

Monthly news from the Scottish Public Services Ombudsman

This month we are laying four reports before the Scottish Parliament, all about the NHS. We are also laying a report on 55 decisions about all of the sectors under our remit. These can be read on our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in March), we received 502 complaints. We determined 486 and of these we:

- gave advice on 240 complaints
- considered 179 complaints at our early resolution stage
- decided 67 complaints at our investigation stage.

We made a total of 151 recommendations.

Ombudsman's Overview



I highlight the following matters this month:

- the investigation reports we are publishing

Complaint investigation reports

We are publishing four cases about the NHS this month, three of which involve the death of an individual. In the first, a man who committed suicide while he was in the care of a psychiatric hospital was not adequately risk-assessed and the possible risks recorded (case 201303790). The board also failed to communicate adequately with his main carer in decisions about his care and treatment. In another, a man died in hospital while being treated for a stroke, and I found that there were a number of failings in his clinical care, as well as a failure to recognise these when responding to the complaint (case 201305972). In a third case, a woman who contacted her medical practice complaining of pain and breathing difficulties died after her cancer returned (case 201400930). Despite her symptoms and medical history, three GPs in the practice who carried out telephone consultations failed to recognise that this was a possibility, and I found that they should have seen her and assessed her physically. I also found elements of the complaint response inappropriate.

The fourth case is about a woman with incontinence problems who experienced long delays before she received treatment (case 201401011). She had surgery some two and a half years after first being referred to hospital, during which time there were unnecessary delays and the board did not refer her to a specialist to consider possible treatment, as had been promised. Again I considered the complaint response inadequate.

I remind health boards and GP practices that I publish these cases so that all may learn from them. I note that in three of the above cases I again identified problems with the healthcare providers' responses to the complaint, including some failures to recognise that care was inadequate. Healthcare providers should examine their arrangements and take all possible steps to avoid similar errors in their own area or practice, whether on the clinical side or when handling the complaint.

Investigation Reports



Investigation report ref: 201303790

Risk assessment; record-keeping; communication

Lothian NHS Board

SUMMARY

Mr A had a history of mental illness and of self-harm, and had been in and out of hospital as a result. He was admitted to the Royal Edinburgh Hospital for treatment after an apparent suicide attempt. He was given a pass to walk unescorted in the hospital grounds, but did not return when expected. Staff decided not to contact the police to report him missing until some two hours after his expected return time. Mr A was found dead outwith the hospital a number of days later. Ms C (Mr A's fiancée and carer) complained that Mr A was not provided with appropriate care and treatment, in that the decision to allow him off the ward unescorted was inappropriate. She also complained that she was not properly involved in the decision making in Mr A's care.

The board carried out an internal review, which found that although the decision to issue the pass was high-risk, the professional judgment of staff was reasonable in the circumstances. They also said that it was reasonable not to contact police earlier, but made five recommendations, including reviews of what should happen if a patient did not return when expected, of liaison with the police and of the risk assessment tool. The board met with Ms C, who had also met the leader of the review team. Ms C remained concerned that the board had failed in its duty of care to Mr A and wanted them to admit this. She wanted a further, independent review. The board did not agree to this, and said that they had taken appropriate action through the review recommendations. They did, however, apologise to Ms C for failures in communication with her in relation to care planning.

I took independent advice on this case from a mental health nursing adviser and a consultant psychiatrist. Mr A was recognised as having unpredictable behaviour, and had returned very late from a previous pass, so both advisers were critical of the assessment of risk, and that this was not updated during treatment, as his condition appeared to be fluctuating. Poor risk recording made it difficult to understand how it had been taken into account when making decisions, there was no mention of what was done to reduce risk and there was no plan of what should happen if he did not return from a pass. Both advisers came to the view that in the absence of a structured assessment of risk, it was unreasonable to grant Mr A an unescorted pass.

I upheld both Ms C's complaints. On the first, I accepted my advisers' view that Mr A's care fell below a reasonable standard in terms of the assessment and recording of risk. I also found that the board's review reached contradictory conclusions on whether it was reasonable for staff not to take action until two hours after Mr A failed to return. Although I cannot say whether this led directly to Mr A's death, such omissions represent a significant failing, and I criticised the board for this. As, however, the board's own review addressed many of these issues through an action plan I made limited recommendations. On the second complaint, appropriate communication with carers is a requirement of the Mental Health (Scotland) Act 2003, and it was not clear from the records whether staff viewed Ms C's as Mr A's main carer. Her status should have been documented so that staff could communicate appropriately with her. I made five recommendations, which can be read in full in my report.

Investigation Reports



Investigation report ref: 201305972

Delay in diagnosis, clinical treatment, communication, record-keeping; complaints handling

Dumfries and Galloway NHS Board

SUMMARY

Mrs C complained that her late husband (Mr A) was not provided with appropriate care and treatment after he was admitted to Dumfries and Galloway Royal Infirmary. Mr A was admitted with a suspected stroke but developed severe diarrhoea. His condition deteriorated significantly over the next few days and he developed a number of other symptoms, including problems with his oxygen levels, his heart and his breathing. He was transferred to intensive care, but died some four weeks after he was admitted. Mrs C said that although she was very concerned about her husband's condition, he was not seen by a consultant until about a week after he was admitted. She repeatedly raised her concerns with staff, but felt these were dismissed. Mrs C felt it took too long to recognise that Mr A had had a heart attack, and said he lost all his dignity while in hospital and suffered unnecessarily.

The board met with Mrs C some months after she first complained, and wrote two months after that to further clarify what had been said, acknowledging her concerns that the heart attack was not diagnosed sooner. They said, however, that they hoped she was reassured that they had carried out a series of appropriate tests to diagnose Mr A's condition, although with hindsight this could have been done more quickly. They apologised for Mrs C's experience.

The records did not show what was said at the meeting, but there were statements from two doctors within the complaints papers. Both acknowledged that it was unfortunate that Mr A was not reviewed earlier, and that there were issues with availability of consultants. I also took independent advice on the complaint from a consultant cardiologist, who said that Mr A died following a critical illness, which culminated in multi-organ failure. Although he already had underlying health conditions, there was evidence of a recent heart attack and a related life-threatening condition. My adviser identified a number of failings in Mr A's clinical care, including that the heart attack could have been diagnosed sooner, fluid therapy was not appropriately managed, and medical records were inadequate, with electrocardiogram (heart function monitor) results that were not properly labelled and that did not appear to have been compared in sequence. This meant that Mr A was not adequately reviewed and his heart problems not considered early enough – critical omissions when planning his treatment.

I accepted this advice and upheld Mrs C's complaint. I found that Mr A was not reviewed by a cardiac consultant early enough, and was placed on inappropriate fluid therapy, which compromised his treatment and meant that his care fell below a reasonable standard. I also found the board's complaints handling and apology inadequate, given that two senior members of board staff identified failures in Mr A's care, and that I saw no evidence of the board taking action to improve procedures as a result of Mrs C's complaint. I made six recommendations, which can be read in full in my report.

Investigation Reports



Investigation report ref: 201400930

Delay in diagnosis, clinical treatment; complaints handling

A Medical Practice in the Highland NHS Board area

SUMMARY

Ms C complained to us on behalf of her client (Mr A) that doctors did not reasonably diagnose that his late wife (Mrs A) had cancer. In late 2012, Mrs A had breast cancer surgery, during which an extremely large high-grade tumour was removed. She contacted the practice some seven months later complaining of back pain and spasms. She also then developed a wheeze and cough. Between 29 July 2013 and 19 August 2013 she had four telephone consultations with three GPs at the practice, who prescribed and adjusted pain relief medication, and later provided Mrs A with an inhaler. The day after the last consultation, she contacted NHS 24 because she was having problems breathing. They arranged for an out-of-hours doctor to visit, who diagnosed pneumonia and said Mrs A should contact her GP. She did this the same day, and saw another GP from her practice, who referred her straight to hospital because of her history of breast cancer. She was found to have cancerous growths and a build-up of fluid in her chest. She was admitted to hospital but died before cancer treatment could be started.

When Mr A complained to the practice they concluded that they did not identify early enough that Mrs A was as unwell as she was, and that it would have been better if she had been more fully assessed. They said that this might have been partly due to a breakdown in communications, apologised for the standard of care provided and said that they would carry out a serious event analysis (SEA) of Mrs A's case. Mr A was not satisfied with this, and took the complaint further, latterly with the help of Ms C. The final outcome was that although the practice agreed that with hindsight things could have been done better, they said that they had found nothing that needed remedy.

I took independent advice from one of my medical advisers, who is a GP. She said that the medical histories taken during the telephone consultations were sparse and that Mrs A's clinical history should have made doctors suspect that the cancer might have come back. The surgeon had told the practice that it was not possible to say whether surgery had achieved a long term cure. Given all the circumstances, my adviser said that Mrs A should have been physically assessed at the time of the first call, and certainly when the pain did not resolve after painkillers were provided. My adviser had several concerns about the lack of assessment before prescribing treatments, and these are detailed in my report. She also pointed out although that the SEA report showed some evidence of reflection on and learning from Mrs A's case, the practice also appeared to have suggested that some of the responsibility lay with Mrs A for not explaining just how much pain she was in.

I upheld Ms C's complaint, as I found that a combination of errors led to an unreasonable delay in diagnosing Mrs A's condition. She should have been seen face-to-face and assessed much earlier, and elements of her care fell below General Medical Council standards. Although the practice accepted that they did not physically assess her early enough and have introduced a new telephone protocol, my adviser identified some other serious failings, especially around prescribing medication without adequate knowledge of the patient's health. I was also concerned that in handling the complaint the practice appeared to ascribe some of the blame to Mrs A, which suggests to me that they had not fully accepted that their handling of her case was not of a reasonable standard. They also appeared to minimise fault on the part of the doctors, and I found the tone of some of their letters inappropriate. I made four recommendations, which can be read in full in my report.

Investigation Reports



Investigation report ref: 201401011

Clinical treatment, delay in treatment, complaints handling

Lanarkshire NHS Board

SUMMARY

Mrs C complained on behalf of her grandmother (Mrs A) about the time it took to provide Mrs A with treatment. Mrs A had a long history of incontinence problems, and her GP referred her to the board in August 2012. In November 2012, Mrs A had her first appointment at Wishaw General Hospital. In May 2013, tests at a second appointment identified the problem as stress incontinence. At a third appointment in October 2013 a doctor suggested that surgery might address this, and said that Mrs A would be referred to a specialist consultant. This, however, did not happen and when by January 2014 nothing had been heard, Mrs A, her GP and Mrs C all contacted the hospital. Mrs A was eventually referred to a consultant in February 2014, and was placed on a waiting list for surgery.

Meanwhile, in September 2013 new national guidelines had been produced for managing incontinence in women and subsequently the board formed a group to discuss the best way to treat patients like Mrs A. The group discussed Mrs A's case at their first meeting in March 2014. They decided that, per the guidelines, rather than her being on the waiting list, they should instead refer her to a specialist centre at another board (hospital 2) to consider her treatment. She eventually had surgery in February 2015, some two and a half years after her initial referral.

In February 2014, Mrs C had complained to the board about the delays. They explained why these happened, acknowledged that they were unacceptable and apologised for this and for the distress caused. Mrs C was unhappy with their response as it did not say whether anything had been done to stop this happening again.

I took independent advice from two advisers, a consultant physician and a consultant gynaecologist. The consultant physician said that the delays after the first appointment were unacceptable, and that there was a failure of care when Mrs A was not referred to the specialist consultant in October 2013. Both advisers found the delay in referring Mrs A to the specialist centre unacceptable, although the consultant gynaecologist confirmed that in Mrs A's case it was entirely correct to follow the guidelines and refer her there for consideration.

I found that there was a general lack of urgency in Mrs A's care, that there were unreasonable delays in investigating and assessing her condition, and that the board did not address these effectively when responding to Mrs C's complaint. I was particularly concerned that Mrs A was not referred to a consultant in October 2013, and that when handling the complaint the board did not try to find out why this happened. I upheld Mrs C's complaint and made four recommendations, which can be read in full in my report.

Complaints Standards Authority (CSA)



NHS

Following the successful programme of 'Patient Experience, Feedback and Early Resolution' events which we jointly hosted with NHS Education for Scotland, we are preparing the next steps in planning for bringing forward changes to the NHS complaints handling arrangements. This will take into account the need to progress legislative change and will involve NHS boards and key agencies throughout the development phase. Our aim remains to work with NHS boards and other stakeholders to develop a model complaints handling procedure (CHP) for the NHS that is more focused on early resolution and takes account of the framework of the Patient Rights (Scotland) Act 2011 and the 'Can I help you?' guidance for handling and learning from feedback, comments, concerns or complaints.

Local government

The chair of the local authority complaints handlers network updated the March meeting of the SPSO/local government sounding board on the progress of the network over the past six months. In doing so she highlighted the analysis of the 2013/14 complaints performance data, which is now helping members to benchmark and learn from each other. She also noted the network's successes in relation to networking, learning from complaints and sharing best practice across the sector.

The next meeting of the local authority complaints handlers network will be held on 12 June 2015 when members will consider the further development of the Local Government Key Performance Indicators for 2014/15 complaints information, particularly in relation to learning from complaints.

SPSO representatives are due to meet with the Accounts Commission, the Improvement Service, COSLA, SOLACE, the Scottish Government and Audit Scotland in May to explore ways in which analysis of the local government annual complaints reports at a national level can be improved. This will also give us the opportunity to share with these key stakeholders the progress that has already been made by the network group in analysing the annual complaints reports.

We are also taking forward work with the Improvement Service on the development of masterclass sessions for elected members and a briefing note on good complaints handling / governance. We will provide further updates on our progress in the following months.

Housing

The housing complaints handlers network met on 27 March in Glasgow, hosted by Queens Cross Housing Association. We were encouraged by the numbers of housing staff who attended from registered social landlords and councils, the level of debate and the commitments shown to improving how we manage and learn from complaints.

A key theme for the network was the performance in managing complaints and how best to make progress towards developing a performance culture across the sector. Attendees also took the opportunity to feed back on their experiences of handling complaints through the model CHP. It was widely agreed that the model CHP had been good for the sector and for customers, with feedback that recording and reporting against SHR indicators was taking place but reporting against SPSO indicators was not being consistently applied by all. The network benefitted from sharing their experiences of good practices through a complaints surgery, helping to address some issues that members had encountered.

It was agreed by members that it would be appropriate for the network to meet quarterly, with the next meeting provisionally scheduled for early July. It was noted that this timing would allow for the collation of complaints performance information from the first quarter of 2015/16 which could be analysed for the next meeting to illustrate the value of benchmarking. If you would like to attend future meetings of the network, please in the first instance drop us an email at csa@spsso.org.uk and we will pass your details to the lead housing officers for the network.

Complaints Standards Authority (CSA)

Further education

The further education complaints advisory group will host a benchmarking workshop for all colleges on 6 May. The group has asked all colleges to present their annual complaints performance data for 2013/14 in a standardised format, within a reporting spreadsheet provided by the group. This will allow for a consistent and meaningful analysis of complaints handling performance across the sector and produce, for the first time, a baseline against which we can benchmark for improvement. This information is key to the success of the benchmarking workshop, and we would encourage any colleges that have not yet provided their complaints performance information in this format, to please do so without further delay. If you haven't signed up for the event please contact Dawn Brooks of the College Development Network at dawn.brooks@cdn.ac.uk

Higher education

The next meeting of the higher education complaints forum will take place on 23 April 2015 at the Paisley Campus of the University of the West of Scotland.

As a reminder, we ask that higher education institutions that have not already done so to please provide us with their annual complaints report, or a link to their published annual complaints report online, by contacting us at csa@spsso.org.uk

For all previous updates, and for more information about CHPs, visit our dedicated website www.valuingcomplaints.org.uk. You can also contact the CSA directly at CSA@spsso.org.uk

SPSO Training Events



Complaint investigation skills (stage 2 of the model CHP): 1 day open course

Wednesday 27 May 2015, central Edinburgh

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Wednesday 27 May 2015 in central Edinburgh. This is open to staff from all sectors under the SPSO's jurisdiction. **Full course details are available on the SPSO Training Unit website.**

For more information and to book spaces please contact training@spsso.org.uk

For more SPSO course information, please visit the SPSO Training Unit website:
www.valuingcomplaints.org.uk/training-centre/

Managing Difficult Behaviour: 1 day open course Monday 22 June 2015, central Edinburgh

This course, new for 2015, is open to staff who might receive negative feedback from the public or other stakeholders. Participants will be given an opportunity to assess their own conflict styles and develop ways of managing their own personal 'triggers'. We will consider a number of different theories and tools that can be helpful in managing conflict. The session will include a number of opportunities to put theory into practice and participants will be able to discuss their own particular concerns. **Full course details are available on the SPSO Training Unit website.**

Price: £180 pp To apply for the course, please email training@spsso.org.uk

Save the date: **SPSO Conference, Thursday 8 October 2015**

With a range of keynote speakers, interactive workshops and cross-sector networking opportunities, our one-day conference will focus on helping you implement improvements to your complaints handling, quality assure your complaints responses, and maximise learning from complaints using root cause analysis.

Location: **COSLA conference centre, Edinburgh (near Haymarket train station)**

Price: **delegate rate £150 pp, including refreshments and conference materials**

Spaces will be limited, but to register your early interest or for more information, please contact training@spsso.org.uk

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 April 2015

The compendium of reports can be found on our website: <http://www.spsso.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.



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