

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid three full investigation reports before the Scottish Parliament today about the health sector. We also laid a report on 73 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in February), we received 457 complaints. In addition to the three full investigation reports we laid before Parliament, we determined 462 complaints and of these we:

- gave advice on 323 complaints
- handled 82 complaints in our early resolution team
- decided 57 complaints through detailed consideration
- made a total of 115 recommendations in decision letters.

## Ombudsman's Overview



### Investigation reports

The three main reports I am laying today are about the NHS. As is so often the case, the events described had devastating consequences for the people involved. The reports also contain lessons for the NHS in Scotland as a whole, particularly in relation to the quality of their investigations into what went wrong. Each complaint I report today had, rightly, undergone an investigation before reaching our office. However, in each case, I found significant failings not only in the clinical care or treatment provided, but also in the investigations themselves, which is a concern and is something which contributes to the high level of health complaints upheld by my office. I want to emphasise the recommendations we are making to those organisations to improve their individual practices. I also want to mention the work we are supporting to build a national approach to learning from adverse events through reporting and review, and our NHS complaints training activities.

In one report (case 201301204), I express great concern about aspects of the ambulance service's internal investigation process into how paramedics treated a man after he fell at home. To address the failings I found, I have made a far-reaching recommendation, requiring the ambulance service to externally audit their complaints handling processes to ensure that they are sufficiently robust and fit for purpose.

In my report about a health board (case 201205005), as well as clinical issues, I found failings in the way the board carried out their critical incident review. The family of a woman who died of ovarian cancer were not told that the review was taking place and did not see a copy of the report of the review until almost a year after it was carried out. There was also significant delay before the board met with the family, and one of the seven recommendations that I made in this case related to that.

In my report about a GP practice (case 201300703), which was about the care of a child who later died, my adviser expressed concerns that one of the conclusions from the practice's significant event analysis (SEA) had not been conveyed to the child's mother. My adviser was also concerned that, after carrying out the SEA, the practice said that they would not in hindsight have managed the child's care in a different way. My adviser expressed concern about what would happen if a similar situation happened again. My recommendation in this case focused on apology and learning. I asked the practice to provide me with evidence that this case has been discussed with all the GPs involved, as a learning tool, and that the learning points are taken forward as part of the GPs' continuous professional development.

## **Supporting improvement**

The findings of our reports can also be a very useful tool for improvement agencies. We are pleased to support Health Improvement Scotland's work to build a national approach to learning from adverse events through reporting and review. HIS published the framework for a national approach in September 2013, and invited SPSO to join one of the work streams they identified, which is about learning and improvement. The work of the learning and improvement group and its findings will be fed back at a National Learning Event later this year. I look forward to continuing to contribute to this work, through highlighting the findings of our investigations and sharing our expertise in complaints handling.

Another way we support improvement is through NHS complaints training. As part of our two-year package of training for the NHS, delivered in partnership with NHS Education for Scotland (NES), we have recently developed with NES an e-learning module on investigation skills for NHS staff who investigate complaints. The modules will be made available to NHS Boards in the coming weeks. They will be accessible from the *Little Things Make a Big Difference* website (a website for NHS frontline staff) along with other feedback and complaints resources.

## **Listening to service users**

As I have reported before, we have set up a series of sounding boards to provide feedback on the way that the SPSO is performing and the opportunity to discuss key issues in complaints and public services. Following the introduction of NHS and customer sounding boards last year, a third sounding board is now in place for the local government sector.

Attendees have found that the meetings provide an excellent forum for discussing both the service provided by SPSO and wider complaints handling issues. Key subjects include access to complaints procedures, using complaints information to improve services and benchmarking of performance as well as forthcoming developments in areas such as social work and the Scottish Welfare Fund. Each sounding board will continue to meet approximately three times a year.

### **Local government sounding board**

The inaugural meeting of this sounding board was held on 12 March. Invitations were jointly issued from the chair of SOLACE (Local Authority Chief Executives) and the Ombudsman. Representatives on the group include SOLAR (Local Authority Lawyers), ADES (Directors of Education), ADSW (Directors of Social Work), HoP (Heads of Planning), CIPFA (Chartered Institute of Public Finance and Accountancy), the Improvement Service and the chair of the local authority complaints handlers' network.

Discussions focused on the successful implementation and operation of the local government model complaints handling procedure, and the shifting focus to consistent reporting and benchmarking of complaints performance and learning from complaints, including how to align the roles of the Improvement Service, the local authority complaints handlers' network and others with a role in supporting improvement. We also discussed progress in relation to social work complaints and the Scottish Welfare Fund.

### **Customer sounding board**

This sounding board is made up of representatives from Citizens Advice Scotland, Consumer Futures, Patient Opinion Scotland, the Tenant Participation Advisory Service, Alliance Scotland, Age Scotland, a prison visiting committee (Cornton Vale), and the Scottish Independent Advocacy Alliance.

At the second meeting, held on 19 March, the sounding board was invited to input on service improvements that the SPSO is currently reviewing and discussed social media and other routes for feedback and complaints. There was also debate about people's experience of health and social care integration complaints pathways, prisoner access to complaints processes and the Scottish Welfare Fund.

### **Investors in People**

I am very pleased to report that we have continued to be recognised as an Investor in People. We achieved IIP recognition in March 2011, and the three year review was carried out earlier this month through an external independent assessment visit. The broad aims were to seek confirmation of good practice and identify development areas to support continuous improvement against the 39 core evidence requirements (Investors in People Standard) with particular focus on:

- The delivery of a high quality service with clear values and standards of performance defined and addressed through effective communication and consultation
- Achieve and maintain a clear and consistent approach to leading and managing people with an approachable, supportive and motivational style
- To be recognised as a learning organisation as a result of the commitment to meeting the learning and development needs of people to build individual, team and organisational capability.

Once the assessor's report has been finalised, it will be published on our website.

# Investigation Reports



Investigation report ref: 201205005

## Clinical treatment; diagnosis

Tayside NHS Board

### SUMMARY

Miss C complained to me about the care and treatment that her late sister (Ms A) received at Ninewells Hospital. She said that her sister, who was in her early thirties, had been reporting symptoms of increasing back pain for some time. Miss C complained to us in particular about a two-month period, after Ms A's GP referred her to hospital again. She had a scan there, which was reported as normal. When her back pain continued to get worse she went to the hospital's accident and emergency department. They, however, referred her back to her GP, under the department's 'three-day guideline'. This says that a patient who has had an injury or illness for more than three days and has already seen their GP about it should be referred back. Ms A's GP then made an urgent referral to the hospital's orthopaedic/physiotherapy clinic, where the consultant downgraded it to routine, and again nothing was found. Ms A had also lost a lot of weight but because of the scan result, this was not considered to be a danger sign. About a week later, she was seen again, this time at the neurology clinic and told she should continue the treatment she was on. Some eight days after that, her GP again referred her to the hospital because of her increasing pain. The original scan was reviewed, and this time an abnormality was pointed out. Ms A was diagnosed with advanced ovarian cancer, and died some four months after the diagnosis.

Having taken independent advice from a number of my advisers, I upheld this complaint. My advisers confirmed that advanced cancer is a rare diagnosis for a woman of Ms A's age. One of them, however, described the abnormality in the initial scan as conspicuous, and said that reliance on the mis-reported scan appeared to have influenced later

treatment and contributed to the delay in diagnosis. Over a relatively short time, Ms A became almost unable to walk, and hospital clinicians who saw her did not appear to take account of her increasingly painful symptoms. Only her GP appeared to recognise this, and continued to press for a diagnosis. Although it is not possible to say whether earlier diagnosis would have made the outcome any different, it could have meant that Ms A had earlier access to proper relief for her symptoms, and she and her family would have had more time to prepare for the outcome.

The month after Ms A died, the board held a Critical Incident Review (CIR) of her care and treatment. Miss C also complained that they did not then provide the family with a copy of the report of that review, despite repeated requests, and did not arrange to meet them. Again, I upheld this complaint. I found that the board did not tell Ms A's family that the review was taking place. Once the family found out, Miss C wrote and phoned asking to see the report, but nothing was provided. In fact my complaints reviewer ultimately provided Miss C with the report, almost a year after it was carried out, and more than a year after her sister died. The board acknowledged that there was significant delay in meeting Ms A's family, although a meeting did eventually take place.

I made a number of recommendations to the board, which can be read in full in my report. These included that the board provide evidence of action taken to address the mis-reporting of the scan; review the application of the 'three day guidance' to ensure that this is being used appropriately; and continue to work towards producing a care pathway to improve the treatment of patients who present with continuing symptoms in this way. I also recommended that they apologise to Ms A's family for the failings identified in my report.

# Investigation Reports



Investigation report ref: 201301204

## **Clinical treatment; diagnosis**

Scottish Ambulance Service

### SUMMARY

Mrs C complained that the ambulance service failed to ensure that paramedics used a stretcher and neck brace when transferring her husband to hospital after a fall. Mr C is now paraplegic, and Mrs C believes that the action of the ambulance staff contributed to her husband's paralysis.

Mr C was brought home by friends, after having been out for a drink. He fell down the stairs at home, and Mrs C found him unconscious and having great difficulty breathing. She called her son for help and together they moved him into the living room and called an ambulance. The ambulance arrived promptly but Mrs C said that the crew seemed initially reluctant to take Mr C to hospital. She said they only did so because his blood pressure was low but she overheard them making comments about 'drunks' which she thought was unprofessional and judgemental. Mr C was transferred to a wheelchair and taken to the ambulance.

Mrs C complained to us that that the paramedics failed to ensure that her husband was treated for the 'worst case scenario', that is, on a stretcher wearing a neck brace. I obtained independent advice from an experienced registered paramedic. Her view was that when they first arrived on the scene, the ambulance crew should have been alert to the fact that Mr C had experienced a significant fall. Once the mechanism of the fall had been established (from Mrs C and her son), coupled with the decreased level of consciousness and apparent alcohol intoxication, manual spinal immobilisation should have been applied at the earliest opportunity. It was not, and so I upheld the complaint.

I also found failings in the ambulance service's investigation. Their response to Mrs C's written complaint to them was entirely inadequate and not proportionate to the seriousness of the allegation. There was no evidence available to me that statements from any of those involved, including the ambulance crew, were obtained. It was only towards the end of my investigation that the ambulance service advised that in response to Mrs C's complaint, a disciplinary hearing involving one of the members of staff concerned (the other staff member had left the service) had been held and action taken.

I am greatly concerned that not all of the available information was provided to me when it was requested and that the missing information was only produced at a very late stage in the investigation process. This does not instil confidence in the ambulance service's internal procedures.

In light of these failings, I made two recommendations to the ambulance service. I asked them to formally apologise to Mr and Mrs C for their failure to properly immobilise Mr C after his fall and for the inadequacies of their internal investigation; and to externally audit their complaints handling processes to ensure that they are sufficiently robust and fit for purpose.



# Investigation Reports



Investigation report ref: 201300703

## Clinical treatment; diagnosis

A GP practice in Fife NHS board area

### SUMMARY

Mrs C raised a number of concerns about the care and treatment that her late son (Master A), who was six and a half years old, received from GPs at his medical practice between May and September 2011. She said that the practice failed to provide her son with appropriate clinical treatment in view of his reported symptoms and unreasonably delayed in referring him for a specialist hospital opinion.

Mrs C told me that Master A attended the practice a number of times with symptoms of weight loss, fatigue, vomiting, nausea and bone pain. He was seen by different GPs and various examinations and tests were carried out. He was eventually referred to hospital in late July and was given an appointment for September. After Mrs C pressed for an earlier appointment, he was seen in August and was later admitted to another hospital where he was diagnosed with cancer. Although he received treatment, he died some months later. The practice carried out a significant events analysis of Master A's treatment. They told Mrs C that they had found his case very difficult to diagnose and that they would have difficulty managing things differently, given his symptoms and their findings at the time, although they apologised for an element of his treatment.

The National Institute for Health and Clinical Excellence issue guidelines for, among other things, identifying warning signs of cancers. I noted that paragraph 1.14 of their guideline 27 outlines a number of key indicators that may identify that cancer is a possibility in cases involving children. It says that there should be an urgent referral where there is no clear diagnosis after about three visits with the same problem, and that the parent's knowledge of the child should be taken into account. It also includes a list of symptoms, including several that Master A clearly had. During my investigation, I also took independent advice from

one of my medical advisers, who is a GP. She noted that before these events Master A had only visited the practice three times for childhood infections. In 2011, in contrast, he had a total of 19 medical contacts, of which 13 were at the practice. Alongside this, she said that the medical records suggest that GPs in the practice should have viewed his symptoms with a far higher degree of suspicion. She noted that there was a failure to repeat blood tests, the hospital referral was marked as 'routine' rather than 'urgent' and she was concerned that the practice had said that they would not, in hindsight, have managed Master A's condition differently. She took the view that they had failed to provide a reasonable standard of care for him.

When I issued the draft of my report, the practice said that the hospital had initially confirmed their diagnosis of gastritis, and they had based ongoing treatment on this opinion. My adviser said that this view had some validity, but also noted that after going to hospital Master A was in further contact with the practice five times, with similar worrying symptoms. My adviser took the view that the practice should have recognised the significance of these.

I upheld both Mrs C's complaints and recommended that the practice write to her and her husband to apologise for the failings identified in my report and offer to meet with them to reinforce their apology. I also recommended that the practice provide me with evidence that their son's case has been discussed with all the GPs involved, as a learning tool, and that learning points are taken forward as part of the GPs' continuous professional development.

# Complaints Standards Authority update



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## Local authorities

The next meeting of the local authority complaints handling network takes place on 28 March. The theme of the day is *'Benchmarking – the journey to service improvement'*. In addition to hearing from guest speakers from Police Scotland, the Scottish Fire and Rescue Service, and the Improvement Service, the network will consider how the key performance indicator information should be presented and reported and will look to identify initial steps towards an effective benchmarking of performance across the sector.

The network is run by the sector for the sector and those who regularly attend recognise the value that it provides for them and for their council. We always promote the fact that the network is open to all complaints handlers, managers and senior managers across the sector. If you are interested in becoming involved, please contact the CSA team directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk).

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## Further education

We have worked closely with Scotland's Colleges Quality Development Network and sector representatives to form the new Further Education complaints handling advisory group. The group's first meeting was on 11 March with representatives from College Development Network, eight colleges and SPSO in attendance. The group discussed the aims and purpose of the network, how it would operate and the prioritisation of key issues such as publishing against the CHP performance indicators, standardising reporting templates and the production of lessons learned reports and good practice guides. The group also learned from one another's experiences of implementing the CHP through a helpful 'case study' presentation.

The group agreed that to operate in the most effective way and to add maximum value across the sector, the complaints network should operate as a sub-group of the Quality Development Network Steering Group. Following a presentation at a Steering Group meeting, that group accepted the proposal and agreed the priorities that the network had developed.

As with other complaints network groups, this network will be run by the sector for the sector with SPSO as equal members. We encourage any sector representatives who are keen to join, or to learn more about the network, to contact the CSA team directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

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

All organisations in this sector are required to have implemented the model CHP by 31 March 2014. Our engagement with them continues to be positive, and we have received a wide range of requests for implementation support from a range of organisations. As ever, where any organisation requires advice or guidance in implementing the CHP, including information on the range of training that we can provide, we would encourage them to contact our CSA team directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

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## NHS review of complaints handling

The Scottish Health Council is currently undertaking a review of NHS complaints handling, commissioned by the Scottish Government. This has involved visits to all NHS boards to meet senior team members and those responsible for complaints and has also sought the views of patients on the operation of the feedback and complaints arrangements. We expect the report in the coming months and look forward to working with the NHS, the Scottish Health Council, Health Improvement Scotland, the Scottish Government and other stakeholders to help take forward areas of improvement and share good practice identified.

## 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 March 2014**

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

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## The Scottish Public Services Ombudsman



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

We are the final stage for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or writing to us, or filling out our online complaint form.

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



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