

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three investigation reports before the Scottish Parliament today. We also laid a report on 81 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (January 2014), we received 464 complaints. In addition to the six reports we laid before Parliament, we also determined 458 complaints and of these we:

- gave advice on 333 complaints
- handled 57 complaints in our early resolution team
- decided 68 complaints through detailed consideration
- made a total of 96 recommendations in decision letters.

## Ombudsman's Overview



### Investigation reports

I am laying three reports about the NHS today. Two are about hospitals and one is about a medical practice, and all of them involve someone's death. In each case, the family asked me to look at the complaint because they were concerned that, had things happened differently, the outcome for their loved one might have been different. There is also an overriding concern that they do not wish what they experienced to happen to anyone else.

I urge NHS boards and GP practices to read the reports carefully and reflect on my findings to ensure that they have appropriate processes and guidance in place in their own areas. I also invite regulators and scrutiny and improvement organisations to use the learning from these complaints, and in connection with this would draw particular attention to my recent response to Healthcare Improvement Scotland's consultation on their draft annual scrutiny and inspection plan.

### Recommendations and redress

In last month's overview, I explained how our investigations add value through the recommendations we make, and how we ask organisations for evidence that they have implemented them. This month I want to focus on what we actually recommend and how we fix things that have gone wrong for people.

We make recommendations in many of our investigations. The ones that receive most attention are those in our full public reports. The three I am publishing this month contain a total of 18 recommendations, and include reviewing guidance on specific issues, explaining the learning the organisation had from the complaint and how they used this to improve, and ensuring that the staff involved discuss at their annual appraisals the failings we identified. We also recommended that the health boards involved apologise to the families involved.

*continued*

However, we make most of our recommendations in investigations that are not full public reports. Last year we carried out 939 investigations, of which 44 were full public reports. This month, as well as the three public reports, we are publishing 81 other investigations, and we made a total of 96 recommendations. Some of these were particularly significant for the individual concerned, and included that:

- a college review a disabled student's application for a place (201300085)
- a health board make a goodwill payment to a man, linked to the cost of his visit to a hospital, because he was put to unnecessary inconvenience (201302973)
- a housing association offer a man a redress payment in line with that offered to other neighbours (201204215)
- a council meet with a woman to explore her options for rehousing (201300781)

These examples show some of the improvements we can make for people. Another, very common, recommendation is that an organisation apologise, or apologise more fully, to the person who has suffered as a result of the problems that led to the complaint. We can also recommend that policies and practices are reviewed and changed where we find they are inadequate, and we can have professionals include discussions in their appraisals about failings that we have identified. Where we see more serious failings, we may also pass on information about this to professional regulatory bodies, such as the General Medical Council.

Complaints about water providers, in particular, can lead to us making recommendations that have a financial implication. Examples from this month include that:

- recovery charges be cancelled (201202828)
- charges on a water account be reassessed (201204363)
- an ex-gratia payment be offered because of delays that impacted on a customer finding out about a leak (201205278)

In a few cases, we do not even need to make a recommendation for our intervention to make a difference. In one case (201301999) our enquiries led to the water provider reviewing the case and deciding to write off a charity's water bill.

## **Financial redress**

We tend to recommend financial redress where we uphold the complaint and the complainant has suffered a demonstrable financial loss because of what happened. Some Ombudsmen routinely recommend financial payments for other reasons, where the loss is not necessarily monetary, for example where it is considered that there has been significant distress. We have recently issued an invitation to tender for research about this area, and will review our redress policy in the light of the results of that research.

# Investigation Reports



Investigation report ref: 201204063

**Diagnosis; clinical treatment; communication; support/information; complaints handling**

Lothian NHS Board

## SUMMARY

Mr A was diagnosed with prostate cancer in May 2011, and was prescribed hormone treatment by a hospital doctor. Mr A had said that another hospital doctor (Dr Y) then told him in August 2011 that he did not have prostate cancer and stopped his treatment. Dr Y did not appear to be aware that in May Mr A had been found to have a high level of prostate-specific antigen (PSA – a protein that may indicate prostate cancer) in his blood. After this, Mr A's diagnosis remained unclear until late November when prostate cancer was again diagnosed and treatment resumed. By the middle of January 2012, however, the cancer had advanced and further tests showed that Mr A's prognosis was very poor. Mr A died six months later.

Mr A's daughter (Miss C) was unhappy with what happened after her late father's initial diagnosis, and complained that the board did not provide him with reasonable care and treatment. She also said that the board unreasonably withheld information about her father's condition from him and his family, and did not provide appropriate help and advice or make his condition clear, and she was unhappy with the way in which the board handled her complaints. Miss C said that the family did not find out until January 2012 that the cancer was advanced, and it was only then that her father met with a cancer nurse for the first time.

After Miss C complained, the board met twice with her and other members of Mr A's family, and provided some explanations for what had happened. They said that the rapidly progressing cancer could not have been controlled by the hormone therapy, and the outcome would have been the same had treatment continued. They did, however, agree that there were issues around communication, and that there had been significant trauma for the family. Dr Y attended the second meeting, and said then that his decision to stop the hormone treatment was correct, and that further scans would not have changed anything.

During my investigation into Miss C's complaints, I took independent advice from one of my medical advisers, who is a consultant with a special interest in prostate cancer. My adviser said that hormone treatment was correct for Mr A, and that he had clearly responded well

to it as his PSA levels had fallen enormously. He also said that the appearance of cancer can disappear quickly after hormone therapy starts. In Mr A's case, the treatment had changed the clinical picture so that when Dr Y saw Mr A he mistakenly concluded that he did not have prostate cancer. The adviser said that stopping the hormone therapy was a significant decision for Dr Y to make without checking why Mr A had been put on it in the first place. He noted that Dr Y did not check whether a PSA blood test was taken at the time of the initial diagnosis. Had Dr Y done so, the high levels of PSA originally recorded should have been picked up, rather than the low level after hormone treatment.

I upheld all of Miss C's complaints. I was critical of both doctors involved in diagnosing Mr A's condition because of their poor management of his care, which resulted in poor co-ordination and communication between key staff. This led to Mr A and the family receiving inaccurate information and poor support from the outset. I also noted that national guidelines were not followed when providing information to Mr A and his family, and that there was no multi-disciplinary meeting to discuss his case until two months after the initial diagnosis. It then took three months to return to the diagnosis of cancer, despite Dr Y being aware by then of the significantly high initial PSA reading, as well as abnormal results from clinical examinations. Finally, I was critical of the board's complaints handling, including that at their two meetings with Miss C they gave her conflicting information about the stopping of hormone therapy, and that they did not provide a clear written response to her complaint.

I recommended that the board review their prostate cancer guidance to ensure it is consistent with national guidelines for the management of patients such as Mr A; ensure timely involvement by a specialist cancer nurse shortly after diagnosis of prostate cancer; ensure Dr Y discusses the failings identified in this report at his next appraisal; and ensure clinical staff clearly record any verbal responses they provide to patient correspondence. I also said that the board should apologise to Miss C and to Mr A's family for the failings identified and in future ensure that complaint responses are consistent, accurate and set out in a structured manner.

# Investigation Reports



Investigation report ref: 201300003

## **Hospital admission; clinical treatment; communication; patient dignity** Grampian NHS Board

### SUMMARY

Mr C was discharged from hospital after heart surgery. Almost two weeks later, however, he was readmitted with stomach pains. He was assessed in the accident and emergency department (A&E) of Aberdeen Royal Infirmary, where medical staff decided that he should be transferred to the acute medical assessment unit (AMAU). However, a large number of patients needed to be admitted that day, and although Mr C had arrived at the hospital in the morning, he was not in fact transferred until the evening, some eleven hours later. For much of the time in A&E, he was lying on a hospital trolley. After he was transferred, he became unwell and he died the next day. The cause of his death was recorded as an ischaemic bowel (inadequate blood flow to the intestines), related to a heart condition. His wife (Mrs C), who also has health problems, had been at home some sixty miles away while he was admitted, and when she received a call to come to the hospital urgently, she was unable to get there before her husband died.

Mrs C complained that the care and treatment provided to her husband were unreasonable. Among other things, she was unhappy about the time he spent in A&E, the lack of treatment there and the time it took for a doctor to see him after he was transferred. She said that she thought these affected her husband's chance of survival. She also told me that after she arrived at the hospital, she was asked to sign her husband's death certificate before she had been given the chance to see him and that when she did see him, staff had not properly laid him out, which she found extremely distressing.

The board said that Mr C was monitored and frequently assessed in A&E and that although at first he was on a trolley, he was provided with a bed there about six hours after he had arrived. When he was transferred to the AMAU he was not in pain but his heart rate was fast and he was breathless. Early the next morning, he became more unwell and showed signs of heart failure. He was treated for this and was moved to the high dependency unit (HDU), but he got worse. Staff called Mrs C to advise her to come to the hospital, but as Mr C deteriorated very quickly, she did not arrive until shortly after her husband died. The board apologised for the time Mr C had spent

in A&E, and for the delay in a doctor seeing him after he was transferred, as well as for the added distress caused when Mrs C saw her husband shortly after he had died. Mrs C also met with representatives of the board, who accepted that many things could have been done better. At the meeting, the chief executive apologised personally to Mrs C for what had happened.

After taking independent advice from two advisers, a nurse and a medical consultant in emergency medicine, I upheld all Mrs C's complaints. I found that, whether or not he was eventually provided with a bed in A&E, Mr C was on a trolley for too long. He received no further treatment there, and our medical adviser said that the delay in transferring him to the AMAU should not have prevented him receiving treatment. The adviser also said, however, that the diagnosis of an ischaemic bowel is particularly difficult. He said that even if Mr C had been seen earlier, this condition would not necessarily have been identified. My nursing adviser pointed out that the notes showed that Mr C's vital signs were well outwith normal limits. She said that nursing staff should have told Mrs C this when they called to tell her that Mr C had been transferred to the HDU, which was in itself an indication that the family should be called to the hospital. I, therefore, found the board had not let Mrs C know about her husband's decline as quickly as they should have done, and that she had been treated with a fundamental lack of sensitivity, both with regard to when she was asked to sign her husband's death certificate and to seeing him after he had died.

Although I noted that the chief executive made a sincere apology to Mrs C for a number of the issues, and that the board had taken steps to address the failings, I made a number of recommendations. These can be read in full in my report, and included: confirming the learning gained from Mrs C's complaint and showing me how this has been passed on to staff; providing me with their plan showing what they have done to prevent Mr C's experience in A&E happening again; emphasising to A&E staff the importance of keeping accurate clinical records; and ensuring staff are aware of their responsibilities, both in preserving dignity in death and in being sensitive to the needs and feelings of family members in such a situation.

# Investigation Reports



Investigation report ref: 201300108

**Delay in diagnosis; clinical treatment; record-keeping; incident review**

**A Medical Practice in the Lanarkshire NHS Board area**

## SUMMARY

Mr C complained to us about the care and treatment of his late mother (Mrs A). Mrs A had multiple medical problems, including a history of kidney problems, and often consulted her medical practice. In October 2011, she was prescribed medication for a chest infection and for back pain, and a few days later she began vomiting and refusing food. She saw doctors from the practice several times that month. She was treated for nausea, and towards the end of the month one of the doctors arranged blood tests. A couple of days later, however, Mr C found his mother in a confused state in her home. He took her to a local hospital, where she was found to be suffering from kidney failure. Although Mrs A was transferred as an emergency to another hospital and dialysis was started, she died a few days later.

Mr C said that his mother should have been admitted to hospital earlier. The day before he took her there, he had been very concerned about her condition and had asked for a doctor to visit. He said that the doctor (Dr Z) said that Mrs A would not be admitted to hospital unless there was concern about her blood test results. (Mr C later learned that these had arrived the next day, and the practice had immediately tried to contact Mrs A, as the results indicated kidney failure.) Mr C complained that doctors at the practice failed to take into account Mrs A's symptoms, previous medical history and family concerns and did not arrange an emergency hospital admission.

The practice said that Mrs A had been visited several times. At the last visit, Dr Z had said that Mrs A seemed alert and responsive, and was not complaining of abdominal pain. The practice noted that Mr C believed that Mrs A's complaint of back pain should have indicated the possibility of kidney failure, but said that as Mrs A also suffered from arthritis, Dr Z suspected that to be the cause. Dr Z had made a clinical decision to await the result of the blood tests, as he had seen no indication that Mrs A should be admitted to hospital. However, the results had been delayed and only became available after Mr C took Mrs A to hospital. They said that because of

what had happened, they would now always consider the possibility of kidney failure in an elderly or vulnerable patient, and had shared with all practice doctors information about how urgent blood samples should be processed.

During my investigation I obtained independent advice from one of my medical advisers, who is a general practitioner. She was concerned about a number of issues, including the repeat prescribing of antibiotics when Mrs A did not appear to have improved, and the standard of clinical assessment, record-keeping and examination. There also appeared to be a failure to look at Mrs A's period of ill-health as a whole. The adviser said that it would have been appropriate to take blood tests earlier and to admit her to hospital on the day before Mr C took her there. She described Mrs A's care as fragmented, and said that the approach appeared to be reactive rather than proactive. I upheld Mr C's complaint and although the practice have taken action to learn from it, I agreed with my adviser that there were still serious unaddressed failings, as well as a factual error in the response to Mr C's complaint.

As a result of these failings, I recommended that the practice: apologise sincerely to Mrs A's family for the failures in her care and treatment; review the General Medical Council guidance on record-keeping and evaluate a sample of their case notes to ensure that they are meeting the required standards; and conduct a significant event analysis of this incident and discuss its findings within the practice team. I also specifically recommended that the practice doctors responsible for Mrs A's care review the relevant guidance on chronic kidney disease and its management. This should be identified as a learning need in their annual appraisals, and they should discuss this complaint and its evaluation at these appraisals.



# Complaints Standards Authority update



---

## Local authorities

Building on earlier sampling activity, as part of our ongoing assessment of compliance with the model complaints handling procedure (CHP) we recently wrote to all councils asking for further information about their reporting of complaints. We are in the early stages of considering the information provided. We will liaise directly with councils to advise on any compliance issues, and will also share best practice through the local authority complaints handlers network. Where appropriate we will also provide a summary of our findings to Audit Scotland, so that this information may be used to inform the shared risk assessment.

We are now in the final quarter of the reporting year and are aware that councils are turning their attention to the requirement to publish their annual complaints handling performance against the SPSO performance indicators. The next meeting of the complaints handlers network will be held on 28 March, where representatives of local authorities will discuss how information should be presented and reported. The network will also discuss the approach to developing the network further as a benchmarking forum for the performance indicators.

If you are interested in becoming involved in the work of the network, please contact the CSA team directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk).

---

## Local authority sounding board

The inaugural meeting of this sounding board will take place in March. It is our third sounding board, following the NHS and customer boards established last year. The Chair of SOLACE (Local Authority Chief Executives and Senior Managers) and the Ombudsman jointly invited members, including representatives of SOLACE, SOLAR (Local Authority Lawyers and Administrators), ADES (Directors of Education), ADSW (Directors of Social Work), HoP (Heads of Planning), CIPFA (Chartered Institute of Public Finance and Accountancy) and the Improvement Service. A complaints manager and the chair of the local authority complaints handlers' network are also included.

Given that the Government is looking at complaints about health and social care integration and social work and is consulting on permanent arrangements for review of the Scottish Welfare Fund, the timing is good for putting a sounding board in place. It is also expected that discussions may arise from the requirements of the model CHP such as the reporting and benchmarking of complaints information, and mechanisms for cross-sectoral learning from complaints, including the local authority complaints handlers network.

---

## Housing

As we work towards the end of the business year and registered social landlords (RSLs) begin to consider their annual performance in relation to handling complaints, we would remind them of the complaints handling performance indicators (published on 18 December 2012). These are designed to be used to assess complaints handling against the requirements of the model CHPs for RSLs and local authorities, in relation to housing complaints. The indicators can be accessed at

[http://www.valuingcomplaints.org.uk/wp-content/media/RSL\\_performance\\_indicators1.pdf](http://www.valuingcomplaints.org.uk/wp-content/media/RSL_performance_indicators1.pdf)

*continued*

# Complaints Standards Authority update



---

## Further education

Good progress has been made on the development and introduction of a further education complaints handlers network group, with the first meeting being scheduled for 11 March. This network will provide a forum for complaints practitioners in the sector to share information and best practice in complaints handling, and to shape future complaints handling arrangements on behalf of the sector, including reporting, publishing and benchmarking information.

If you are interested in joining the network group, please contact the CSA team directly at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk)

---

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

The model CHP for these organisations was published on 28 March 2013, and they are required to have implemented it by 31 March 2014.

Since publication, we have engaged with several organisations to offer advice and guidance to help them develop and implement their CHP. More generally, we are aware from our contact with a range of organisations that most are on target to achieve implementation by the required date. We remain committed to providing support, advice and guidance to any organisation that requests it. We can also advise on the range of training that the SPSO can provide. Please contact our CSA team by emailing [csa@spsso.org.uk](mailto:csa@spsso.org.uk) for further information.

## 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, 26 February 2014**

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

For further information please contact:

**Emma Gray**

**Communications Team**

Tel: **0131 240 2974**

Email: [egray@spsso.org.uk](mailto:egray@spsso.org.uk)

## 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.



**COMMUNICATIONS TEAM**

T **0131 240 8849**



**SPSO WEBSITE**

W [www.spsso.org.uk](http://www.spsso.org.uk)



**CONTACT US**

T **0800 377 7330**

W [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)

**VALUING COMPLAINTS WEBSITE**

W [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)