Health

SPSO Scottish Public Services Ombudsman

SPSO COMPLAINTS REPORT 2013 – 14

This is one of a series of reports through which we are continuing to put key messages, information and analysis of complaints about the health sector into the public domain.

We expect health boards to use this report to enhance their learning about the issues the public bring us about the NHS in Scotland and about the quality of their complaints handling. We anticipate that Parliamentary committees, government departments, regulators and other improvement and scrutiny bodies will use it to identify issues arising from the complaints we see.

Equally, we hope it will prove useful to members of the public, and advice and advocacy groups that represent them, by providing information about the kinds of complaints that are escalated to the SPSO, how we handle them, and how we put things right though our recommendations, where we can.

October 2014

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While I think this office makes a difference in all the public service areas we take complaints about, I think our impact is clearest in the health sector. These complaints are frequently serious and often harrowing. They may have caused significant distress because of a death or the poor treatment and care of the person who has complained or their loved one. People who raise concerns about the way they or someone else felt they were treated by the NHS are, understandably, highly motivated to make sure that lessons are learned. They want action to be taken to ensure that the same thing does not happen to anyone else.

The way we ensure that this happens when we find things have gone wrong is through our recommendations for redress and improvement. We made 684 recommendations to health boards last year, well over half the total of all the recommendations we made.

The case studies in this report give an idea of the kinds of recommendations we make. We often ask boards to apologise for failings, and some recommendations go much wider, such as asking them to review or change a policy, or to carry out staff training or awareness raising. We publicise as many investigations as we can, along with our recommendations, so that health boards and others can learn from our findings and use them to improve services.

This past year, I have been pleased to see how our work is contributing to the many initiatives underway in Scotland to create a more person-centred NHS. 2013/14 saw a further strengthening of our relationships with other scrutiny and improvement bodies such as the Scottish Health Council, Healthcare Improvement Scotland and NHS Education for Scotland. I welcome such partnership, and am confident that working in tandem with these organisations and others will help to ensure that the NHS in Scotland has the tools it needs to continuously improve.

I am particularly pleased that the Scottish Health Council have recommended that our Complaints Standards Authority lead on developing a more succinctly modelled, standardised and person-centred complaints process for NHS Scotland. This builds on our successful work in developing standardised complaints handling procedures for other public sector areas in Scotland and we look forward to taking this work forward, along with other SPSO-related recommendations.

Volumes and issues

First, the numbers:

- we received 1,379 complaints about the NHS (almost 31% of our caseload)
- this was 11.5% more complaints than last year
- the rate of upheld complaints was 55%, up from 52%
- the rate of complaints coming to us too early dropped again from 30% to 26%

The issues people brought us were similar to previous years, with GP and hospital services topping the list. Prison healthcare complaints moved up to third place, and complaints about dental and orthodontic services dropped. There was a large increase in the number of complaints reaching us about clinical treatment and diagnosis, which is not surprising given that this is the key service provided by the NHS. Complaints about care of the elderly have also continued to rise – again not surprisingly, given our aging population.

Ombudsman's introduction

I welcome the continuing decrease in complaints reaching us too early. I am, however, concerned about the small rise in upheld complaints, and particularly about those health boards that have the highest rates of upheld complaints. The Patient Rights (Scotland) Act 2011 introduced the Charter of Patient Rights and Responsibilities. The Charter explains that the Act gives all patients the right that the health care they receive will:

- consider their needs;
- consider what would most benefit their health and wellbeing;
- encourage them to take part in decisions about their health and wellbeing; and
- provide them with the information and support to do so.

Some three years down the line, some of the complaints that I see indicate that there is still much to do to ensure that the rights that the Act envisages are upheld.

As I do each year, I have sent each chief executive and board chair a letter providing their own board's statistics (these letters and the statistics are available on our website). I expect them to use this information, in conjunction with other complaints data that they are now required to gather and publish under the Patient Rights Act, to analyse their complaints handling performance. They should use all this information to assure themselves of the quality of their complaints handling procedures and the tangible learning and improved services that have resulted from handling complaints well.

Looking ahead

For some considerable time now, I have been voicing my concern about the time it is taking for coherent complaints procedures to be put in place for services delivered under the integrated health and social care models, where there are conflicting existing legislation-based complaints processes. People using these services can often be vulnerable. They need to know where to turn if things go wrong. The organisations delivering the services and those with an oversight and improvement role – the regulators, inspectorates and scrutiny bodies – also need clarity on this and I will continue to push for it.

Another area of concern that I have raised repeatedly is prisoner access to the NHS complaints procedure. Although some action has been taken to remove the barriers that prisoners are experiencing, I am very disappointed that we are continuing to find that some boards are failing to give prisoners the same access to complaints processes as other people.

I have continued to find a great deal of value in our sounding boards this year. We have a customer sounding board, with members from advocacy and advice organisations across a wide range of areas, including representatives of the Patient Advice and Support Service and Patient Opinion. Our NHS sounding board is made up of many different stakeholders including a director of nursing, a member of a GP representative body, a health board chief executive, a health board chair, a medical director, a complaints manager and an infection control manager, as well as representatives from Healthcare Improvement Scotland and the Scottish Health Council. I have listened hard to the views expressed and found that each board facilitates two-way discussions that are frank and insightful, and provide mutual benefit in sharing expertise and knowledge. I am very grateful to all the members for their time and input.

Over the coming year, I look forward to continuing to work with others to ensure that the needs of people using the NHS are central to how they are cared for, and that they feel able to voice any concerns they have about the decisions made and the quality of the care they receive. In this way, we will continue to have an NHS in Scotland of which we can be proud.

Jim Martin, SPSO

Casework

Complaint numbers

In 2013/14 we received and dealt with 11.5% more complaints about health than in 2012/13. We received 1,379 (31% of total complaints) compared to 1,237 (30% of total) the year before. The rate of increase in complaints received slowed compared with the 23.5% increase in 2012/13. Our sense is that these increases are not in themselves a concern. They most likely reflect a positive trend in people feeling more able to complain and more hopeful that doing so will lead to change.

Premature complaints

The rate of health complaints coming to us too early is always low in comparison with other sectors, and this year it dropped again from 30% in 2012/13 to 26%. This traditional low rate in premature complaints can be attributed to the fact that for many years now the NHS has operated a more streamlined complaints process than other sectors. This has now changed, however, as a result of our complaints standards work, with other sectors catching up and implementing standardised, simplified complaints handling procedures, with a subsequent reduction in premature rates across all sectors.

Complaints investigated

We investigate a higher proportion of complaints about the NHS than about any other sector (almost one in three). This is partly because of the low premature rate, which means that more complaints come to us that are 'fit for SPSO' (ie cases that are about something we can consider and that are ready for us to look at). Another, more significant, reason is that we have greater powers in health than in any other sector. In other sectors, we are precluded by the law from looking at professional judgement; in health, however, we have specific powers to look at clinical judgement. This means we can consider what health professionals did and whether this was reasonable in the circumstances. This allows us, for example, to examine the nurse's care, the GP's diagnosis or the surgeon's decision and come to a conclusion, usually with the help of independent specialist advice, about the reasonableness of their actions.

Upheld complaints

We uphold complaints wherever we find fault, even if this has already been recognised by the board. We do this to recognise the validity of the complainant's experience. People come to us for an external, independent judgement about what happened and if we find that something went wrong it is important for the complainant that we acknowledge this. We also include in our reports how the board or GP practice responded to the original complaint and any action that they took, or plan to take, to put things right. Where a board or practice has responded well, while we will uphold the complaint, we may also publicly commend them for acknowledging the mistakes that happened and the action they took to resolve this for the complainant, and we are unlikely to need to make recommendations.

Public interest reports

As a result of the higher proportion of investigations, and the serious consequences of something going wrong, the majority of complaints that we publish as 'public interest' reports are about the NHS. In 2013/14, 38 of our 44 detailed public investigation reports were about the health sector. They covered a range of issues, including mental health, pressure sores, care of vulnerable adults, barriers to prisoners accessing the NHS complaints process and record-keeping.

Casework

What do people complain about?

The top two areas complained about remained the same, and the number of prison healthcare complaints received more than doubled and moved to third place in the table. There is a section specifically about prison complaints later in this report. Complaints about care of the elderly in hospital rose from 58 to 86, and complaints about A&E doubled, but on small numbers (from 34 to 68). Dental and orthodontic services was the only area where we received fewer complaints in 2013/14 than in the previous year.

The top five subjects complained about remained the same. There was a 55% increase in the number of complaints reaching us about clinical treatment and diagnosis. This is not surprising, given that this is the key service provided by the NHS. Other areas where numbers increased were complaints about communication (up 22%) and appointments and admissions (up 78.5%) although these were both on very much smaller figures of complaints received, meaning that any increase appears more marked.

Top areas of health complaints received 2013/14

Area of complaint	Number of complaints received received	As % of all health complaints
GPs and GP practices	250	18
Hospitals – general medical	219	16
Prison healthcare	129	9
Hospitals – care of the elderly	86	6
Hospitals – A&E	68	5
Dental & orthodontic services	61	4
Hospitals – gynaecology & obstetrics (maternity)	60	4
Hospitals – orthopaedics	58	4
Hospitals – psychiatry	52	4
Hospitals – general surgical	46	3

Top subjects of health complaints received 2013/14

Clinical treatment/diagnosis	913
Communication/staff attitude/ dignity/confidentiality	128
Appointments and admissions/waiting lists	75
Policy/administration	57
Complaints handling	43
Admission, discharge & transfer procedures	26
Continuing care	15
Nurses/nursing care	15
GP lists	12
Record-keeping	10

Casework

Key figures in health complaints 2013/14

We received **1,379** complaints and dealt with **1,324***

The rate of upheld complaints was **55%**, up from 52% last year, and higher than the year's overall rate of 50%

The rate of complaints coming to us too early dropped from 30% to **26%** compared to last year (the overall rate for all sectors is 34%)

People who received advice, support and signposting **740**

Cases decided after detailed consideration pre-investigation **198**

Complaints fully investigated **386**, with **382****publicly reported to the parliament during the year, including 38 detailed investigation reports

We made **684** recommendations for redress and improvement

* There is some carry forward each year.

** Some cases published in 2013/14 will have been handled in 2012/13. In a small number of cases, we do not put information into the public domain, usually to prevent the possibility of someone being identified.

Issues in health complaints

As we have already highlighted, the cases reaching us about clinical treatment and diagnosis increased by 55% in 2013/14. This is a very broad subject and complaints were about equally broad areas of the NHS – mainly across hospital services, GPs and dentists. Of the 214 health cases in which we upheld or partly upheld the complaint, the vast majority (156, or 73%) related to clinical treatment or diagnosis. It is worth noting, however, that a complaint about clinical treatment often involves other issues; for example the nursing care a person received, a concern that their dignity was compromised or their needs not taken into account, or that records were not properly kept.

Key case study

Failings in GP treatment and diagnosis

A young child had been suffering serious symptoms including weight loss, fatigue, vomiting, nausea and bone pain. His family took him to their medical practice many times, where he was seen by different GPs who carried out examinations and tests. He was eventually referred to hospital, although not urgently. His mother pressed for an earlier appointment, which he got. The child was eventually diagnosed with cancer and although he received treatment, he died some months later.

After this the practice carried out a significant events analysis of the child's treatment. We were particularly concerned that although they apologised for an element of his treatment they said they would not, with hindsight, have managed his care differently, given his symptoms and their findings at the time. Our GP medical adviser pointed out that there are guidelines for identifying warning signs of cancers, including in children, and that the medical records showed that the child had several relevant symptoms. We also found that before this happened he had only been to the practice three times in six years, yet in the year in question he had been there thirteen times and had other medical contacts. Our adviser identified a number of failures in the GPs' handling of the child's care and said that the medical records suggested that they should have viewed his symptoms with a far higher degree of suspicion and recognised the significance of his symptoms.

We recommended that the practice write to the child's parents apologising for the failings we identified and offer to meet with them to reinforce that apology. We also said that they should provide us with evidence that the child's case has been discussed with all the GPs involved, as a learning tool, and that learning points are taken forward as part of their continuous professional development.

Case 201300703

Vulnerable people

We continue to receive complaints about the treatment of vulnerable people, who often cannot speak up for themselves. This group includes patients with dementia or learning difficulties as well as those in the care of mental health services either in hospital or, more often these days, in the community. Where we can, and where we can do so without breaking our duty of confidentiality, we will let other organisations that may be able to help know about the issue.

Key case study

Capacity for decision-making

This complaint concerned the care of a woman who had Down's Syndrome, a learning difficulty and severe dementia. She had no family and no welfare guardian, and an independent advocacy worker had been appointed to ensure that her rights were enforced and protected. The woman was in hospital several times. She couldn't feed herself, and was fed through a tube. Hospital doctors decided that she should not be resuscitated if her heart stopped, and staff decided to remove her feeding tube during one admission to hospital.

After the woman died, her advocate complained to us about these decisions. We found that the decision to stop feeding was taken before the woman's dementia status was assessed. We also found that the medical records did not support some of what the board said about the background to that decision. The doctor in charge had the final say on the resuscitation decision, but no-one spoke to the advocate or the woman's carers about it to explain it or find out what she might have wanted, which is what we would expect to have happened.

The board have made several positive changes since this happened. However, we were very concerned about how they decided about treatment and how they dealt with the woman's decision-making capacity. They knew they were dealing with a very vulnerable person, but there were significant delays in acting on legal safeguards that should have protected her. We recommended that the board use the woman's case to review their practices when caring for patients with learning difficulties and suspected dementia, particularly in decision-making. We also asked them to improve their record-keeping in a number of areas. Because of our concerns, we highlighted her case to the Mental Welfare Commission for Scotland.

Case 201104966

The care of older people is another area where patients may be particularly vulnerable, and about which we regularly receive complaints. During the year, we upheld or partly upheld complaints in 31 cases that we recorded as being directly about care of the elderly. We recorded many more cases involving older people's care and treatment.

Key case study

Lack of assessment of care needs and rehabilitation

This case raised important issues under the Charter of Rights for people with dementia and their carers in Scotland. A man was taken to hospital after a seizure. He had early onset dementia, and sight and hearing difficulties. He had a stroke in hospital and was discharged to a care home, where he was given no physiotherapy care. His wife felt that he was left to vegetate and said that, despite her having welfare power of attorney for her husband, the hospital had not included her when making decisions about his care and treatment.

Among other failings, we found that the man's care needs were not adequately assessed, there were no meaningful attempts at rehabilitation or to discharge him home, and his dignity was not respected. The man and his wife suffered a significant personal injustice and we also identified broader failings in hospital staff's general understanding of peoples' rights under the relevant legislation (the Adults with Incapacity (Scotland) Act). To redress the personal injustice as far as possible, we recommended that the board apologise to the couple and that, if his wife agreed, they thoroughly assess the man to find out whether he would benefit from physiotherapy and if so, arrange this. We also made recommendations to improve staff training in the care of people with dementia, and asked the board to audit the ward's compliance with the legislation.

Case 201204498

In another example an elderly man was not properly assessed and his family were not communicated with properly (case 201202679). The man was 87 years old and was admitted to hospital after falling at home. While he was in hospital, he suffered further falls and fractured his hip. He died in hospital nine days after surgery on his hip and, because of a delay in the death certificate being issued, funeral arrangements had to be postponed, further adding to his family's distress. We upheld the family's complaint that the board did not assess the man's risk of falling when he was admitted, or often enough during his stay, even though he was known to be at high risk of this and his family had warned staff about it. We also found that food and fluid intake management and monitoring were insufficient and that staff did not communicate effectively with the man's family during his care and after his death. We made eight recommendations for improvement to the board concerned, including that they review their falls risk assessment policy and procedures; ensure that staff are trained in using this and in monitoring patients considered to be at risk, and ensure that they remind staff of the importance of food and fluid management and communicating effectively with patients and their families.

Casework

Nursing care

Concerns about nursing care are often an underlying issue in broader complaints about hospital care and treatment. Areas where we have come across problems include assessing patients for risks, such as their risk of falling or of developing pressure ulcers, and the steps taken to minimise that risk. When reporting the key case study described here, the Ombudsman issued a strong message in his monthly commentary, stating that pressure ulcers should be a thing of the past in Scottish hospitals. Ulcers are often avoidable if the patient is correctly assessed, proper equipment provided and monitoring carried out. Sadly, once they occur, healing and treatment can be very difficult, as this example shows, where a woman experienced significant complications because of pressure ulcers, which meant that she could not return home and had to remain in hospital.

Key case study

Poor nursing care

A woman who is paraplegic was admitted to hospital with severe headache and neck pain. She was there for seventeen days, being treated for meningitis. When she came home, her husband found that she had developed extensive and serious pressure ulcers, and he contacted the district nurse for help in dressing these. The nurse said she did not know that the woman had them. The woman had to return to hospital because the ulcers and associated complications meant she could not be nursed at home, and she was still in hospital when we investigated the complaint some time later. Her husband complained, among other things, that there was no discussion about arrangements for his wife's care at home or equipment needed to manage her pressure ulcers, although a hospital bed was brought there some two weeks after she left hospital. Our nursing adviser said that no-one seemed to consider the fact that the woman was paraplegic or that she was acutely ill, and there was little evidence of what was done to reduce the risk of pressure ulcers. Communication between hospital and community nursing staff was poor, and meant that the district nurse lacked key information and equipment.

The woman should not have been discharged until a suitable bed had been provided for her return home.

The board concerned had acknowledged that their risk assessment for pressure sores was incorrect, there was no tissue viability nurse service, and there were communication issues and concerns around the discharge arrangements. They provided an action plan to address the issues they found in the complaint. This was appropriate but we found the key problem to be a lack of cohesion between the board's very clear policies and what staff actually did. Staff carried out only parts of the policies, which meant that what they did wasn't effective. We made a number of recommendations, including that the board apologise to the couple, provide staff training on proper implementation of policies, including recording the actions taken; and provide us with evidence of what they have done to implement their action plan.

Case 201103459

In another case we found that an elderly woman, who has since died, was not properly assessed when she was admitted to hospital (case 201204018). Staff had used a risk assessment tool, but had not scored her correctly on this when assessing her risk of falling. This meant that she did not get the intensive care plan that she needed. We were also concerned that when the board investigated the complaint they did not spot that the scoring was wrong. We recommended, among other things, that the board should apologise to the woman's family and look again at the assessment process to ensure that in future staff exercise clinical judgement when assessing risk, and keep accurate records.

Communication

We all know that good communication between healthcare professionals and patients, clients and relatives is a key factor in how we experience healthcare. When people are properly involved and engaged in care and treatment, they are more likely to be satisfied with the care provided. The value of connection to and compassion from another human being when we are vulnerable cannot be underestimated. It is, therefore, no surprise that failings in communication continue to feature strongly in many of the complaints that people bring us.

Casework

We receive complaints that express many emotions such as frustration, anger, sadness and fear. We hear about people being deeply disappointed and upset with the level of information given and shared. And we also hear about information being given too late, with important consequences. Below are two examples of such complaints, where there was a lack of communication with the family and between healthcare staff. The failings resulted in the families not being contacted or consulted about major decisions.

In the first, a woman's father was taken to hospital when he was very unwell with pneumonia and kidney damage (case 201301771). He also had an abdominal aortic aneurysm (a bulge in a blood vessel caused by a weakness in its wall). At first, he responded well to treatment, but his condition deteriorated and he died. His deterioration was consistent with the aneurysm having burst. His daughter complained it took too long to find out that this had happened, and that staff did not communicate adequately with the family.

We found that the man's treatment was reasonable, but we upheld the complaint about communication. Conversations between staff and relatives were not documented and there was little evidence to suggest that the family were made aware of the treatment being carried out, or were involved in conversations about the man's care. Our nursing adviser said that they should have been contacted sooner about his deteriorating condition, and should have been included in major decisions about his treatment. We recommended that the board apologise to the family for the communications failures and remind staff to inform relatives about and involve them in the patient's care, and to properly record discussions with them.

In the second case, a man went to A&E with stomach pains (case 201300003). Staff decided that he should be transferred within the hospital for further assessment, but this did not happen for some eleven hours. After he was transferred, he became unwell and died. His wife had been at home some sixty miles away, and could not get to the hospital before her husband died. She complained to us about his care and treatment and about what happened after she arrived at the hospital.

Among other things, our nursing adviser said that nursing staff should have told his wife how ill the man was when they phoned to tell her that he had been transferred to the high dependency unit. The fact that he had been transferred there in itself indicated that she should have been called to the hospital. We found that she had been treated with a fundamental lack of sensitivity, particularly when seeing her late husband after he died. Staff had not properly cared for him after death and, understandably, she found this extremely distressing. She told us that, when she saw him, he looked as if he had died in extreme pain and she has been unable to remove that image from her mind. The chief executive had apologised personally for what had happened, but we made a number of recommendations including ensuring that staff are aware of their responsibilities, both in preserving dignity in death and in being sensitive to the needs and feelings of family members in such a situation. As guidance in this area[1] makes clear, caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right.

In this case, the man was clearly dying, yet his family were not told and were unable to prepare for his death. There was evidence in the notes that both the nursing and medical staff knew he was nearing the end of his life, yet no one clinician took responsibility to call his family. Families should be given the opportunity to be with their loved ones if they wish, as being unable to say goodbye can affect the grieving process. Healthcare professionals also have a duty to consult families when patients are deteriorating or nearing the end of their life. These conversations are important and should include preparing families for death and dying.

1 *Guidance for staff responsible for care after death* **www.nhsiq.nhs.uk/media/2426968/care_after_death___guidance.pdf**

Casework

Waiting lists and delays in receiving treatment

We dealt with 71 complaints about delay in receiving appointments or treatment in 2013/14. In some cases, the problems were serious. One such example was of a young man with mental health problems who was twice on the waiting list for treatment (case 201204084). He was not, however, seen as both times the board removed him from the list because he was either being investigated by the police or was awaiting trial. The board said that they did this in accordance with their usual protocol. We took independent advice on the case from a consultant forensic psychiatrist, who said that the board's protocol went against the NHS policy of individualised care according to need. The young man's requirements and circumstances had not been properly taken into consideration and he had received no treatment for his significant psychological needs. As well as apologising and making sure that the young man's outstanding mental health needs are now addressed, we said that the board should look again at their protocol in terms of the Healthcare Quality Strategy for NHS Scotland 2010.

In many cases, however, we found that nothing had gone wrong. For example, a woman complained that she was not immediately offered physiotherapy after she was discharged from hospital (case 201304536). The board explained that they provide physiotherapy advice before discharge and the patient should continue with these exercises until their normal six week review. We found that this practice is commonly used throughout the NHS, and that staff followed normal procedures. In another case, a man complained of delay in carrying out his knee surgery, and that this breached waiting times (case 201203486). There was a gap between his first consultant appointment and the second (at which the consultant decided to go ahead with surgery). We found, however, that this was because tests were needed to make sure that surgery was the right option, and because of the complexity of his operation. The waiting time target only applied once it was certain that the man would be having surgery, and once this decision was made, the operation was carried out in three weeks.

Apology

It is possible that when things go wrong staff may be concerned about apologising. However when staff do make mistakes, early communication is vital. Being able to say 'I am truly sorry…' allows a member of staff to make a connection as a fellow human being and can be the first step in resolving an issue. We encourage NHS staff at all levels to apologise when things go wrong.

The quality of written apologies that boards and GP practices provide to complainants can be variable. Some are clear, empathetic and personal, others sound formulaic and formal. To support boards in making meaningful apologies, we have produced SPSO guidance on apology and we offer training in this area as well.

Record-keeping

A regular learning point from our NHS investigations is the importance we place upon medical records as a primary source of evidence. It is essential that clinical and nursing staff accurately record what has been done, or not done, both from a medical care and a communication point of view. Equally importantly, the record should show why particular action was taken or not taken, especially when standard practice is not being followed.

In one example, a cancer patient was undergoing treatment and had to have a Hickman Line (a tube for administering chemotherapy) inserted (case 201203628). He complained that this caused him a great deal of pain. We found no evidence that the procedure was not carried out properly. Our medical adviser said that patients will experience differing levels of pain and there was no evidence that anything went wrong. However, the adviser pointed out that nothing was written in the medical records at the time about the problems the man experienced. The radiologist who performed the procedure had spoken to the man afterwards, and agreed to make a record in the clinical notes and to put an alert on the electronic records saying that he needed sedation for this in future. This, however, did not happen and when the man had to be admitted for a further line to be inserted he was, understandably, distressed that the team were not aware of his experience. Because of this, although we did not uphold the complaint about the procedure, we made recommendations about record-keeping.

In a different example, a man went to A&E with a badly cut hand (case 201203387). He was assessed by an emergency nurse practitioner, who said he had superficial cuts, and treated them by closing them with adhesive strips. Over the next year or so the man continued to have problems with his hand, for which he was reviewed by his GP and orthopaedic specialists and discharged on each occasion. He complained to us that his finger was bent and painful and that the nurse should have conducted a more thorough assessment or asked a doctor for advice.

We found that the record-keeping of the initial assessment was not of a reasonable standard. It did not show that the nurse carried out a full examination of the injury including of movement and the wound base of the cuts. Our nursing adviser said that it was difficult to know from the records if there was evidence of a further injury that would have meant the man should have been referred to a specialist. We were happy that the follow-up treatment was reasonable, but upheld the complaint about his treatment in A&E.

Prison healthcare

Nine of the 14 regional health boards in Scotland have responsibility for the healthcare of prisoners. This responsibility moved to them from the Scottish Prison Service in 2011, and since then we have been the final stage for prisoners with complaints about their healthcare in prison. As in other areas of healthcare, most of the complaints we received and dealt with were about clinical treatment and diagnosis.

Although we received few complaints directly about complaints handling, we did in a number of cases find failures in this in addition to the main issue complained about. We also identified the issue of failure to follow the NHS process, and this features as a case study later in this section (case 201203374).

Prison healthcare cases received by subject 2013/14

Clinical treatment/diagnosis	104
Appointment and admissions/waiting lists	8
Complaints handling	8
Communication/staff attitude/ dignity/confidentiality	6
Policy/administration	2
Nurses/nursing care	1
Total	**129**

We determined 122 prisoner complaints about healthcare in 2013/14. Of these we investigated 32 in detail. We partly or fully upheld 17 and did not uphold 12.

Casework

One the main reasons prisoners complain to us is that they have been prescribed a different medicine from the one that they were prescribed when they were in the community. This is most commonly medicine used to treat pain or a sleeping disorder. We usually ask our clinical advisers to look at these cases and provide independent advice. While in the majority of cases they agreed with the prison's assessment that it was reasonable for the prisoner to be prescribed the different medicine, in a few cases our advisers identified that the person's needs were not properly considered.

An example of each type of case follows – in the first, where we did not uphold the complaint, a prisoner complained about the drug prescribed for his sleeping disorder (case 201300723). He was unhappy that his prescription for this was reduced, then stopped. He was given an alternative but said that it did not agree with him. Our adviser said that the prison health centre acted reasonably in reducing the drug, which is in fact only licensed for short term use, and pointed out that the man was aware of this when it was first prescribed. There was also evidence that he was reviewed appropriately, and was told several times that the prescription needed to be reduced.

In a case where we did uphold the complaint, a prisoner told us that the prison health centre stopped his pain medication (case 201302414). He said he was prescribed this in the community, and it was the only one that helped with his pain. The community GP had confirmed this to the prison health centre, but staff there had decided he did not need it and prescribed different medication. Our adviser said that they did not appear to have assessed the circumstances in detail, and that the original medication was in fact likely to be suitable for that type of pain. The information suggested the man had tried various types of pain relief but they had all been unsuitable. We recommended that the board review his clinical need for the pain relief he requested.

Another feature we noted was an increase in complaints about delay in or failure to provide both medical and dental care. One of the issues that seems to have underpinned this is that when responsibility for these complaints changed there were no guidelines in place aimed specifically at the treatment of prisoners. This has now been addressed, with the Scottish Government drafting principles for treatment, and boards with responsibility for prison healthcare reviewing their practices.

Key case study
Prison healthcare

A prisoner said that the prison dental hygienist did not see him quickly enough, and that when he reported a broken tooth it was nearly four months before he saw a dentist. The board told us that when they took over responsibility for prison healthcare they had no guidelines for the treatment of prisoners but this was now in hand. They also said that the prison had audited their practice against the board's new dental services standard statement.

The hygienist had recommended that the man be seen again after three months, which our adviser said was appropriate, and we could not find out why it took eleven months for this to happen. The man's gum disease got worse while he was waiting to be seen. It also took too long for him to see a dentist, which was likely to have contributed to his tooth decay and the possibility that he might lose a tooth. We were concerned that the board did not identify this while investigating his complaint. As well as asking the board to apologise to the man for the delays, we asked them to show us evidence of the audit they carried out.

Case 201204744

In another case, a prisoner normally attended the prison health centre two or three times a month (case 201202627). At one point he asked several times to see a doctor but was only given reply slips in response. These either asked for more information or said he did not need an appointment as his medication was correct. The board told us that doctor appointments are made after referral by a nurse. They said the doctor knew about the requests and had decided he did not need to see the man. We found that the prisoner's medical treatment was correct, but that he was not given a doctor's appointment until some five months after asking.

Although it is reasonable for a nurse to assess the need for the appointment, we thought it unreasonable to repeatedly block access, particularly if a patient thought their condition had changed. We said that prison healthcare staff should be made aware of our view that it would have been better for the doctor to have seen the prisoner to discuss this, and explain what happened.

Prisoner access to the NHS complaints process

Through our investigations (for example cases 201203514 and 201203374) we have highlighted serious concerns about prisoners' access to the NHS complaints procedure. We have found that there appear to be two main obstacles. The first is that some prisoners find it difficult to get beyond the feedback stage. They say that when they want to complain, they are given a feedback form, and that complaints forms are not being provided. Others say that, because of misunderstanding by prison medical centres about the process that should be used, they are effectively forced to go through an additional 'feedback' stage before they can reach the complaints stage.

This is at odds with the Scottish Government *Can I help you?* guidance from which it is clear that NHS users are not required to complete a feedback process before accessing the complaints procedure, and that the same applies to those receiving NHS care and treatment in prison.

In the policy and engagement section, we outline in more detail how and where we have raised these concerns.

Key case study

Prison complaints handling

A prisoner was unhappy with how his healthcare complaints were treated. He had sent the board a lot of feedback forms and a complaint form. Although the amount of work involved meant that these would have taken time to deal with, we found that the board did not handle them properly. We said they should apologise and ensure that their local process is in line with the guidance.

Of even more concern, however, was that we found that prisoners' access to the complaints process was restricted. Although the board said that they thought forms were available to those who wanted to complain, and that prisoners could write directly to the board with a complaint, we found that prisoners normally had to complete a nurse referral form, then ask for a complaints form. Even then, they sometimes only received a feedback form, unless they said that they didn't want one. This meant that in some cases the feedback process was used as an extra level of the NHS complaints process. NHS users don't have to do this before accessing the complaints process, and this should still be the case when people are in prison. We recommended that the board make sure that prisoners could in future have easy access to NHS complaint forms.

Case 201203374

Impact

This section outlines what we have done to ensure that the outcomes of our consideration of complaints, in particular our recommendations, were relevant, joined-up and drove improvements in public services. We also highlight how we have shared strategic lessons from complaints and what we have done to further strengthen our relationships with advocacy and advice groups that support complainants.

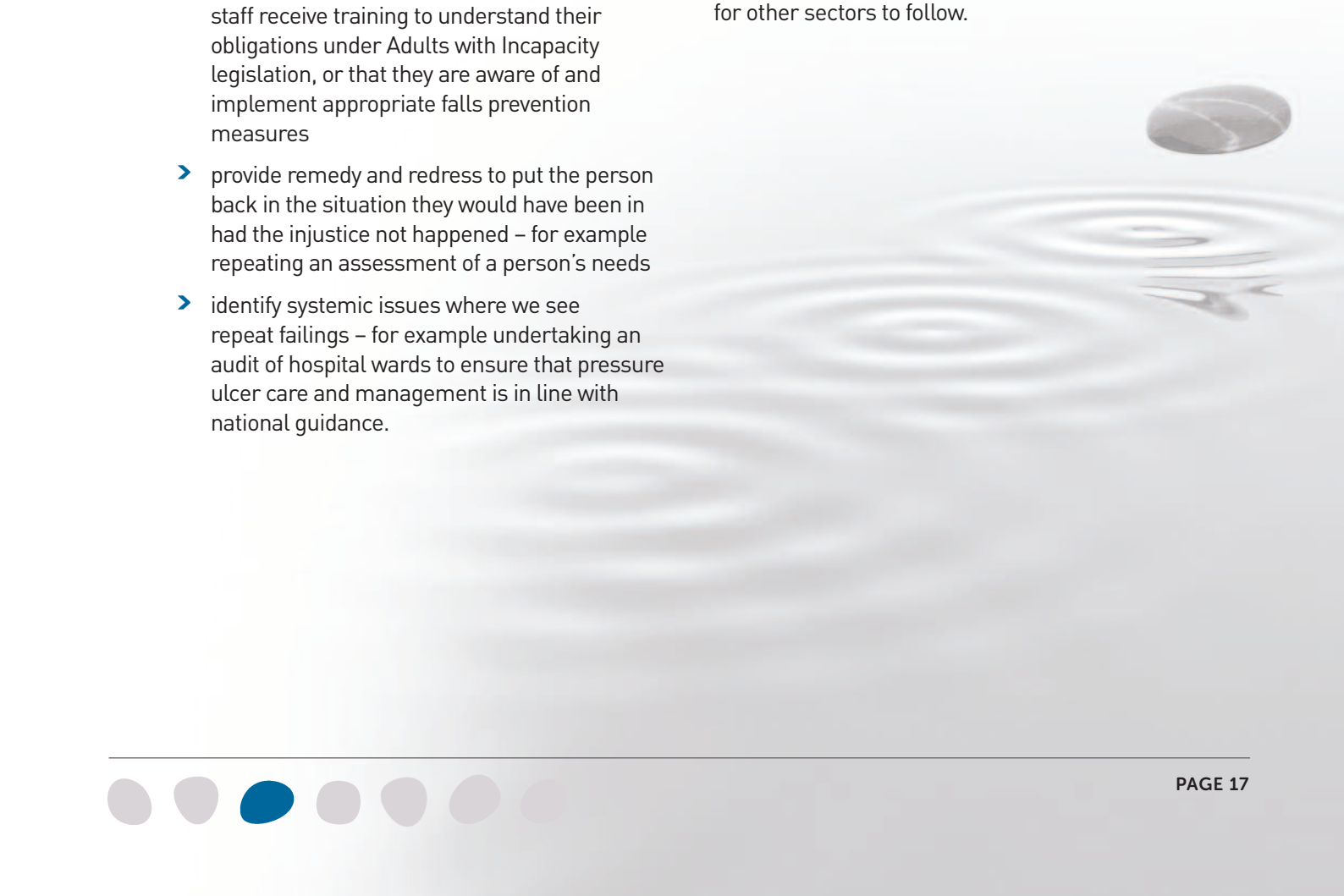
Tracking and following up recommendations

In 2013/14 we made 684 recommendations about the NHS in Scotland, up from 557 the previous year. As the case studies we highlight in this report show, we use recommendations to put things right, as far as we can. They may include asking boards to:

- recognise the impact the injustice has caused – for example through a letter of explanation and apology
- prevent the same thing happening again, and where relevant prevent it happening to other people – for example ensuring that staff receive training to understand their obligations under Adults with Incapacity legislation, or that they are aware of and implement appropriate falls prevention measures
- provide remedy and redress to put the person back in the situation they would have been in had the injustice not happened – for example repeating an assessment of a person's needs
- identify systemic issues where we see repeat failings – for example undertaking an audit of hospital wards to ensure that pressure ulcer care and management is in line with national guidance.

We are rigorous in asking boards for evidence of implementation by the deadline we set. Evidence includes copies of apology letters demonstrating that they satisfy our guidance on meaningful apology; copies of the new policy/procedure or review/audit we have asked for, with the action plan for implementation; documentation showing that the staff training we asked for has been carried out or that findings from our investigation have been shared with the relevant staff and reminders have been communicated.

Where appropriate, we will ask one of our independent advisers to assess this evidence as well. This can happen with any of our recommendations, but we do so particularly where we have identified systemic issues. If we find that an organisation has not provided robust evidence, we go back to them until the recommendation has been implemented to our satisfaction. We also liaise with the Scottish Government Health and Social Care Directorate, which tracks recommendations within the health sector, and we see this as a progressive model for other sectors to follow.



Impact

Sharing strategic lessons

Through our recommendations we try to fix things for people and ensure that the NHS learns lessons from complaints and monitors improvements. While it is ultimately for health boards themselves (supported and driven by regulators and other improvement and scrutiny bodies) to bring about change on the ground, our recommendations are significant tools that can help bring about that change.

We see our role as identifying failings and making recommendations that put organisations back on the right track. We see it as the role of other scrutiny bodies to regularly review processes and ensure that organisations are on that track on an ongoing basis. To put it another way, our investigation is a red flag that should make an organisation sit up, take notice and make changes. Regulators and other improvement and scrutiny bodies carry out green flag checks in a continuous and systematic way that show that the organisation are acting properly.

There are three main ways in which we share learning:

- putting information, including analysis and trends, into the public domain;
- working alongside regulators and other improvement and scrutiny bodies to ensure that people's concerns are fully addressed and they do not fall between the cracks; and
- encouraging regulators and other improvement and scrutiny bodies to build key aspects of good complaints handling into their work where possible, to help drive a valuing complaints culture across the public sector.

Publishing information

We share learning from the complaints we see through:

- publishing a significant volume of decisions and statistics about sectors and individual service providers on our website
- e-newsletters, sectoral reports, annual letters and our Valuing Complaints website
- consultation and inquiry responses
- providing written and oral evidence to parliamentary committees and others
- participating in working groups
- conferences, meetings, presentations, visits and so on.

Our annual letters to the health sector[2] provide details of the complaints we received and dealt with, along with premature and uphold rates, compared with the previous year. Healthcare providers and other organisations in the sector use these statistics to help assess complaints performance.

As we reported last year, we also worked with individual organisations, some in the health sector, that we identified as having both high volumes of complaints reaching us and high uphold rates after investigation. Having analysed the reasons for these last year, we are continuing to work with a small number of organisations where we feel a greater strategic focus on good complaints handling will help them reduce both the volume of complaints and their uphold rates.

Maximising the impact

We share the outcomes of our investigations with regulators and other scrutiny and improvement bodies, to maximise the change that can come about from our findings and recommendations. An example of the interrelatedness of our work was highlighted in our April 2013 commentary about the care and treatment provided to a young man before he committed suicide (case 201003482). The **Mental Welfare Commission for Scotland** (MWCS) had conducted a review into the man's death and used the case to raise broad concerns about how services respond to young people with multiple problems. When we investigated the case, we did so from our specific standpoint of looking at the individual experience of the person who had brought the complaint, in this case the father of the young man.

Given our different roles and remits, the MWCS review and our investigation examined some different areas. However, the two reports complemented one another in many ways, and several of the conclusions were similar.

2 http://www.spso.org.uk/statistics-2013-14#letters

Impact

We have a duty to alert the appropriate authority if we see serious failings and may also do so if our investigation points to the possibility of a systemic issue. In these cases we may pass on information to professional regulatory bodies such as the **General Medical Council**. We have arrangements with regulators and others set out in protocols and memoranda of understanding, which are published on our website.[3]

Encouraging good complaints handling

The key elements that we encourage regulators and other scrutiny and improvement bodies to ensure are built in are:

- clear accessibility and visibility of the complaints procedure and related information. This includes clear signposting and support for those with needs or difficulties in accessing the system, as well as ensuring that real or perceived barriers to complaining have been identified and removed
- a focus on resolving things early at the frontline, including ensuring apologies are given freely and action taken where things go wrong
- recording all complaints and reporting this regularly in line with model complaints handling procedures or other requirements such as the Patient Rights Act
- learning from service failures, with systems in place to analyse and report on complaints outcomes, trends and actions taken. This would include seeking opportunities to share learning across the relevant sector.
- ensuring that processes are in place to identify and respond immediately to critical or systemic service failures or risks identified from complaints
- strong, visible leadership on complaints from senior staff, including support and training and a recognition of the importance of effective complaints handling to good governance.

Engaging with advice and advocacy workers

People who make complaints to us are often supported by advice and advocacy workers, in particular by Patient Advice and Support Service (PASS) advisers. To ensure good mutual understanding of the services we each provide, we met regularly with Citizens Advice Scotland and PASS coordinators to discuss how to raise awareness of any areas of concern or ways to resolve issues that the public brought us. In 2013/14, we developed a guide to all our key information leaflets for bureau managers, and an e-learning module about the SPSO for bureau staff and PASS advisers. This material is also available through the Scottish Independent Advocacy Alliance.

We were pleased that the independent feedback website Patient Opinion continued to grow, and we welcome their emphasis on the positive as well as the negative experiences of people using the NHS. We also supported the work of the NHS Complaints Personnel Association Scotland (NCPAS) through attending their meetings as observers. We provided input about the complaints handling issues that we saw and received valuable feedback about our service and about the challenges faced by NHS complaints handlers.

3 http://www.spso.org.uk/memoranda-understanding

Case studies

This is a selection of case studies from investigations we published for 2013/14.

Some illustrate the double injustice that can happen when a poorly delivered service is compounded by poor complaints handling. Other case studies are included to show some of the positive actions that organisations take in response to complaints. To share this good practice, in the report on our website we normally highlight where an organisation has taken such action. Others are included as examples of where organisations have delivered a service and investigated the complaint properly.

These case studies are brief summaries and may not contain all the information we published about the complaints. You can find more information online at **www.spso.org.uk/decision-reports.**

Adults with incapacity – board's guide not followed

A woman had power of attorney to make decisions for her late brother, who had profound learning and communication difficulties. He was admitted to hospital, where he died three days later from a blood infection. The woman told us that hospital staff did not discuss his care and treatment with her. She said that when her brother deteriorated, she could have provided important information about his normal condition, which could have informed how he was treated. The board apologised that staff did not act on changes in her brother's medical condition but said this was not due to his learning disabilities.

The board have a good best practice guide in line with the principles of the Adults with Incapacity Act (Scotland) Act 2000. It says that as well as the views of the individual, staff should as far as possible take account of the views of family and carers. However, the guide was not followed in this case. The woman was not involved in the decision-making process and, more importantly, her information about her brother's deterioration was not taken seriously. We said that the board should apologise to her, remind staff of the best practice guidance and make sure it is used for relevant patients.

Case **201304515**

Case studies

Inappropriate removal from GP list

A medical practice suddenly removed a woman and her elderly mother from their list of patients, because of the woman's behaviour. They did not warn her that this was going to happen, nor did they invite her to discuss it with them. The practice said that they believed they had followed procedures because they told the health board about the removal. We found, however, that they had not followed relevant guidance and the NHS General Medical Services Contract, which says that deregistration should only be a last resort. Medical practices are entitled to remove patients from their list, but should only do so after warning the patient that their behaviour is giving cause for concern, that they have to improve it and that if the patient doesn't, they risk being deregistered. The only exception to this is where violence is involved, which can trigger immediate deregistration. As this was clearly not the case here, we upheld the complaint and recommended that the practice apologise to the family and ensure that staff understand what they need to do if something like this happens in future.

Case **201300401**

Communicating treatment options

A woman complained that her dentist didn't give her enough information about available treatment options and costs. She said that this meant that she was treated as a private patient rather than by the NHS. We found, however, that the dentist gave her a written estimate of the cost of treatment. Our dental adviser also examined the records, and confirmed that she received the appropriate treatment and had consented to it being provided privately. The dentist had correctly explained the options, and had also explained that the treatment the woman wanted could not be provided on the NHS without a six month delay. Our adviser also pointed out that there was no guarantee that the dentist could have provided it on the NHS, as he would first have had to obtain permission to do so.

Case **201104023**

Case studies

Delays in treating patient with profound disabilities

A mother complained about delays in providing dental treatment to her profoundly disabled daughter. She said that after her daughter went to the dentist it was seven months before she received treatment and that, because of her disability, her daughter received a poorer standard of care than that given to the general population. She also complained that the board did not deal with her complaint properly.

After taking independent advice from our dental adviser on the care and treatment provided, we found that the mother had initially questioned both the treatment and the approach recommended by the dentist. Because of this, the board were in the unusual position of having to have two dentists present during the treatment, and also had to satisfy themselves that what was being agreed with the mother was in accordance with the policies with which they had to comply. These complex discussions and additional arrangements created understandable, and not unreasonable, delay. However, after an approach was agreed upon it was three months before this was confirmed to the patient and her mother, which we did find unreasonable. We also found that the board showed a similar lack of urgency in responding to the complaint. We recommended that they apologise, confirm that they have put a protocol in place to avoid this happening again and remind staff of the importance of following the complaints policy.

Case **201300258**

Delay in assessing for and providing weight-loss surgery

A man's GP referred him to a health board's weight management service in August 2009. They lost the paperwork and the GP sent it again in February 2010. The board told the man that he would be psychologically assessed within a couple of months, but this did not then happen for a year. In October 2011, it was confirmed that he met the criteria to be assessed for surgery, for which he would be referred to another board. His GP referred him there, but nothing happened. This was because referrals were not being accepted because of the level of demand for the service, but no-one explained this to him. Meanwhile in July 2012 new criteria were put in place and in October that year the board told the man that he did not meet these and was no longer eligible to be referred.

Our investigation found that, but for the loss of the referral and the delay in psychological assessment, the man would have been assessed for surgery under the criteria in place before July 2012. We said that the board should have followed through on their agreement to further assess his suitability, and that they should now consider prioritising this and apologise to him for the delay and lack of information.

Case **201202880**

Case studies

Clinical treatment and diagnosis by ambulance team

A woman had experienced severe breathlessness, and had collapsed several times at home. During one of these episodes an ambulance was called, but was cancelled when she became more alert. Another ambulance was called later when she collapsed again. The ambulance crew helped her into bed, but said that there was not much more that could be done at that point, even if they took her to hospital. She continued to struggle with her breathing and in the early hours of the following morning, an ambulance took her to hospital. Shortly after arriving there, she collapsed and, despite attempts to revive her, she died. The woman was found to have a pulmonary embolism (a blockage in the artery that transports blood to the lungs). Her father complained to us because he thought that she might have survived had an ambulance crew taken her to hospital earlier, or had the crew that did eventually take her to hospital acted with more urgency.

We found that the ambulance crews obtained relevant information about the woman's recent symptoms and made thorough examinations. Our medical adviser said that the woman was displaying two symptoms that could indicate pulmonary embolism, but that these were also symptoms of more common illnesses, including viral infection, which is what her GP thought she had. Although with hindsight it was clear that her symptoms were related to a serious underlying condition, this would not have been clear to the ambulance crews at the time.

Case **201300911**

Ambulance transfer and complaints handling

A man, who had been out for a drink with friends, fell downstairs at home. His wife found him unconscious and finding it very hard to breathe. When an ambulance arrived she said the crew didn't seem to want to take him to hospital and she overheard them talking about 'drunks'. She said they only took him because his blood pressure was low. The crew transferred the man to a wheelchair to take him to the ambulance. He ended up paralysed, and his wife thought that this had something to do with the way the ambulance crew transferred him.

We couldn't say whether what the ambulance crew did had any effect on what eventually happened. But we found that once they realised how he had fallen, and that he had been unconscious, they should have immobilised him as soon as possible, and they didn't do that. The ambulance service's response to the complaint also didn't reflect the seriousness of this allegation and suggested that the staff involved weren't interviewed. Much later, we were told that one of them had in fact left and the other had been disciplined. We were very concerned that the ambulance service did not send us all the information at the start, and that they gave us the missing details so late. We said they should have their complaints process externally audited to make sure it was fit for purpose. We also said they should apologise to the man and his wife because he wasn't properly immobilised and because their investigation wasn't good enough.

Case **201301204**

Case studies

Mental health assessment and complaints handling

A young man with a history of mental health problems and drug/alcohol abuse had been trying to sort out his problems, and had been drug-free for some time. However, he relapsed, after which he became very distressed and pleaded with his parents to help him. They took him to A&E, and told a doctor that he had expressed suicidal thoughts. The doctor asked an on-call mental healthcare nurse to make a psychiatric review, but the nurse said that the young man was too intoxicated. He was discharged, and was found dead from an accidental overdose three days later. The young man's parents complained that the care and treatment provided was inadequate – they thought that he should have been admitted to hospital.

The board said that there is a national gap in service provision in such cases, and our medical advisers agreed that this is true for patients who present with both substance misuse and mental health problems. Our mental health adviser also pointed out, however, that the on-call nurse wrote nothing in the medical notes. The nurse later wrote to the man's GP saying that a mental health assessment was needed, as he couldn't assess the young man because he was unable to wake him. We found no evidence of this, however, and it contradicted medical evidence in the notes that the young man was conscious and alert an hour before. Our adviser said that the nurse should have made every effort to wake and assess him, and appeared to have disregarded the parents' concerns about the mention of suicide. The adviser pointed out that there was no physical medical reason to admit the young man to hospital, but the lack of psychiatric assessment meant that there was no evidence about whether he was mentally fit for discharge.

We recognised that this was a difficult situation but upheld the complaint about his care and treatment because the young man was discharged without a mental health assessment. We also found that the board's complaints handling was poor, as there was delay, and a lack of empathy towards the young man's parents. We recommended that the board apologise to them for these failings, and create a protocol for dealing with patients who attend A&E with issues relating to both substance misuse and mental health.

Case **201203602**

Improving complaints standards

NHS complaints handling

In March 2012, the Scottish Government revised their *Can I Help You?* guidance on the NHS' standardised complaints handling framework. In line with this, since 1 April 2012 NHS boards in Scotland have been required to produce an annual report on their use of feedback, comments, concerns and complaints. The Scottish Health Council (SHC) undertook a review[4] of the first reports published for 2012/13, comparing how boards responded to the new requirements and identifying potential areas for future improvements in reporting.

The SHC concluded that 'The reports from the NHS Boards vary significantly in terms of both format and content. Some NHS Boards did not produce all the required information, some produced what was required, and others went beyond this to provide a fuller account of feedback, comments, concerns and complaints on their services. In future it may prove useful to develop a framework for how NHS Boards report this information.'

Following this, the Scottish Government initiated a review of feedback and complaints in the NHS through the SHC and Healthcare Improvement Scotland. The review involved visits to all 21 boards to meet senior management teams and those responsible for complaints and also sought the views of patients on feedback and complaints arrangements.

Their report *Listening and Learning*[5] was published in April 2014. It made a number of specific recommendations to the SPSO's Complaints Standards Authority. Since the report's publication, we have been involved in discussions with the Scottish Government, SHC and others on taking forward these recommendations and we look forward to working in partnership with the sector in doing so. Our aim will be to align the NHS model as much as possible with the model CHPs we have developed in other sectors, within the framework of the Patients Rights Act and associated requirements.

SHC *Listening and Learning report* recommendations

1. The Complaints Standards Authority has developed a number of modelled complaints processes across other areas of the public sector. As experts in that area, they should lead on the development of a more succinctly modelled, standardised and person-centred complaints process for NHSScotland, in collaboration with the public, NHS Boards and the Scottish Health Council. This should build on the requirements in the guidance and legislation but articulate more clearly the outcomes expected and the indicators and measures that will demonstrate quality alongside timeliness.
2. Explicit reference should be made in that process to address the following.
   - Assist the staff managing feedback, comments, concerns and complaints to better understand the definitions of each.
   - Ensure that service users, carers and families can be involved to the level they wish.
   - Encourage early resolution and front line ownership.
   - Ensure that the focus on improvements as a result of the learning from all types of improvement is clear.
   - Ensure that the processes for complex complaints are integrated with the management of serious and adverse events.
   - Focus on quality alongside timeliness.

4 www.scottishhealthcouncil.org/publications/research/review_of_nhs_feedback.aspx
5 www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx

Improving complaints standards

Training

Listening and Learning also identified a role for the SPSO's training unit. The report said:

'The range of training made available recently via NHS Education for Scotland and the Scottish Public Services Ombudsman has been extremely helpful and supportive to NHS Boards and independent contractors in enabling them to ensure their staff can respond to feedback and complaints and use this as a means of delivering service improvements. The blended learning approach taken of e-learning, master classes and face-to-face training has enabled learning right across organisations from the boardroom to the ward or clinic and also for individual practice.'

E-learning

The SHC report highlighted that to date around 3,000 NHS staff members had undertaken e-learning modules developed by SPSO and NHS Education for Scotland (NES), and that evaluation of these was positive.

Our e-learning partnership with NES began in 2012 and in 2012/13 we jointly developed modules for frontline NHS staff. In 2013/14, we built on this, developing an e-learning module on investigation skills. This helps participants explore the complaint investigation journey from first receipt through to the final decision. It also deals with how lessons from complaints can be learned and shared, and includes examples of good practice.

All our e-learning training materials are currently free and available to all public sector organisations. The NHS in England are adapting the modules for use in training their staff.

SHC *Listening and Learning* report recommendations

- NHS Education for Scotland/Scottish Public Services Ombudsman online e-learning modules are recognised as an essential basic training requirement for all staff providing direct services for patients, as a priority.
- Power of Apology training is made a priority for those staff with responsibility for managing, co-ordinating and contributing to complaints responses. Consideration should be given to central funding to support the attendance and delivery of this locally/nationally as required.

NHS Education for Scotland should:

- Ensure that the new complaints investigation skills e-learning module is publicised and disseminated across NHSScotland for staff who are investigating complaints including those who are involved in preparing and writing complaints responses. This may include the provision of face-to-face training to supplement the e-learning, where necessary.

Direct delivery courses

In 2013/14 we provided four direct delivery courses to health organisations, our main focus having been on other sectors. We do, however, anticipate further demand from the NHS in the future following the SHC report's recommendations on training and on developing the NHS complaints process.

In addition to the direct delivery courses, we developed tailored materials for GPs and dentists. With the support of NES, we created audio case studies as a training tool for practice managers. SPSO trainers also delivered workshops on how to use the material to over 200 GP and dental practice managers, who could then cascade the learning throughout their own practices.

Improving complaints standards

Accountability and governance – creating the right culture

Listening and Learning also drew attention to the Ombudsman's master classes on complaints as part of corporate governance and responsibility for executive and non-executive board members. We developed these in partnership with NES and ran them in November and December 2013. They were designed to support these board members and senior level staff by raising awareness of the importance of robust complaints and feedback arrangements in improving the care and experiences for people who use their services. They focused on the value of complaints as indicators of performance, service quality and risk and used lessons from the Francis report on the failures at NHS Mid-Staffordshire to highlight the risks of not including complaints information as a core part of a board's approach to gaining assurance about the service being provided. A video recording of the session is available on the NES website alongside all the other tools that we have developed for NHSScotland staff.

Participants reported that the sessions had significant impact and the Ombudsman has since delivered a number of tailored sessions to individual NHS boards. This reflects how vitally important it is that the leaders of organisations create and embed a culture of person-centredness, transparency and candour, where complaints are welcomed and valued, wherever they come from.

For more about our training activities, visit **www.spsotraining.org.uk**

Policy and engagement

In 2013/14 we strengthened our links with other scrutiny, regulatory and improvement agencies, as well as with NHS boards and other stakeholders, in order to maximise the learning from the complaints people bring us. In the previous section we outlined the work that we will be taking forward with the Scottish Health Council and others to improve the NHS complaints procedure and wider aspects of complaints handling. Other key interactions with stakeholder agencies are described below.

Adverse events working group

We took part in Healthcare Improvement Scotland (HIS)'s working group looking at new guidance for adverse incident reviews. There were areas of clear mutual learning – for example, the group noted a significant overlap in the skills needed to investigate complaints and to review adverse events, and looked at supporting NHS boards to translate learning into service improvement and to share outcomes across services and boards. The working group reported in May 2014, and we are continuing to work with HIS to take forward the recommendation to align learning from complaints and adverse events.

Sounding boards

We want to involve the public and the organisations that we investigate in helping us improve our service. We also want to understand the challenges faced by the NHS, and ensure that our recommendations are clear and relevant. To support this aim, we set up two sounding boards in 2013/14.

The customer sounding board is made up of members of different public service user groups including Age Scotland, Alliance Scotland, a prison visiting committee, Citizens Advice Scotland, Patient Opinion Scotland and the Scottish Independent Advocacy Alliance. We welcomed their input to the information we give customers about our service and on initiatives such as our proposed revised service standards. The sounding board also discussed more general themes such as social media and other routes for feedback and complaints, people's experience of health and social care integration complaints pathways and prisoner access to complaints processes.

In 2013/14, our NHS sounding board met twice, following its inaugural meeting in March 2013. It is made up of senior NHS professionals from across Scotland, including representatives of chairs of boards, chief executives, medical and nursing directors and complaints handlers. The sounding board allows for frank, two-way discussions about our role and effectiveness. It helps us listen to where we can improve our service, and provides a constructive environment for discussion and better understanding of issues, away from the consideration of individual cases. At its most recent meeting, areas discussed included the Scottish Health Council's review of complaints and feedback; the key role of governance and culture in complaints handling; SPSO's NHS training; how the SPSO uses independent professional advice; prisoner healthcare; health and social care integration; and redress and apology.

Evidence to committees and consultation responses

The complaints that people bring us provide a valuable source of information about their direct experiences of using health services and complaints systems. We use this knowledge to inform our responses to inquiries and consultations.

For more information visit **www.spso.org.uk/sounding-boards**

Policy and engagement

Health and social care integration

In October 2013, Parliament's Health and Sport Committee invited us to give evidence about the role of regulators and complaints bodies in relation to integration. We highlighted how important it is for the complaints route to be clear and accessible to service users, and for there to be no legislative barriers that restrict the ability of public bodies to investigate and respond to complaints in a joined-up way. We remain concerned that it is still unclear how complaints about the new bodies and integrated services will be handled, and we continue to raise this issue. These concerns are all the stronger because people using health and social care services can often be vulnerable.

At the evidence session, the Ombudsman expressed his concern about the time it is taking for simple, coherent and effective complaints procedures to be put in place. He commented *'...If we are serious about integration, all aspects [...] should be looked at, which should include complaints. It is a matter of some urgency. I would not want a system to be put in place and then have a lag on the complaints side that causes people to become frustrated with the system and begin to lose confidence in it. I urge people to think carefully about that.'*

We highlighted the need for clarity around complaints in two other policy areas in 2013/14. These were in our responses to separate Scottish Government consultations on guidance in relation to self-directed support and to the delegation of some local authority functions under mental health and adults with incapacity legislation.

Barriers to prisoners raising complaints

Following the transfer of responsibility of healthcare in prisons to the NHS, we identified some barriers to prisoners raising complaints. We raised these concerns early on, most publicly in January 2013 when the Ombudsman gave evidence to the Health and Sport Committee. In a May 2013 investigation (case 201203514) we found that a prisoner had been unreasonably denied access to the process. We commented in our newsletter and subsequent evidence to the Health Committee that: *'It is now 18 months since the transfer of responsibility and it is high time that these issues were fully addressed.'*

In October 2013, we highlighted the same issues appearing in a different health board – this features as one of our case studies elsewhere in this report (case 201203374). In written evidence to the Health Committee before a second appearance there in February 2014, we said that while we appreciated there would be a time lag while problems are ironed out, we would be very disappointed if we were continuing to report on access issues into 2014.

We receive dozens of contacts from prisoners across the Scottish prison estate. Like everyone who is concerned about their health, some of the prisoners phoning our office are, as well as needing medical attention, very anxious and upset. Those feelings are compounded by frustration at being unable to access the NHS complaints procedure. We have been advised by Scottish Prison Service staff that this can lead to potentially difficult situations arising. We have shared this warning with Scottish Government officials and were pleased to see some progress in the form of reminders to relevant health boards about the correct process and the need for complaints forms to be made available.

It is clear from discussions with some health boards that access by prisoners to the NHS complaints process remains problematic. It is worth noting that the numbers of complaints we receive remains well below the levels escalated to Scottish Ministers under the previous complaints system. It is also clear to us that the quality of health boards' responses to complaints from prisoners is variable. We are continuing to raise this with the boards concerned.

For more information see **www.spso.org.uk/consultations-and-inquiries**

Statistics

Health cases determined 2013/14

Stage	Outcome	Admission, discharge & transfer	Appliances, equipment & premises	Appointments/admissions	Clinical treatment/diagnosis	Communication, staff attitude, dignity, confidentiality	Complaints by NHS staff	Complaints handling	Continuing care	Failure/delay in sending ambulance	Hotel services (food, laundry)	Hygiene, cleanliness & infection control	Lists	Nurses/nursing care	Other	Policy/administration	Pre-contractual/commercial matters	Record-keeping	Subject unknown/out of jurisdiction	Total
Advice	Not duly made or withdrawn	4	1	11	220	33	0	5	2	2	0	0	3	3	4	12	0	1	30	331
	Out of jurisdiction (discretionary)	1	0	0	17	4	0	0	1	0	0	0	0	0	0	0	0	2	0	25
	Out of jurisdiction (non-discretionary)	0	0	0	5	4	3	1	0	0	0	0	0	0	3	1	0	1	1	19
	Outcome not achievable	3	2	4	30	9	0	3	1	1	1	1	1	0	0	8	0	1	1	66
	Premature	11	1	25	162	28	0	15	4	2	0	0	3	3	2	21	0	2	18	297
	Resolved	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	2
	Total	**19**	**4**	**40**	**434**	**78**	**3**	**25**	**8**	**5**	**1**	**1**	**7**	**6**	**9**	**43**	**0**	**7**	**50**	**740**
Early Resolution 1	Not duly made or withdrawn	2	0	3	23	13	0	0	3	1	0	0	1	0	0	2	0	1	0	49
	Out of jurisdiction (discretionary)	0	0	1	17	4	0	2	0	1	0	0	0	0	0	0	0	1	0	26
	Out of jurisdiction (non-discretionary)	0	0	0	6	3	0	0	0	0	0	0	1	0	1	3	1	0	0	15
	Outcome not achievable	0	0	3	21	5	0	1	1	1	0	1	1	1	1	1	0	0	0	37
	Premature	1	0	5	36	4	0	3	1	0	0	0	0	1	0	2	0	0	0	53
	Resolved	1	0	0	10	3	0	1	1	0	0	0	0	0	1	1	0	0	0	18
	Total	**4**	**0**	**12**	**113**	**32**	**0**	**7**	**6**	**3**	**0**	**1**	**3**	**2**	**3**	**9**	**1**	**2**	**0**	**198**
Early Resolution 2	Fully upheld	0	1	2	5	4	0	2	1	0	0	0	2	0	0	0	0	0	0	17
	Some upheld	0	0	1	2	0	0	0	0	0	0	0	0	1	0	0	0	0	0	4
	Not upheld	1	0	6	24	6	0	2	0	0	0	0	0	1	1	1	0	0	0	42
	Not duly made or withdrawn	0	0	0	5	0	0	1	0	0	0	0	0	1	0	0	0	0	0	7
	Resolved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**1**	**1**	**9**	**36**	**10**	**0**	**5**	**1**	**0**	**0**	**0**	**2**	**3**	**1**	**1**	**0**	**0**	**0**	**70**
Investigation 1	Fully upheld	3	0	7	53	4	0	2	0	1	0	0	0	0	0	2	0	1	0	73
	Some upheld	4	2	0	63	5	0	1	0	0	0	0	0	4	0	2	0	1	0	82
	Not upheld	0	0	3	99	8	0	1	1	0	0	0	0	1	0	2	0	0	0	115
	Not duly made or withdrawn	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
	Resolved	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total	**7**	**2**	**10**	**223**	**17**	**0**	**4**	**1**	**1**	**0**	**0**	**0**	**5**	**0**	**6**	**0**	**2**	**0**	**278**
Investigation 2	Fully upheld	0	0	0	23	0	0	3	0	0	0	0	0	1	0	0	0	0	0	27
	Some upheld	1	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
	Not upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**1**	**0**	**0**	**33**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**38**
	Total complaints	**32**	**7**	**71**	**839**	**137**	**3**	**44**	**16**	**9**	**1**	**2**	**12**	**17**	**13**	**59**	**1**	**11**	**50**	**1,324**

Further information is available at **www.spso.org.uk/statistics**

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