, in response to my investigation of Ms C's complaint, the HSCP said that:

- they are not a separate authority to the Greater Glasgow and Clyde NHS Board. The HSCP explained that it is an organisational arrangement for the delivery of both health and social care services under the direction of the Glasgow City Integration Joint Board using powers and resources delegated to it from both Glasgow City Council and Greater Glasgow and Clyde NHS Board. They also explained that the HSCP deals with community-based health matters, rather than acute services. The HSCP said the services that Ms C complained about are managed by the HSCP and it was, therefore, appropriate that her complaints were responded to by the HSCP.
- their complaint response of 31 October 2017 did address the concerns Ms C raised in her letter of 16 October 2017 about the police. The HSCP acknowledged that they should have responded to the point Ms C raised about her GP. The HSCP said that their next letter to Ms C of 15 November 2018 addressed all the points she raised in her complaint of 16 October 2017.
- it was relevant to mention the complaint Ms C made on behalf of her sibling because that complaint had been submitted at around the same time as Ms C's other complaints and had created a risk of confusion between responses.
- they did not infer or imply that Ms C is unable to perceive her own mental health problems. The HSCP explained that other agencies had referred Ms C to the HSCP services on the basis of concerns about her mental health and they have a statutory duty to respond to these referrals for both individuals who do and do not accept their mental health problems.
- they made no statement that they would pre-judge any future complaints from Ms C as being without grounds. The HSCP clarified they meant that should Ms C repeat an identical complaint that staff ought not to be writing to her offering appointments or services then there would most likely be no valid grounds for that particular complaint.

- they only sent a response to Ms C on 15 November 2018 because the SPSO insisted upon it. The HSCP said that the insubstantial, irrational and vexatious nature of the complaints should be evident to any person who reads them and they were bemused at being asked by the SPSO to explain these matters again.

Relevant policies, procedures, and principles

28. When the HSCP reply to complaints about service delivery they should be following the NHS Greater Glasgow and Clyde Complaints Handling Procedure (the NHSGGC CHP) or the Glasgow City Social Work Complaints Policy and Procedure (the social work CHP). Ms C submitted complaints about both social work and NHS services. As Ms C's complaint of 16 October 2017 was about the letter she received from the Community Mental Health Service, the HSCP confirmed that they dealt with Ms C's complaint under the NHSGGC CHP. The NHSGGC CHP and the NHS Scotland Complaints Handling Procedure (the model CHP) set out that:

- complaints must be acknowledged within three working days.
- a full response to the complaint should be provided as soon as possible but not later than 20 working days from the time of receiving the complaint for investigation.
- if there are clear and justifiable reasons for extending the timeline, senior management should agree an extension and set time limits on any extended investigation. The customer must be kept updated on the reason for the delay and give them a revised timescale for completion.
- the response to the complaint must address all areas that the organisation is responsible for and explain the reasons for the decision.
- all complaints must be recorded in a systematic way. A structured system should be in place for recording complaints, their outcomes and any resulting action.

(a) Decision

29. In reaching my decision I have considered the individual points Ms C raised with me about the way in which her complaint had been handled as follows:

Response from the HSCP rather than the NHS Board

30. On 26 September 2017 Ms C complained to Greater Glasgow and Clyde NHS Board about the Community Mental Health Service contacting her and offering an appointment without explanation. On 3 October 2017, the HSCP responded to Ms C's complaint. No explanation was provided as to why the HSCP were responding

rather than Greater Glasgow and Clyde NHS Board with whom Ms C had raised her complaint.

31. While I accept the HSCP's explanation that they are not a separate organisation from the NHS Board and that they are responsible for the services Ms C was complaining about, such arrangements may not always be clear to the general public. Given Ms C had complained to Greater Glasgow and Clyde NHS Board it should have been clear to the HSCP that she was not aware these services were provided by them. Not explaining this to Ms C from the outset caused unnecessary confusion.

32. Despite Ms C then continuing to raise concerns with Greater Glasgow and Clyde NHS Board, it was only when the HSCP wrote to Ms C on 15 November 2018, over a year later, that they explained why they had responded and that the services she complained about, including social work services and the Community Mental Health Service, are both delivered by the HSCP. While it was appropriate for the HSCP to take the lead on responding to Ms C's complaint, I consider that the HSCP should have explained to Ms C clearly in October 2017 why her complaint was being responded to by them, rather than by Greater Glasgow and Clyde NHS Board. The delay in doing so was unreasonable.

Delay in receiving the HSCP's final response

33. I note that Ms C submitted a number of complaints in quick succession to various people throughout health and council services. I appreciate how this could present difficulties when coordinating complaint responses. Ms C made a complaint on 16 October 2017 expressing her dissatisfaction with the previous Stage 1 response she had received regarding the Community Mental Health Service offering her an appointment. Ms C also submitted a complaint on 18 October 2017 about correspondence from social work.

34. While I appreciate how this approach may have presented administrative challenges, equally I would have expected the HSCP to have in place systems to mitigate this. I have found that some basic requirements as set out by the model CHP were not followed. I have not seen evidence that Ms C's complaint of 16 October 2017 was acknowledged by the HSCP. The NHSGGC CHP and the model CHP state that complaints must be acknowledged within three working days. The acknowledgement would also have been an opportunity for the HSCP to explain why they would be taking the lead in responding to her complaint, rather than Greater Glasgow and Clyde NHS Board, as outlined above.

35. The HSCP's complaint response of 31 October 2017 refers to Ms C's complaint of 18 October 2017 and focuses on social work services engagement. This letter sets out, in general, what action the HSCP will take when referrals are received about a person's mental health, physical safety or well-being. However, this response does not specifically refer to Ms C's complaint of 16 October 2017 about being offered an appointment with the Community Mental Health Service in September 2017 without explanation. In Ms C's complaint of 16 October 2017, she also raised a concern about her GP. The HSCP did not respond to this point in their letter of 31 October 2017. Under the model CHP and the NHSGGC CHP, complaints should be fully investigated and the issues raised appropriately responded to.

36. On 23 January 2018, my office contacted the HSCP to query whether Ms C's letter of 16 October 2017 had been responded to. The HSCP were not able to tell my office whether Ms C's complaint had been responded to. I consider this was unreasonable. Complaint responses should be appropriately tracked and recorded under the model CHP and the NHSGGC CHP.

37. On 1 February 2018, my office asked the HSCP to respond to Ms C's complaint of 16 October 2017 because it did not appear that Ms C had received a response. On the same day the HSCP told my office that a final response may have been sent to Ms C's complaint. They said they were sourcing all of their internal paperwork to establish what had happened. The HSCP said that if a response had not been sent, they would be happy to write to Ms C to conclude the matter. The HSCP's correspondence indicated that they would either inform my office if a response to Ms C's complaint had already been sent or they would write a response to Ms C. Unfortunately this did not happen.

38. Following communication from Ms C that she had not received a response from the HSCP, my office contacted the HSCP on 19 February 2018, 6 March 2018 and 5 November 2018 to follow this up with them. On each occasion my office was given assurances that a further response would be sent to Ms C. The HSCP did not send a response to Ms C until 15 November 2018.

39. When my office asks an organisation to respond to a complaint, I expect this to be done in accordance with their complaints handling procedure and the model CHP. The NHSGGC CHP and the model CHP state that complaint responses should be provided within 20 working days. If that timescale cannot be met the HSCP should keep the complainant updated on the reason for the delay and provide a revised timescale for completion. In correspondence with my office from February 2018 onwards, the HSCP continued to provide assurances that a response would be sent

to Ms C. Despite this I have seen no evidence that this happened nor did the HSCP update Ms C between February 2018 and November 2018. I consider the HSCP's lack of action, despite assurances to my office that action was being taken, to be completely unacceptable. I also consider that the length of time it took the HSCP to issue a response to Ms C's complaint was wholly unreasonable, particularly taking into account my office had asked for a response to be sent. I note that the HSCP apologised to Ms C for this in their letter of 15 November 2018. I am very critical of this significant delay.

Communication with my office

40. I am concerned that the HSCP's complaint response to Ms C of 15 November 2018 gives a totally different account for the delay than that provided to my office. The HSCP's response to Ms C indicates that they did not respond to her complaint due to workload and resource issues. However, the HSCP have told my office that they only sent the response to Ms C on 15 November 2018 because my office insisted upon it.

41. The HSCP's response to my office suggests to me that the HSCP made an active choice not to respond to Ms C's complaint, despite the request to do so by my office on 1 February 2018 and despite the assurances given to my office and in turn, by my office to Ms C that a response would be sent. This left Ms C without a final response to her complaint for a significant period of time and there was no communication with my office or with Ms C to explain why.

42. In the HSCP's response to Ms C of 15 November 2018 and in correspondence to my office on 8 March 2019, they said that their complaint response of 31 October 2017 was their final response to all the complaints Ms C had submitted up until that point. If that was the HSCP's position, it is not clear why they did not confirm this to Ms C or to my office when enquiries were made in January 2018. My investigation has established that the HSCP's letter of 31 October 2017 does not specifically address Ms C's concern about the Community Mental Health Service offering her an appointment in September 2017 and does not address the concern that Ms C raised about her GP. Therefore the HSCP's position that they had previously responded to all the points raised is not tenable.

43. Notwithstanding this, if the HSCP considered a response was not required at the time my office requested one this should have been clearly stated at the time. Simply not to respond because it was felt not necessary, while telling my office a response would be sent and then later telling Ms C the delay was due to workload pressure does not demonstrate the level of openness and accountability my office

requires and the public rightly deserves from a public body. Poor complaint handling also has a wider impact in that it undermines trust and confidence in public services.

44. The HSCP have commented that the insubstantial; irrational and vexatious nature of the complaint should be evident to all concerned and they were bemused by my office's request. I do not consider there is evidence to substantiate this statement and I consider the HSCP's differing explanations for the failure to respond to be both deeply concerning and unjustifiable.

HSCP's response of 15 November 2018

45. I note that Ms C has a number of concerns about the HSCP's response of 15 November 2018. I have addressed these concerns below.

46. The HSCP stated that Ms C had 'yet another ongoing complaint' with the adult learning disability team regarding her sibling's care management. The HSCP's letter does not go into any detail regarding the complaint about Ms C's sibling. I consider it was reasonable for the HSCP to refer to this complaint because it was mentioned to explain why the HSCP had asked the Community Mental Health Team not to correspond separately with Ms C so as not to confuse matters between the separate complaints she had submitted. However the language used, referring to 'yet another complaint' was unhelpful and unfortunate.

47. I appreciate Ms C is concerned that the HSCP's complaint response suggested that she is unable to perceive her own mental health problems. I have considered this carefully and I note that the HSCP acknowledged that Ms C does not accept that she has any mental health problems. While the HSCP have explained that they have a statutory duty to act on referrals they receive regardless of whether the individual does or does not accept their mental health problems, I consider this should have been communicated to Ms C in a far more concise and sensitive way, thinking about how she would receive and understand the point.

48. The HSCP have explained that their reference to future complaints from Ms C in their letter of 15 November 2018 was to explain that they would not be responding in full to future complaints about the same matter and they have confirmed this in their correspondence to my office. I consider that this could have been explained better and more clearly because the way the HSCP worded their response could be read as them saying that any future complaints about contact from social workers and community-based health workers would be without grounds. Such a statement would be inappropriate as it prejudges the complaint before it is made and should not be open to interpretation in this way.

Concluding comments

49. In conclusion, my investigation has identified a number of significant failings:

- it was not made clear to Ms C why her complaint to the Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP.
- Ms C's complaint of 16 October 2017 was not acknowledged in writing within three working days in line with the NHSGGC CHP and the model CHP.
- in January 2018, the HSCP were not able to tell my office whether Ms C's complaint of 16 October 2017 had been responded to.
- there was a significant delay of over eight months in Ms C receiving a response to her complaint after my office referred the matter back to the HSCP. Under the model CHP a response should have been provided within 20 working days.
- Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale.
- substantially different reasons were provided to Ms C and to my office about the delay, demonstrating a lack of openness and accountability as to why the significant delay occurred.
- the tone and language used in the HSCP's complaint responses was, at times, inappropriate. The HSCP should ensure that their complaint responses are professional and empathetic.

50. The public are entitled to expect openness and accountability in the way in which their complaint is handled by a public body. These principles were established a number of years ago by the Committee on Standards in Public Life and enshrined in the "Nolan Principles" designed to improve standards of behaviour in public organisations. Sadly, in this case, I have found that the HSCP have failed to live up to these principles in the handling of Ms C's complaint and the way in which they have responded to my office.

51. Having considered all the evidence carefully, I uphold this complaint.

52. I have made my recommendations at the end of this report.

53. The HSCP have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The HSCP are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the HSCP to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	It was not made clear to Ms C why her complaint to Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP. Ms C's complaint of 16 October 2017 was not acknowledged in writing within three working days. There was a significant delay in Ms C receiving a complaint response after my office referred the matter back to the HSCP. Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale.	Apologise to Ms C for not making it clear to her at the earliest opportunity why her complaint to Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP; for not acknowledging her complaint of 16 October 2017; for the significant delay in sending her a final complaint response; for not keeping her updated about the reasons for the delay or providing a revised timescale; for the lack of openness and accountability as to why the significant delay occurred and for the tone and language used in the complaint responses. The apology should meet the standards set out in the SPSO	A copy or record of the apology By: 18 September 2019

Complaint number	What we found	What the organisation should do	What we need to see
	Substantially different reasons were provided to Ms C and to this office about the delay and there was a lack of openness and accountability as to why the significant delay occurred. The tone and language used in the HSCP's complaint responses was, at times, inappropriate	guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	

We are asking the HSCP to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a)	It was not made clear to Ms C why her complaint to the Greater Glasgow and Clyde NHS Board was being responded to by the Glasgow City HSCP. Ms C's complaint of 16 October 2017 was not acknowledged in writing within three working days. In January 2018, the HSCP were not able to tell my office whether Ms C's complaint of 16 October 2017 had been responded to.	The necessary systems should be in place to ensure that complaints are handled in line with the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure and that all staff responsible for dealing with complaints should be aware of their responsibilities in this respect. The tone and language used in complaint responses should be professional and empathetic	Evidence that training has been carried out with relevant staff involved in this complaint to remind them, in a supportive way, of the principles underpinning the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure. Evidence that the HSCP's systems demonstrate senior level/governance responsibility for complaint handling. Evidence of an audit of a sample of complaint responses since September 2017 to ensure

	There was a significant delay in Ms C receiving a complaint response after my office referred the matter back to the HSCP. Ms C was not kept updated with the reasons for the delay in issuing the complaint response and was not provided with a revised timescale. Substantially different reasons were provided to Ms C and to this office about the delay and there was a lack of openness and accountability as to why the significant delay occurred. The tone and language used in the HSCP's complaint responses was, at times, inappropriate		that complaints are being handled in accordance with the Glasgow City HSCP's complaint handling procedure and the model complaints handling procedure and that the tone and language used is professional and empathetic By: 21 November 2019

Terms used in the report **Annex 1**

CHP	Complaints Handling Procedure
Ms C	the complainant
the HSCP	the Glasgow City Health and Social Care Partnership

List of policies and principles considered **Annex 2**

NHS Greater Glasgow and Clyde Complaints Handling Procedure.

NHS Scotland Complaints Handling Procedure.

The Nolan Principles (established by the Committee on Standards in Public Life which was chaired by Lord Nolan).