

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid two investigation reports before the Scottish Parliament today. We also laid a report on 53 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in October), we received 458 complaints. In addition to the three reports we laid before Parliament, we determined 452 complaints and of these we:

- gave advice on 314 complaints
- handled 93 complaints in our early resolution team
- decided 45 complaints through detailed consideration
- made a total of 104 recommendations in decision letters.

## Ombudsman's Overview



### Assuring quality

Last month, I was invited to give a presentation to the Scottish Parliamentary Corporate Body (SPCB) about our casework quality assurance (QA) process. This is the process we have developed for assuring ourselves, the public and other stakeholders that the decisions we come to are the right ones, by providing demonstrable evidence of the soundness of these decisions. The SPCB's invitation followed a presentation I gave to the National Seminar of the European Network of Ombudsmen in Dublin after our QA process was selected by our international peers as an example of innovation in Ombudsman offices.

I was pleased on both occasions to have the opportunity to explain our process and to outline other factors that feed into providing a quality service, including organisation design, process efficiency, service delivery and learning. My philosophy is that quality is built through an integrated programme of continuous service improvement and that ultimately, to deliver quality, our actions must be driven by what matters to our customers and whether or not we are adding value for them and for public services.

### Sounding board initiatives

One way we are building quality is by increasing our engagement with the general public and local authorities. We have set up sounding boards to help us understand what people are looking for from us, how we can improve our service to them, and how we can help service providers get things right first time, or where they do not, to help them learn from their mistakes.

Our customer sounding board, made up of representatives of different public service user groups, will meet for the first time next month. I see the sounding board as a key contributor to our review of our customers' journey, helping us ensure that we continue to build clarity, transparency, timeliness and empathy into our service for complainants. I also want the sounding board to help us in our goal of raising wider awareness of our service, and to look at issues such as how we gather evidence and our powers of investigation.

The members include representatives from Citizens Advice Scotland, the Scottish Independent Advocacy Alliance, the Tenant Participation Advisory Service, a Prison Visiting Committee, Patient Opinion, Alliance Scotland and Consumer Futures.

We have also begun discussions with the Society of Local Authority Chief Executives and Senior Managers (SOLACE) about setting up a sounding board for local authorities. This will further our aim of ensuring that service providers are the owners of how complaints are handled, learning is shared and improvements are made.

## **Housing and prisons complaints reports**

Since my last e-newsletter, we have published two further annual complaints reports, about the housing and prisons issues that we considered in 2012/13. Like the other sectoral reports we have published, they contain:

- key complaints figures
- issues and themes arising from the complaints we see
- how we share learning and how we work with other organisations
- an overview of the relevant activities of our complaints standards authority
- our policy engagement.

To read the reports and access other sectoral information, visit

<http://www.spsso.org.uk/sector-specific-information>.

To view our annual statistics, visit <http://www.spsso.org.uk/statistics>.

## **Prison complaints proposals**

We responded to the Justice Committee's call for evidence on the Public Services Reform (Prison Visiting Committees) (Scotland) Order 2014. In general, we welcomed the proposal to provide lay monitors with a role in complaints handling, building on the existing role of the Prison Visiting Committees. However, we said that further clarity may be needed to ensure that roles in complaints handling are defined well and work together, rather than separately, and that the existing process for handling complaints, particularly that of the Scottish Prison Service, remains the principal avenue through which prisoners can raise complaints. We also propose that there is greater clarity on the status of reports and recommendations. We highlight the importance of transparency of decisions and consistency in what is reported, and say that publishing complaints outcomes provides great benefit in terms of analysing trends and identifying improvements and should be given further consideration. Read our full response [here](#).

# Investigation Reports



Investigation report ref: 201203086

## **Delay in diagnosis; communication; policy/administration; complaints handling** Lanarkshire NHS Board

### Summary

Mr C's complaint was about significant delays in diagnosing his lung cancer and about the way that the diagnosis was communicated to him. In May 2012, Mr C was receiving treatment about a neurological condition and was referred for a CT scan of his head and chest. The scan showed a suspected nodule in his lung and he was referred for a follow-up scan. However, Mr C was not told about the suspected nodule until August when he was attending his GP practice about another matter. The follow-up scan eventually took place in September but there were then further delays before the diagnosis of lung cancer was confirmed after a biopsy.

My investigation found that there were repeated delays in arranging the follow-up scan, caused by a range of problems. For example, radiology staff were unable to access blood test results, the request for a follow-up scan was initially rejected because there was no record of the original scan having taken place and a consultant was on leave and no arrangements were in place for reviewing results in her absence. There was also no robust plan in place in the radiology department for distinguishing between urgent and routine requests, or for identifying and prioritising possible cancer patients. My medical adviser, a consultant in respiratory medicine who provided independent advice on the complaint described 'a string of failures on the part of the board and specifically on the part of the radiology department' in diagnosing Mr C's cancer.

I was also critical of the way in which Mr C had the diagnosis communicated to him. He should have been told in May about the suspected nodule in his lung by the consultant neurologist who was responsible for his care. It was her responsibility to inform him of the changes in his diagnosis and treatment. The failure to communicate with Mr C added to the distress and uncertainty that he and his family experienced. I am also critical of the board for not considering this element of his original complaint. While it did not form the main part of that complaint, the board should have acknowledged the importance of timely communication with patients.

In their response to Mr C's original complaint, the board did accept and apologise for the delays in arranging the follow-up scan. However, I am concerned that, despite the clear difficulties that the card-based scan request system caused in this case, at the time of my investigation the electronic system intended to replace this had not been introduced, due to technical difficulties. In addition, the board has not conducted a Serious Incident Review into the delay in diagnosing Mr C's cancer. The board have said that as the delays were not recorded on the Datix system (a computerised system for reporting and recording incidents affecting patient safety), they had not been reported as a serious clinical incident. The board do not appear to have considered whether the delays should have been recorded on the Datix system and I consider this to be a failure of their investigation into the complaint. Given the numerous failings identified, I made seven recommendations for redress and improvement. By specified deadlines, I have asked the board to:

- confirm when the new system will be fully operational in all the hospitals they are responsible for;
- provide evidence that they have reviewed with the clinical staff involved why no report of the failures we identified was made on the Datix system;
- provide evidence that they have carried out a Critical Incident Review;
- review the arrangements for providing cover for absent staff to ensure that urgent test results are reviewed timeously;
- review the procedures within the radiology department to ensure that urgent test requests are identified and treated appropriately to avoid undue delay to patients;
- provide evidence that clinical staff have been reminded of the importance of effective communication with patients, especially when there may have been changes to their diagnosis; and
- apologise in writing to Mr C for the failures identified in my report.

# Investigation Reports



Investigation report ref: 201202679

## Care of the elderly; clinical treatment; delay in medical assessment; communication Fife NHS Board

### Summary

Mrs C raised a number of concerns that her late father (Mr A) received inadequate care and treatment in hospital. Mr A was 87 when he was admitted for dizziness, a swollen leg, a 'blister' on his toe and a general feeling of being unwell and tired. He underwent an angiogram (a special x-ray of the blood vessels) and was being followed up as an outpatient. He was readmitted the following month after a fall and a collapse at home. During his second admission, Mr A suffered further falls and fractured his hip. Mr A 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.

I upheld Mrs C's complaint about the board's failure to carry out a falls risk assessment when Mr A was admitted for the second time. Despite Mr A's known previous high risk of falling (an assessment had been carried out at his first admission) and the fact that he was admitted for the second time having fallen at home, he was not assessed until four days after being admitted. Mr A's family said that they had warned staff that he had previously fallen, and said that he had suffered several falls while in hospital which were witnessed by other patients and/or visitors but not recorded by staff. Mr A's risk score meant that he should have been reassessed daily, but the records showed that during the second admission he was only assessed every other day. I criticised the board's lack of a multi-disciplinary team approach to assessing, monitoring and recording Mr A's falls risk, and made two recommendations to improve the board's practice. I also made two recommendations in relation to another part of the complaint that I upheld. These were to ensure that staff are made aware of the importance of food and fluid intake management and monitoring, and the importance of communicating effectively with patients, loved ones and/or carers on all aspects of care, including food and fluid intake.

I also upheld the complaint about the failure to communicate appropriately with the family following Mr A's death. I understand the shock that Mrs C and her mother felt when they saw Mr A following the doctor's examination and declaration of death. There was also a lack of communication about the delay in providing the death certificate. The family were initially told that the certificate would be ready for collection later the same day. However, it was not, and her brother called the hospital four times over the next few days only to be told that, for various reasons, it had not yet been signed. The family was then contacted by the police for information on behalf of the Procurator Fiscal's Office (PFO), and this was the first time they were made aware that the matter had been referred to the PFO. By the time the certificate was finally issued, the date and time of the funeral had been arranged and publicised but had to be changed because of the delay, causing the family additional distress. Again, I made a number of recommendations, including ensuring that staff are made aware of the importance of good communication and of providing information to families about the rules on reporting cases to the PFO, where appropriate.

I did not uphold the complaint about the delay in operating on Mr A as I found that the decision to delay surgery was reasonable. However, I was concerned about the apparent lack of assessment, monitoring and planning of Mr A's condition during the wait for surgery and immediately afterwards, and I made another recommendation to address this point.

# Complaints Standards Authority update



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## Model CHP for the Scottish Government, Scottish Parliament and associated public authorities in Scotland

Excellent progress has been reported by organisations as they work towards implementing the model CHP by 31 March 2014. We have now been in direct contact with the small number of organisations that have yet to provide the required information, to offer our support and guidance as they work towards implementation. Feedback from those organisations indicates that they will all be in a position to report compliance by March 2014.

We are planning to introduce a network/networks of complaints handlers for the sector. If you are interested in joining the network, please contact us at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk)

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## Higher and further education

Having successfully implemented the model CHP across all institutions in these sectors, we are now working to coordinate and support complaints handling network groups with sector representatives. We have received expressions of interest from both sectors to help lead the networks, building on existing groups.

We will attend the November meeting of Colleges Scotland 'Quality Development Network' to raise the profile of this important initiative, and we also plan to work closely with representatives of Scotland's Universities to establish a network for that sector.

As reported previously the aims of the networks will include:

- enabling complaints practitioners to share information and best practice in complaints handling
- increasing knowledge and awareness of complaints handling to improve skills and competence across the network
- developing key performance indicators and performance management arrangements
- creating a standardised approach and consistency across institutions for complaints handling
- shaping future complaints handling arrangements on behalf of the sectors.

If you are interested in joining a network group for your sector, please contact us at:

[CSA@spsso.org.uk](mailto:CSA@spsso.org.uk)

## **Local government**

The next meeting of the local authority complaint handlers network group is scheduled for March 2014. In advance of the next meeting we will be working to identify and share examples of good practice in learning from complaints, and to develop additional guidance specifically relevant to education complaints.

In order to test compliance with the requirements of the CHP we are undertaking an informal sample assessment of the accessibility of local authority CHPs and the quarterly publication of outcomes, trends and actions taken in response to complaints received. Our initial findings suggest that some local authorities are not yet reporting quarterly in line with the requirements of the CHP and that there are some issues in terms of easy access to the customer CHP leaflet. We will report our findings in this regard through the network.

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## **Housing**

We are also testing compliance with the requirements of the CHP across a random sample of RSLs in Scotland. This includes issues such as the definition of a complaint, accessibility to the CHP via websites and leaflets, timescales, stages and signposting to the SPSO. We will also assess performance in relation to recording, reporting, learning from and publicising complaints information. The outcomes of this assessment will be reported to the Scottish Housing Regulator.

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## **NHS**

Having spoken at the October NHS Education for Scotland Masterclass for Executive and Non-Executive NHS board members, the Ombudsman will speak at further Masterclasses scheduled for November in Dundee and December in Edinburgh. The focus of his presentation is on the importance of complaints in the governance of organisations and their value as indicators of performance, service quality and risk, particularly for health boards in the light of the findings of the Francis report.

With NHS Education for Scotland we continue to develop and roll out further training and awareness for NHS staff, and we recently delivered a number of training sessions for GP Practice Managers. Further training is also planned for prison health centres and for the NHS.



## Compliance and follow-up



In line with SPSO practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

**Jim Martin, Ombudsman, 20 November 2013**

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

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## The Scottish Public Services Ombudsman



The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial and free**.

We are the final stage for handling complaints about councils, housing associations, the National Health Service, 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. Members of the public can then bring a complaint to us by visiting our office, calling or writing to us, or filling out our online complaint form.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaints handling in bodies under our jurisdiction.



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**SPSO WEBSITE**

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