SPSO NEWS

OCTOBER 2014

Monthly news from the Scottish Public Services Ombudsman

This month we are laying seven reports before the Scottish Parliament – six about the NHS and one about a local authority. We are also laying a report on 60 decisions about all of the sectors under our remit. These can be read on our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in September), we received 440 complaints. We determined 475 complaints and of these we:

- gave advice on 280 complaints
- considered 107 complaints at our early resolution stage
- decided 88 complaints at our investigation stage.

We made a total of 133 recommendations.

Ombudsman's Overview

I am highlighting three matters this month:

- a local authority's planning decision on a wind farm application;
- the variety of ombudsman approaches to financial redress;
- failings we found in the NHS investigations including delays in diagnosis and treatment, lack of joined-up care and oversight of that care, and poor communication with the patient and their family or between health professionals.

Local government

Planning applications are often contentious, and councillors on planning committees have to make difficult and sensitive decisions about developments. In the investigation published today (case 201204546), I found that there were important failings in the information that officials gave councillors about the noise impact of the development and the decision-making process. This was despite the officials being aware that operators of a neighbouring wind farm had raised concerns about the potential noise impact when both wind farms were operating simultaneously. It is not possible to say what decision would have been made or whether councillors would have chosen to use a different process in making that decision, had they been aware of the full information. The important point here is that council officials should ensure that councillors are given accurate, complete and helpful information before they make their decisions.

One of my recommendations in this case was for a financial payment to ensure that local residents are refunded for an expert report they had prepared to support their case. This was a recommendation I would have made anyway, given my findings, but I am pleased to note that the council in fact offered this themselves during my investigation.

Redress

I seek to use complaints to resolve systemic failings when they are identified and often the main reason people ask me to look at their complaint is to prevent a problem happening again. However, it is also my role to help try to put the individual back in the position they would have been in if the error had not occurred. In this context, I will sometimes recommend that the public authority involved make a payment to the aggrieved person. I do this only where I consider that it is particularly relevant to the injustice the person has suffered, and there are examples of such cases in some of the reports published today. As well as the recommendation in the planning case above, I also recommended that a health board should refund a woman the remaining costs of her treatment abroad (case 201302855). And in one of our decision reports, I recommended that a council reimburse a woman's legal fees, as their actions meant she had little option but to seek legal advice (case 201301819).

The ability to secure appropriate redress for individuals is something I consider carefully and I keep our practice about this under review. As I explain above, I make recommendations for financial redress only where I find it the most appropriate form of remedy in the particular circumstances of the case, and in many situations this does not apply. We are, however, carrying out research specifically on the use of financial redress. Over the years, UK ombudsman offices have developed different policies on redress, including a wide range of approaches to financial remedy. Earlier this year we tendered for research to provide an analysis of the current practice of public sector ombudsmen, with an assessment of the advantages and disadvantages of each approach. We will publish more information about this when the research is complete.

NHS

Issues that I have highlighted recently are flagged again in the reports published today including delays in diagnosis and treatment, lack of joined-up care and oversight of that care, and poor communication with the patient and their family or between health professionals.

While I recognise that diagnosis is often a process of elimination, and can take time, in three of these cases I found delay caused by avoidable errors or oversights. In the first (case 201305435), a woman who had twice had cancer before and was well aware of the symptoms of cancer, went to A&E when she experienced suspicious symptoms. There were then significant delays in diagnosing the cancer that she turned out to have. It was not identified at a point when my medical adviser said it should have been suspected, and the board's investigation did not pick this up. My adviser made the point that none of the many doctors involved saw the bigger picture that her symptoms painted.

In a second case in the same health board (case 201302377), a man with bowel problems did not receive an appointment for nearly six months after his GP first referred him to hospital. When he was eventually seen, he was diagnosed with advanced bowel cancer and he died some six months later. His wife later complained and when the board responded to her complaint they gave inaccurate information about why he had not had an appointment. I also found that they had not told his GP that he had in fact been removed from the waiting list.

NHS continued

In a third example, (case 201300651) a woman's multiple sclerosis took many months to diagnose. I identified a range of errors in the monitoring of her care and treatment and in the communication with the woman and between health professionals. This confusion and lack of clarity for the patient over many months added to the distress of her eventual diagnosis. In this case, the board involved did pick up a number of these issues during their investigation of the complaint and took steps to remedy these, but I found the complaint response inaccurate in parts.

One of the other health cases I investigated was also about unacceptable delays – in this case delays in the treatment of a woman with cancer (case 201303376). By the time she was scheduled for an operation, her cancer was too advanced, surgery was no longer possible, and she later died. I was extremely concerned about the lack of urgency in or oversight of her care.

The Patient Rights (Scotland) Act 2011 sets out what people can expect, and what is expected of them, as users of the NHS in Scotland. In the other two cases, one about an incorrect post-natal mental health diagnosis (case 201302855) and the other about a locum GP's poor clinical treatment for and a lack of empathy with a man who was dying (case 201305316), the people involved clearly did not receive the care that they could reasonably have expected, and which the Act envisages.

In the majority of these cases I found omissions or errors in the board's complaints handling. When a public authority receives a complaint, they have a duty to carefully analyse what happened, identify where things went wrong and put them right where they can. The fact that I identified errors in responses as well as picking up on issues that boards did not identify as problematic is evidence that there needs to be better quality control of complaints handling. I would urge all public authorities to reflect on the effectiveness of their complaints handling and learn from the examples I provide today. This is also something that I will feed into the specific work on NHS complaints procedures that we are taking forward with the Scottish Health Council, as a result of the recommendations from their review of NHS feedback and complaints.

Annual sectoral reports

At the end of October I will publish my annual report about complaints in the health sector for 2013/14. I will also send the chief executive and chair of each health board a letter with the statistics for their board for that year. In early October I sent similar letters to local government chief executives and council leaders along with my local government report.

Reports for other sectors will follow in the coming months. We publish all the statistics, annual letters and reports on our website.

Investigation Reports

Investigation report ref: 201204546
Handling of planning application
East Ayrshire Council

SUMMARY

Mrs C was one of a number of local residents concerned about a planning application for a wind turbine development. She complained to the council about the way they handled the application. Council officers had recommended refusal but councillors voted to approve the development. The councillors also said that the decision notice could only be issued once certain agreements were reached. Councillors' decisions on planning applications are ultimately their responsibility and they are democratically accountable. I do not look at concerns about such decisions simply because someone complains to me that a different decision was possible or desirable. It is, however, important that councillors have all the relevant information in front of them when they make these decisions. My investigation found that councillors on the planning committee were not given adequate information before they made the decision.

The proposed development was near a much larger wind farm that was already operating. This meant that the cumulative noise effect of all the turbines operating together had to be considered. The council relied on their own internal expertise in evaluating this, and told the committee that although they did not consider it to be a problem, some conditions about noise should be included if consent was granted, and this is what the committee did. I would not generally criticise a decision to rely on internal experts, but I found that the existing wind farm operators had clearly told the council beforehand that there were mistakes in the environmental statement submitted by the applicant about the effect of both wind farms operating together. The existing operators had pointed out that if both operated fully at the same time this would likely create a noise nuisance. The council did ultimately get an expert acoustic report, which identified problems with both wind farms operating together. However, they only did this after the committee had decided to grant the application and the council had seen an expert report (paid for by residents) showing that a problem could exist. The objections from the neighbouring wind farm operators should have led council officials to obtain a report before the decision was made, and their failure to do so meant councillors did not have enough information about noise before deciding.

I also found that council officers did not give the committee enough information about the process. Applications for what are classed as major developments that amount to significant departures from the development plan have to be dealt with through a special process, but the report to councillors simply noted that the application was not a departure from policy, and provided no information to allow councillors to decide whether that was the case. The officers also provided no information on what might happen if councillors, as they did, decided to reject the recommendation to refuse and voted instead to consent.

Although I found failings in the information provided, it is not possible to say what decision would have been made if councillors had had all the information. The committee voted unanimously to consent to the application, despite a recommendation from officials to refuse and might have taken the same decision with additional information. Given this, my recommendations concentrate on ensuring that better information is provided in future and I have also recommended that the council apologise to Mrs C. During my investigation they also offered to pay for the expert report prepared for the residents, which I agree is wholly appropriate.

Investigation Reports

Investigation report ref: 201305435
Delay in diagnosis, complaints handling
Lanarkshire NHS Board

SUMMARY

In June 2013 Mrs C, who had had cancer twice before, was concerned about her symptoms and went to A&E at Wishaw General Hospital. An ultrasound scan identified lumps in her groin. She also had a computerised tomography scan (CT scan) arranged for early July and was discharged. On receiving the CT scan results, Mrs C's GP referred her urgently to the hospital, suspecting that the cancer had returned. In late July, Mrs C went to an appointment at a consultant surgeon's clinic, where she was seen by a junior doctor. She was told that the x-ray department would take a biopsy. However, when she went back for a pre-procedure assessment in mid-August she was told she would have a different procedure from the one she had been told about, and that she might have to wait until October for this. She contacted the hospital and was told that the doctor decided on a weekly basis upon which patients she would operate. Meanwhile, there was also some confusion about whether Mrs C was on the biopsy waiting list or not. The biopsy was carried out in early October and the cancer diagnosis was confirmed the following week. Mrs C complained to the board as she was concerned that the delay in the biopsy – particularly with her history of cancer – might have allowed it to spread further, as well as causing her stress and worry.

The board apologised that it had taken so long for Mrs C to receive a diagnosis and acknowledged her distress. They explained that the first doctor she saw in A&E had arranged several investigations, including the ultrasound scan and a review by the on-call gynaecology team. That doctor also organised the CT scan and told Mrs C to contact her GP for the results. The CT scan was done on 1 July and the results were reported the same day, showing enlarged lymph nodes. The board said that there were no other abnormal findings and the results were made available to hospital doctors. They also said that when Mrs C attended an out-patient appointment in August there was no evidence of a recurrence of cancer based on the investigations so far.

Mrs C complained to me that the board did not provide her with reasonable care and treatment over this period and that their response to her complaint contained inaccuracies. I took independent advice on her case from one of my medical advisers, who is a consultant gynaecological cancer specialist. He explained that the results of the ultrasound scan were probably not enough to be certain of a cancer diagnosis. However, he said that the enlarged nodes that the CT scan identified reflected the classical spread of womb cancer, which should have been suspected at this point, particularly because of Mrs C's symptoms. The diagnosis should have been confirmed when a blood test taken in July was reported on. My adviser also took the view that another doctor – the consultant gynaecologist – should have taken responsibility for acting on the test results. This doctor did not see Mrs C, but had an oversight role in her care and treatment, and was aware of the CT scan results. Mrs C saw at least six doctors during the period concerned, and my adviser said that there was effectively a lack of ownership of her care and that doctors failed to recognise the severity and urgency of her situation. He did, however, also say that although Mrs C waited too long for a biopsy, he did not think that having it earlier would have improved the outcome for her.

Investigation Reports

Investigation report ref: 201305435
Delay in diagnosis, complaints handling
Lanarkshire NHS Board

SUMMARY CONTINUED

In reaching my decision, I took particular account of my adviser's main point – that none of the many doctors involved saw the bigger picture in Mrs C's symptoms. I also considered the worry, upset and anxiety that the delay caused Mrs C, and noted that the way in which the board handled her care did not help at what was already a stressful time. I upheld her complaint as the evidence indicated that the board did not provide her with reasonable care and treatment.

On the complaints handling, although I did not find the issues that Mrs C pointed out to be unreasonable, I did find a problem in the board's response. I have already said that my adviser disagreed with their statement that there was no evidence of a recurrence of cancer at Mrs C's August appointment. He also pointed out that the results of the CT scan were known then and that, according to information in the board's complaint file, one of the doctors involved in her care acknowledged during their investigation that this scan indicated that the tumour had spread. The board should have picked this up and so I upheld this complaint.

I recommended that the board apologise to Mrs C for the failings identified, ensure that her case is raised as a learning point at the consultant gynaecologist's next appraisal; and carry out a significant incident review to ensure that the failings in care are fully addressed to stop this happening again. I also said they should address the reasons for the inaccuracies in their complaint response as part of the significant incident review.

Investigation Reports

Investigation report ref: 201302377

Delay in diagnosis, communication, waiting lists, complaints handling

Lanarkshire NHS Board

SUMMARY

Mr C was having bowel problems and his GP referred him urgently to Hairmyres Hospital for these to be investigated. When, four months later, he had not received an appointment, the GP referred him again. Mr C had a colonoscopy (bowel examination) some seven weeks after the second referral, and a sigmoidoscopy (examination of the rectum and colon) a month after that. He was diagnosed with advanced bowel cancer, and he died six months later. His wife (Mrs C) complained about the delay in him being seen at the hospital, and about the initial appointment for the sigmoidoscopy.

The board at first told Mrs C that the reason her husband was not seen sooner was because he made an appointment but phoned them and cancelled it. They said they had then removed him from the waiting list as he did not ask for another date. She told them, however, that he had never received a letter and could not have called as he had had a stroke and would not have been able to speak to them by phone. My investigation found that the board could not provide any evidence to show what had happened, and they acknowledged that they had got this wrong. They also failed to tell his GP that he had been removed from the waiting list. Although my medical adviser said that the delay was unlikely to have affected the outcome for Mr C, I upheld this complaint. I criticised the board for failing to follow their own procedure, in not telling the GP that Mr C had been removed from the waiting list, and for the error in their complaint response. The board acknowledged this and said they would discuss it at an appropriate meeting. However, I also recommended that they share this with their patient booking service, audit a sample of patients removed from the list for similar reasons, to ensure that their appointment protocol had been correctly followed, and consider reviewing the protocol itself.

I also upheld the complaint about the sigmoidoscopy procedure. Mrs C explained that by then her husband had been diagnosed with cancer. On the day of his initial appointment, she said he waited for four hours in pain before being told he would have to come back another day, with no explanation. The board told Mrs C that they could not say why this had happened. My investigation confirmed that the initial examination was cancelled and I asked the board why. They said that Mr C was on medication to stop his blood clotting. This put him at risk of bleeding, and was why the procedure was postponed. They agreed that this should have been explained to him at the time and said they were making sure that relevant staff understood the importance of proper communication. My medical adviser said that the board acted appropriately in postponing the appointment because of the risks. However, doctors should have known in advance that this might complicate Mr C's care and acted accordingly, by stopping the drug for a few days before he went for the procedure. He should also have had a proper explanation on the day. I recommended that they provide me with evidence of the feedback to staff and apologise to Mrs C.

Investigation Reports

Investigation report ref: 201305316

Clinical treatment, communication, staff attitude, complaints handling

A medical practice in the Greater Glasgow and Clyde NHS Board area

SUMMARY

Mr C suffered from mesothelioma (cancer affecting the lining of the lung), and his condition was terminal. He had been receiving treatment at home from his GP practice and district and palliative nurses. When his condition worsened, an out-of-hours (OOH) doctor went to Mr C's home. She examined him and gave him a pain relieving injection. As Mr C wanted to stay at home, the OOH doctor suggested that a syringe driver (a device that continuously supplies pain relief) be started the next day.

Mr C's wife (Mrs C) said that the following morning a locum GP from their practice phoned to say that that he was going to amend the OOH doctor's suggestion about the syringe driver, but he would maintain the existing pain relief. He then phoned back to say that, in light of one of Mr C's symptoms, he was referring Mr C to hospital. After receiving treatment there, including starting a syringe driver, Mr C was discharged the following day. The locum had also provided a prescription for Mr C's medication (including pain relief) but the dispensing pharmacist at first could not provide this due to the way the prescription was written.

Mr C's condition got worse and he died less than a week after returning home. Mrs C phoned the practice to tell them this. As Mr C had mesothelioma, the locum GP also had to report this to the Procurator Fiscal. There was, however, a delay in notifying the Fiscal, which significantly delayed the funeral arrangements. Mrs C also said that the locum did not visit her and instead phoned her about her husband's death.

When Mrs C complained to the practice about this, their response came from the locum she had complained about. He said that he felt the decision to admit Mr C to hospital was appropriate based on his symptoms at the time. In response to Mrs C's concerns about the incorrectly written prescriptions, the GP suggested that as the palliative care nurse instructed these, it would be more appropriate to direct enquiries about them to the nurse. He said that the practice had been unusually busy due to staff shortages and that he had a very high number of patients. He also said that he was due to be away from the practice for three days immediately after Mr C died, which meant that he was unable to attend Mr C after his death or to notify the Fiscal. He said, however, that he had asked staff in the practice to contact the Fiscal about this.

I took independent advice on this complaint from my GP adviser, who said that the actions taken by the OOH doctor to relieve Mr C's symptoms were excellent, and in keeping with the wishes of Mr and Mrs C. In contrast, the locum decided to put Mr C back on his original pain relief medication without ever seeing him. My adviser took the view that this decision was taken with insufficient information. Although admitting Mr C to hospital was clinically correct in terms of treating one of his underlying symptoms, not visiting Mr C and not discussing this decision with him and his family was wrong, and my adviser said that the locum acted unreasonably. The locum's comments about working in a short-staffed practice were a mitigating factor but cannot excuse the poor assessment and decision-making in Mr C's care. My adviser commented that most GPs are under huge pressure every day but should ensure that they assess their patients' needs and wants properly before deciding what to do.

Investigation Reports

Investigation report ref: 201305316

Clinical treatment, communication, staff attitude, complaints handling

A medical practice in the Greater Glasgow and Clyde NHS Board area

SUMMARY CONTINUED

I was very critical of the way in which Mr C's death and the certification of his death were handled. The adviser said that it was unreasonable to have tried to manage this by phone, and that it was good practice to visit the family. Although recognising that the locum was unable to make contact with the Fiscal's office on the day of Mr C's death, the adviser said that more should have been done. This was such an important matter that it was unreasonable for the locum not to have maintained contact with the practice while he was away, or not to have tried the following day to ensure that the Fiscal was informed, allowing the death certification process to begin. My adviser said that the locum showed a lack of empathy for Mr C and his family.

I made recommendations to address the locum's failings including that he discuss the issues identified in the report at his next formal appraisal and demonstrate that he has learned lessons from this complaint by completing appropriate professional training.

Mrs C also complained that the response from the practice to her complaint was inadequate. I upheld this complaint and, although I did not make a specific recommendation, I asked the practice to reflect on the fact that it may be appropriate to avoid having the person complained about respond directly to a complaint, as this may give the impression that matters have not been thoroughly investigated.

Investigation Reports

Investigation report ref: 201303376
Delay in treatment, communication
Lothian NHS Board

SUMMARY

After Mrs C was treated for cancer, a routine follow-up scan found that she had secondary liver cancer. Her local health board could not provide the full treatment and she was referred to NHS Lothian for possible surgery. A multi-disciplinary team (MDT) meeting was held a few days later and Mrs C then had an scan. She met a consultant surgeon just over two weeks later. Although he did not have the scan results, the surgeon discussed surgical and non-surgical options with Mrs C. The non-surgical option needed an anaesthetic and a consultant anaesthetist decided that Mrs C was suitable for this.

The scan result was discussed at a further MDT meeting about a month after Mrs C saw the surgeon. Surgery was felt to be a viable option but as the surgeon was not at the meeting the decision was delayed until he could consider this and about nine days later he referred Mrs C to the anaesthetist for review for surgery. When Mrs C met the anaesthetist a week later, the computer system was down and the anaesthetist mistakenly assumed that Mrs C was there to discuss the non-surgical procedure, rather than to be reviewed for surgery. The anaesthetist and the surgeon discussed Mrs C later that day and decided that surgery was the best treatment. The earliest date then available was more than five weeks away. A further scan immediately before surgery, however, showed that the cancer had developed and surgery was no longer possible. Mrs C complained about this to the board and then to me, but died before I completed my investigation. Her husband, Mr C, then took forward the complaint.

I took independent medical advice on this complaint and found that there were unacceptable delays in many aspects of Mrs C's care. The reporting of the scan results and the associated MDT meeting, anaesthesia discussions and the final scan on the day of Mrs C's planned surgery should all have taken place sooner. The board said that the waiting time guarantee did not apply to Mrs C because it only applied to primary cancer and Mrs C's cancer was complex. I accept that the waiting time guarantee only applies to primary cancers but found nothing to suggest that complexity can be taken into account in justifying a breach of this target. More importantly, the absence of a waiting time guarantee does not mean that the time taken cannot be criticised. Decisions should be based on clinical need and the fact that Mrs C had a secondary cancer that had recently spread should have made this more urgent, not less. I was very concerned that there was no urgency or oversight in this process, which allowed an operable cancer to progress to a point where it became inoperable. While it is not possible to say whether the outcome would have been different, I found that there were unacceptable delays that caused Mrs C and her family significant distress. I made recommendations with the aim of improving timescales in the future.

Investigation Reports

Investigation report ref: 201303376
Delay in treatment, communication
Lothian NHS Board

SUMMARY CONTINUED

Mrs C also complained about the board's communication, saying that she had been given conflicting or no information. She received a letter saying that she would be treated within 12 weeks but was then told this would not apply. After this, she heard nothing for some two months, until she called the hospital for information without success. She received a letter saying that surgery was the best option, despite having the day before discussed the non-surgical option. She was only made aware of the final decision to operate during a phone call, and had to arrange her own referral to local services for chemotherapy after her operation was cancelled. The board apologised for some of the confusion and showed that they had referred Mrs C to local services shortly after the cancellation.

I upheld this complaint, as Mrs C was not kept up to date and the board failed to inform her of the options and risks being discussed by clinicians. She should have been better informed and copied into important correspondence. I also found that communication between clinical staff was unreasonably slow even given Mrs C's complex medical position, and the failure to coordinate communication was one of the reasons for the delay in treatment. I concluded that this would have caused Mrs C unreasonable distress, and recommended that the board review their communication with her to see where this could have been improved, and apologise to her family.

Investigation Reports

Investigation report ref: 201302855

Diagnosis, clinical treatment, hospital discharge

Lothian NHS Board

SUMMARY

Ms C, who was pregnant, was experiencing low mood and had been referred to mental health services twice. A few months after her baby was born, she called the police as she was concerned that she might harm herself or her daughter. She was assessed and admitted to the Royal Edinburgh Hospital. She was diagnosed with a personality disorder, and discharged the following week without medication. A friend was concerned about her condition and she contacted Ms C's mother (who lives abroad) and arranged for Ms C to fly there the next day. Ms C was diagnosed there with puerperal psychosis (a treatable condition that can affect new mothers, with psychotic-type symptoms) and was admitted to a local psychiatric hospital for three weeks.

After she came home, Ms C's GP referred her to mental health services, where she was seen by a consultant psychiatrist, who agreed with the diagnosis of puerperal psychosis. Shortly after this, Ms C was hospitalised for a short time, then discharged into her father's care. He took her abroad again, where she was under hospital care (as an inpatient, then an outpatient) for the next six months. After returning to Scotland, Ms C complained that she was unreasonably diagnosed with a personality disorder and discharged from hospital without medication. She said that the diagnosis impacted severely on her and her recovery from her actual condition. It also affected her relationship with her child, as they were separated when her daughter was only four months old, and she lost all custody rights. She explained that she had also suffered financial loss for some of the cost of her medical treatment abroad.

The board met Miss C about her complaint, and told her that the diagnosis was made after a thorough assessment, which did not provide evidence of psychotic illness or mood disorder. They said that this seemed correct at the time, although later events did point to puerperal psychosis. They offered to annotate her medical notes to reflect the updated diagnosis.

I took independent advice on the complaint from an experienced psychiatrist, who took the view that there was not enough evidence in the medical notes for a diagnosis of personality disorder. It was likely that Ms C was suffering from puerperal psychosis at the time, and there was not enough in the notes about the thinking behind the diagnosis given. My adviser also agreed that staff did not obtain enough information about Ms C's background and 'normal' behaviours and that communication with her friends, who could have provided this, was poor. I upheld the complaint about diagnosis, and criticised the board for this. I also criticised them for an inaccurate note in the records that they did not pick up or acknowledge when investigating the complaint. I made a number of recommendations, which can be read in full in my report, including that they appropriately annotate and clarify Ms C's medical records, raise the findings of my report with relevant staff and develop strategies for improving carer involvement and information-sharing.

I also upheld Ms C's complaints about discharge and medication after this diagnosis. The board said that there was no evidence of treatable mental illness or risk. My adviser said, however, that Ms C was displaying evidence of an abnormal mental state, and there was no communication with her carer or friends or proper assessment of her needs. Based on all my adviser's comments about this event, I upheld these complaints as I was concerned that Ms C was discharged without enough consideration and without appropriate support. Although I noted that the decision not to prescribe medication was consistent with the diagnosis at that point, there was no record of any discussion around this. I made recommendations about improved discharge planning and record-keeping, as well as that the board should meet Ms C's outstanding treatment costs.

Investigation Reports

Investigation report ref: 201300651

Delay in diagnosis, communication

Ayrshire and Arran NHS Board

SUMMARY

In May 2012, Mrs C had a severe migraine that left her with reduced vision in one eye. In July 2012 she had a small lesion removed from her nose and later a lesion was removed from her left thigh. As a result of these unrelated issues, she attended six hospitals in two health board areas over many months. During this time, Mrs C saw specialists in ophthalmology, neurology and dermatology. In May 2013, she was given a diagnosis of multiple sclerosis (MS). In October 2013 the investigations into the lesion were concluded, as part of which Mrs C had been investigated for a possible significant genetic condition. Mrs C complained to us that a lengthy list of errors and omissions by the various specialist services and a failure to coordinate her care and treatment caused her stress, and ultimately led to a delay in her being diagnosed with MS and starting treatment.

Mrs C had a complex care pathway, and I took medical advice from three separate specialists. I found no failings in the assessments and was satisfied that the treatment Mrs C received had been appropriate and reasonable. Prior to my involvement, and as a result of their investigation into Mrs C's complaint, the board had identified a number of errors and issues around administration and communication. They accepted that these contributed to delays in appointments and the processing of test results. They had apologised and told Mrs C they had put steps in place to remedy this.

Despite this, I identified a number of additional errors and made 11 recommendations on this case. I upheld complaints around the monitoring of Mrs C's care and treatment; about the way the various departments and the boards involved co-ordinated and communicated with each other and that, despite their investigation, Mrs C's health board failed to ensure that their response to her complaint was accurate. While I noted the actions already taken, my recommendations highlight that more needs to be done to remedy the additional failings identified by my investigation.

While I have been advised that the delays are not likely to have been of critical significance, they must have caused Mrs C concern and upset at a difficult time and delayed the start of treatment. Significantly, I also found that communication with Mrs C was not adequate. She was not always aware of what was happening, what conditions were being considered and why. My recommendations, therefore, include steps to improve communication to patients, improve the system of referrals, and review protocols that failed or were not implemented effectively. I have asked for additional apologies to Mrs C and that the board ensure that relevant staff are made aware of my advisers' comments.

Complaints Standards Authority update

Local government

The next meeting of the local authority complaints handlers network will consider the theme of learning from complaints. The network will again look at benchmarking complaints performance as it considers the findings of the benchmarking pilot referred to in our last update. It will discuss the requirements of the **SPSO performance indicators for the local authority model complaints handling procedure** and how the information from the indicators can be used in context to baseline a council's complaints handling performance. The network's complaints surgery will also consider issues around dealing with complaints about political decisions, complaints for arm's length external organisations and school related complaints.

We would remind local authorities that have not already done so to either send us (or send us a link to) their complaints handling performance, in line with the SPSO performance indicators referred to above. We continue to monitor local authority annual performance complaints handling reports and, as previously reported, have seen variations on the way in which information is being presented. We will continue to discuss with the sector how they can ensure that they report consistent and comparable information, including demonstrating the learning from complaints, and ensuring this is shared both within and across local authorities.

Housing

Since our last update we have met with the Scottish Housing Regulator to discuss the publication of Charter performance data, and the requirements of registered social landlords (RSLs) to publish full complaints data in line with the complaints handling procedure (CHP) and self-assessment indicators. The information RSLs publish will allow them to compare their complaints handling performance across the sector.

We are keen to work with the sector on benchmarking to better understand existing approaches and how these may be developed further to meet the reporting requirements of the model CHP.

Higher education

Earlier in October we attended a higher education complaints practitioners meeting at Heriot-Watt University, Edinburgh. This gave us the opportunity to update sector representatives on our work and to discuss and clarify a range of issues on operation of the model CHP and good complaints handling more widely. We were encouraged by the progress this group has made in sharing good practice on complaints handling, and reaffirmed our view that the sector would find benefit in the group benchmarking performance and seeking to share learning from complaints across the sector. We will attend further meetings of the group to further update members on the work of SPSO, and look forward to working more closely with the group to ensure best practice across the sector.

As with other sectors, we remind all universities of the requirement to report on their complaints handling performance annually in line with SPSO requirements, as documented in the **CHP implementation guide** (PDF, 101KB).

Complaints Standards Authority update

Further education

Working closely with the sector's complaints handling advisory group, we are developing further guidance on the performance indicators that will form the basis of benchmarking complaints performance information. The indicators against which colleges are required to publish information for the academic year just past are outlined in the implementation guide accompanying the model CHP and published in 2013 [**The Further Education Model Complaints Handling Procedure (Model CHP) Guide to Implementation**]. This work was shared with the Quality Steering Group, (which oversees the work of the complaints advisory group), and will be used to support and inform a workshop event to help colleges benchmark complaints performance across the sector. We are currently in discussion with the complaints advisory group members to plan the workshop and will provide a further update on progress as soon as possible.

Health

We continue to discuss with the Scottish Government and other key stakeholders the recommendations arising from the Scottish Health Council (SHC)'s review of NHS feedback and complaints. In line with the recommendations, we are looking at the potential to develop an NHS model CHP for the sector. We are keen to align NHS complaints handling with the approach adopted in other sectors, including encouraging early resolution and frontline ownership as recommended in the SHC report. We believe that an NHS model CHP will achieve significant benefits, by providing clarity and consistency on how NHS complaints should be handled.

The Scottish Prison Service

We have in the past worked closely with the Scottish Prison Service to provide advice and guidance in respect of handling prisoners complaints. We will attend a workshop with their managers and complaints handlers in October, to consider information on their complaints handling performance, areas of best practice and improvements to complaints handling and learning from complaints to deliver operational improvements.

For this and previous updates, and for further information in relation to CHPs, visit our dedicated website **www.valuingcomplaints.org.uk**. The CSA can also be contacted directly at **CSA@spso.org.u**k.

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, 22 October 2014

The compendium of reports can be found on our website: **http://www.spso.org.uk/our-findings**

For further information please contact:

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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.