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## Monthly news from the Scottish Public Services Ombudsman

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This month we are laying four reports before the Scottish Parliament, three about the health sector and one about a local authority. We are also laying a report on 85 decisions about all of the sectors under our remit. These can be read on our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in June), we received 482 complaints. We determined 492 and of these we:

- gave advice on 273 complaints
- considered 150 complaints at our early resolution stage
- decided 69 complaints at our investigation stage.

We made a total of 134 recommendations.

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## Ombudsman Overview



This month I am publishing three cases about the health sector and one about a local authority.

A man who had previously undergone surgery to remove a tumour experienced significant delays of more than a year in receiving scan results which showed that it was likely that his cancer had spread (case 201402286). There were then further delays in arranging follow-up scans, which I found to be unacceptable. The board had also not apologised for this additional delay, and I am very critical of this too.

A woman who had presented at hospital twice with symptoms including severe headaches was then found to have a brain abscess which required emergency surgery (case 201401793). I found that the care and treatment she received fell below the standard she could have reasonably expected. There was also unreasonable uncertainty from staff around infection control whilst she was in hospital, and poor communication relating to her discharge from hospital.

In the third case, a man had called an emergency ambulance to his home and had reported his underlying health condition to staff (case 201305392). I found that there were a number of significant failings in the ambulance crew's assessment of the man including failing to find out about his underlying condition before advising him that he did not need to attend hospital. I was also critical that the number of calls the man had previously made to the ambulance service wrongly influenced their decision-making on that occasion.



These failings by healthcare professionals caused significant personal injustices to the patients and their families. I encourage all healthcare providers to consider these investigations and the recommendations I have made as wider opportunities for learning.

A local authority's handling of a planning application also fell below the standard that could have reasonably been expected (case 201301594). An omission in properly logging an objection to the development had a number of knock-on consequences in how the application was handled. In light of the numbers of failings I identified, one of the recommendations I have made is that the council consider options for enforcement and/or whether it would be appropriate to pursue a discontinuance order or alteration on the development.

## **MP / MSP Guide**

This month I have written to MPs representing Scottish constituencies in the UK Parliament to outline the work of the SPSO. I have also provided them with a copy of our guide to SPSO for MPs, MSPs and their staff. As with previous editions, this publication is available on our website at <http://www.spsso.org.uk/fact-sheets>

As well as our usual Complaints Standards Authority update, there is information below about a major SPSO Conference and forthcoming training events.

# Investigation Reports



Investigation report ref: 201402286

## **Clinical treatment, delay in diagnosis, delay in treatment**

Lanarkshire NHS Board

### SUMMARY

Mr A had an operation in May 2011 to remove half of his large bowel due to a malignant tumour. In May 2012, Mr A had a follow-up appointment and his GP was contacted to say that blood tests had been taken, a scan was to be arranged, and that Mr A would be seen again in six months. Mr A had his scan in July 2012. No action was taken by the board as a result of the scan test, and Mr A did not have another appointment until September 2013. It was at this appointment that he learned that the results from the July 2012 scan indicated that it was likely that cancer had spread to his liver and one of his lungs. At this point a second scan was arranged, but there were further delays at this point in obtaining a scan. Mr A's daughter (Mrs C) had to contact the board a number of times to get an appointment for her father. She complained to the board but was not satisfied with their response, and so complained to my office. Mr A began chemotherapy in late 2013, and died in August 2014.

As part of my investigation I took independent advice from a consultant physician and a consultant oncologist.

On Mrs C's first complaint about the delay in assessing her father's test results, I found that a combination of errors and inadequate systems resulted in a failure to assess and refer Mr A for treatment of his cancer. My physician adviser noted that the board had not more thoroughly investigated the handling of the test and scan results in their response to Mrs C. Given that neither set of results had been handled correctly, the adviser was concerned that this reflected a more general failure of results gathering / scrutiny by the board. Whilst some changes to test result handling procedures have been made by the board since the time period under investigation in this case (as a result of a recommendation in a previous SPSO case 201305802), further action will be required to fully address the concerns outlined in my investigation. My adviser was also concerned to note that the board's response to Mrs C's complaint did not reflect on their role in regard to the long period between follow-up appointments. I am therefore concerned that this situation could arise again.

The delays in arranging a second scan were also unacceptable. Whilst the board accepted that Mrs C had to make an unreasonable number of calls to chase an appointment, they have not apologised for this. My advisers both noted that, given the circumstances surrounding the initial delay in communicating the scan results to Mr A, it was not reasonable to leave Mr A and his family waiting again for the second scan. The board had also not apologised to Mrs C for the second delay, and I am very critical of this.

Mrs C had noted that when her father saw the cancer specialist after the second scan, he was told that even if the July 2012 scan result had been picked up earlier, he would not have been offered further surgery and that starting chemotherapy at an earlier stage would have been unlikely to make any difference to his prognosis. However, the advice I received from my oncology adviser was that Mr A received very poor care: even if there was no treatment to cure his cancer at that time, being told of the results more than a year prior to when he actually found out would have given him and his family more time to know that he was terminally ill and to plan accordingly.

# Investigation Reports



Investigation report ref: 201401793

**Clinical treatment, nursing care, hygiene, communication, complaints handling**

Lothian NHS Board

## SUMMARY

Miss C was suffering from a severe headache with associated flashing lights that was not relieved by painkillers. Following referrals from her GP she twice attended an out-patient clinic at St John's Hospital where on both occasions she was reviewed by staff and sent home with medication. She had a computerised tomography scan two days after the second appointment which showed that she had a brain abscess. She was transferred to another hospital for emergency surgery, followed by another operation to further drain the abscess. Miss C raised a number of concerns about the care and treatment she received while attending St John's Hospital, in particular, that the delay in undertaking investigations necessary to diagnose her condition may have led to a more serious outcome and unnecessary prolonged pain and distress.

When Miss C was transferred back to St John's Hospital, she was unhappy with the care she received, in particular the attitude of staff on the ward. Miss C also complained to us about the delay in diagnosing her condition and the way the board handled her complaint.

I took independent advice from a general medical adviser and a senior nursing adviser. On the initial diagnosis of Miss C's condition, my medical adviser said that there were sufficient red flag symptoms for Miss C's condition, which was deteriorating over time, to prompt clinicians to investigate further. Although it is not possible to know if an earlier operation would have improved the outcome for Miss C, I found that the board failed to give her the care and treatment she could have reasonably expected. I found that in terms of infection control on the ward, there was an unreasonable level of uncertainty from medical staff. I also found that there was inadequate communication with Miss C and her family. There had also been errors in relation to one of Miss C's prescriptions and her discharge medication which, whilst my medical adviser said would not have caused any harm, further reduced the confidence of Miss C in the ability of the ward to care for her. I am also critical that whilst the board apologised, they did not explain how these errors occurred in the first place. During my investigation, the board also failed to send copies of information sent by them to Miss C's GP. I was also critical of this, as this was relevant information given that Miss C also complained about poor communication between the board and her GP following her discharge from hospital.

In terms of the nursing care she received, my nursing adviser said that whilst there are notes documenting regular interaction between nursing staff and Miss C, some of the notes were poorly completed, so I have concerns about record-keeping. There was also a breach in nursing protocol in relation to the disposal of a used syringe. The board has accepted that this protocol had been breached and has assured us that action will be taken to address this.

Although there were some aspects of the board's complaints handling that could have been better, on balance I considered that Miss C received a reasonable level of service in this regard so did not uphold her complaint about the way her complaint was dealt with.

# Investigation Reports



Investigation report ref: 201305392

## **Clinical treatment**

Scottish Ambulance Service

### **SUMMARY**

Mr A had collapsed at home. He had phoned for an emergency ambulance and explained that he had a condition called idiopathic thrombocytopenic purpura (ITP – a disorder that can lead to excessive bruising and bleeding including bleeding into the brain which can be fatal). Mr A also had alcohol-related health issues, and was in contact regularly with healthcare services. When the ambulance arrived at his home, he explained to the paramedic and technician that he suffered from ITP. After assessing him, the ambulance crew did not transport him to hospital. The following day he was found dead at home, and ITP was recorded as one of the causes of death. Mrs C, who complained on behalf of Mr A's son, complained that the ambulance crew should have taken Mr A to hospital when they attended, and was concerned they did not do so because of his alcohol-related health issues and the fact that he had previously called for an ambulance on several occasions. The ambulance service said that from the records, it appeared that Mr A had been observed appropriately, and he had declined hospital treatment.

I took independent medical advice on the complaint from a paramedic adviser, who told me that the assessment of Mr A was not reasonable, as Mr A's symptoms (along with the readings taken at the time and his pre-existing ITP diagnosis) indicated that he needed assessing at hospital, and he should have been advised of this. The paramedic's statement that reflected on the number of Mr A's previous hospital visits should not have influenced the decision-making as to his treatment on that occasion.

Whilst my adviser recognised that the paramedic should not necessarily have had knowledge of the condition ITP, the records show no sign of them having tried to get more information about it: they should have sought more specialist advice before diagnosing a simple faint and advising Mr A, on that basis, that he did not need to go to hospital. The advice I received is that the paramedic involved failed a significant number of professional standards, and this led to Mr A being given insufficient information, or a reasonable assessment to make a decision as to whether he should go to hospital.

It is also clear to me that the ambulance service's investigation into what happened was extremely poor. They appeared to have taken the crew's statements at face value without further investigation, and they failed to recognise the clinical failings and take action to address them. I upheld the complaint and made a number of recommendations.

# Investigation Reports



Investigation report ref: 201301594

**Planning: enforcement, handling of planning application**

Fife Council

## SUMMARY

Mr C complained to us about the way the council handled a planning application for a development in the rear garden of a hotel next to his mother (Mrs A)'s property. Mr C raised a number of concerns about the handling of the matter by the council's planning service including issues around neighbour notification; the description of the proposed development; the need for a design statement (required for some proposed developments within conservation areas, which Mr C said applied in this case); inaccuracies in the submitted plans; and considerations about environmental health, potential noise and light pollution, and potential daylight and sunlight restrictions caused by the proposed development. He also complained that representations from the local preservation trust objecting to the proposal had been disregarded, and that the council made their decision before the statutory deadline given to the community council to respond to the planning application had passed. In addition, Mr C complained that the structure that was built was different to that for which permission was given by the council.

We took independent planning advice on this complaint. Although we found that in some cases, the council's actions had been reasonable or had been decisions that they were entitled to take in the course of their consideration of the development, there were a number of aspects to their handling of the matter that we were critical of.

We found that the council should have sought to change the applicant's description of the structure, as it did not accurately reflect the permission being sought and may have misled interested parties; they acted unreasonably in not requiring a design statement to be submitted with the application, which my planning adviser told me had major consequences for the assessment of the application; the council delayed in logging an objection received and the handling report stated that no representations had been received. This was a serious omission which also was consequential to the way in which the application was subsequently handled. We found that the council failed to complete a daylight and sunlight assessment; the development was not properly assessed for its impact on the conservation area that applied to the location; and the decision was made prior to the end of the time allocated for statutory consultation with the community council.

In relation to Mr C's complaint that the final structure differed from what was applied for, my adviser told me that there is no specific requirement on the council in relation to how much an application can vary: this is for them to decide. However, in this case, the council failed to appropriately log the objection made, which had a knock-on effect in relation to the council's decision to treat some of the variations as minor so, on balance, I upheld Mr C's complaint about this.

In view of all of these failings, based on the advice received from my adviser, I recommended that the council should consider taking enforcement action or discontinuance under section 71 of the Town and Country Planning (Scotland) Act 1997. I also found that the council had failed to respond adequately when Mr C had raised his concerns with them.

# Complaints Standards Authority (CSA)



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## Local government

The next meeting of the local government complaints handlers network is scheduled for 30 October 2015. Performance management is a standing agenda item at network meetings where performance against the key performance indicators is discussed. These indicators were initially drafted in 2012 when the model CHP was introduced and councils have made considerable progress in the way in which complaints performance is captured and reported to produce a baseline of complaints handling performance. The next meeting of the network will consider the annual complaints performance for 2014/15, and the development of guidance to support the learning from complaints.

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## NHS

Our work continues towards bringing forward changes to the NHS complaints handling arrangements. The intention is to adopt a partnership approach to include a working group made up of NHS Board representatives and other NHS stakeholders to take this work forward. The aim of the working group will be to work with the CSA to develop a standardised model CHP for the NHS within the framework of other model CHPs developed and introduced across the public sector in Scotland. It will take account of appropriate amendments to the regulations and directions associated with the Patient Rights (Scotland) Act 2011 and to the Scottish Government's 'Can I Help You' guidance. Further information will be provided soon.

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## Housing

The meeting of the housing complaints handlers network planned for July has been rescheduled to August with the most likely date being 14 August depending on the final venue. The chair of the network will write to members to confirm the arrangements. One of the main features of the network meeting will be comparing complaints handling performance from the first quarter of 2015/16 and benchmarking of performance within the network.

Further information on the role of the network, including details of how you may join, can be obtained from [anne.fitzsimons@tollcross-ha.org.uk](mailto:anne.fitzsimons@tollcross-ha.org.uk)

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## Further education

An update on the work to consider the current categories of complaints used across the sector and the approach to measuring customer satisfaction with the complaints procedure with a view to identifying and sharing good practice across the sector will be provided in due course.

We would encourage any colleges that wish to join the further education complaints advisory group to contact us at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk) and we will pass your details on to the chair of the group.

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## Higher education

We encourage all higher education institutions to contact us directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk) for advice on performance reporting, the compliance requirements of the Scottish higher education model CHP or for generalist advice on complaints handling.

For all previous updates, and for more information about CHPs, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

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## SPSO Training Events

### Bookings are now open for the first ever SPSO Conference

Thursday 8 October 2015, COSLA conference centre, Edinburgh

Complaints processes generally concentrate on 'putting it right' for the consumer. Using the intelligence that can be derived from complaints, how can we ensure we 'get it right' next time for everyone else? How do we ensure that our complaints processes and responses are fit for purpose and allow us to identify where there is learning and meet the needs of the consumer?

Keynote speakers from the SPSO and public and private sector organisations will talk about their real-world challenges in changing organisational culture, embedding potential learning and improving future practice. A series of workshops and ample networking opportunities will enable delegates to meet with colleagues across the public sector and beyond.

#### Who should attend?

- Those with lead responsibility for monitoring and improving organisational performance
- Managers with responsibility for organisational learning from complaints and feedback
- Quality Assurance Managers
- Complaints and customer service managers
- Organisations with an interest in consumer redress.

#### Where and when?

9am – 4pm, COSLA conference centre, Edinburgh (near Haymarket train station).

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

For further information or to request a booking form, please contact us at [training@spsso.org.uk](mailto:training@spsso.org.uk)

### Booking now:

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

Wednesday 9 September 2015, central Edinburgh

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Wednesday 9 September 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](mailto:training@spsso.org.uk)

We have more information about courses that we can offer to organisations in our new flyer:  
**SPSO Training 2015 (PDF, 40KB)**

## 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 July 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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