

## Monthly news from the Scottish Public Services Ombudsman

This month we are laying three reports before the Scottish Parliament – all about the NHS. We are also laying a report on 73 decisions about all 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 December), we received 394 complaints. We determined 421 complaints and of these we:

- gave advice on 236 complaints
- considered 125 complaints at our early resolution stage
- decided 60 complaints at our investigation stage.

We made a total of 124 recommendations.

## Ombudsman's Overview



I highlight the following matters this month:

- three investigation reports about the NHS in Scotland
- discussion of our 2013/14 annual report with a parliamentary committee and the issue of our report on complaints about prisons

### Complaint investigation reports

This month I report in detail on three complaints about the NHS. Sadly, in each case, the patient involved died, and it was a relative who brought the complaint to us. The reports highlight failures on which I have commented many times before, including problems with diagnosis, care and treatment, referrals and record-keeping. All of these are serious and significant issues, and some meant a particularly traumatic experience for the people involved and their families. Today, however, I want to draw attention to the fact that in all three cases, there was a failure to investigate properly after the event – in two cases I found that a health board did not fully investigate the complaint brought to them (cases 201400437 and 201304549) and in the other a medical practice carried out a review of their care of a patient and came to the conclusion that nothing had gone wrong (case 201402431).

The detail of what happened is contained in the reports, and the fact that my investigations found significant failings in each case tells its own story. I am extremely disappointed that the authorities concerned did not identify these before the complaints reached me, when they had a clear opportunity to identify, apologise for and take action on what went wrong in caring for the people involved. This also meant that learning opportunities were lost. I recently reported that we are discussing proposals that our Complaints Standards Authority take the lead in developing a standardised NHS complaints process in Scotland. This is a positive step, but a system will not solve the problem on its own. It is crucial that authorities across the public sector ensure not only that they have appropriate processes in place, but that the techniques used to investigate complaints are thorough, the staff that do so are trained well and that they robustly examine and test the evidence in each case. No-one should be afraid of finding and acknowledging that something has gone wrong, and where it has, it is a fundamental principle of complaints-handling to say so, learn from it, and take steps to change things to try to ensure that such failures do not happen again.

## **Annual report and sectoral reports 2013/14**

On 7 January, I and members of my team attended the Scottish Parliament's Local Government and Regeneration Committee to discuss my 2013/14 annual report<sup>1</sup>.

We also recently issued our annual complaints reports about prisons for 2013/14. It contains statistics and examples of the complaints we received and determined during the year, as well as information about other aspects of our work.

We received 311 complaints about prisons, representing almost seven percent of all the complaints we received during the year. Numbers remained fairly similar to those for 2012/13, against the trend of rising complaints numbers in other sectors. We upheld more of these complaints than last year and received more of them prematurely but, despite this, the upheld and premature rates were still well below the average for other sectors.

Complaints about communications and records topped the list, followed closely by those about security, control and progression and privileges/prisoner property. We determined 306 complaints, with the rate of cases we upheld rising to 32%. We fully investigated 103 complaints, including two detailed investigation reports, and made 63 recommendations for redress and improvement. The report is available in full on our website<sup>2</sup>.

<sup>1</sup> <http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9710&i=88513>

<sup>2</sup> <http://www.spsa.org.uk/information-prison-sector>

# Investigation Reports



Investigation report ref: 201400437

## **Diagnosis, referral, complaints handling**

Lanarkshire NHS Board

### SUMMARY

Ms A had previously had breast cancer treatment at Wishaw General Hospital, for which she had an annual check-up. Shortly after her last review, she began to feel unwell and about five weeks later went to A&E at Hairmyres Hospital with her sister (Ms C). She had a chest x-ray and was told it was clear. She still felt unwell, however, and about three weeks later, she was admitted to Hairmyres Hospital where it was found that the cancer had returned and spread. A consultant there told her that he would refer her to the oncology team (specialist cancer team) for treatment, but she was not given an appointment and had to chase this up. About two weeks after being discharged, Ms A was given an appointment, but she died before she could attend it.

Ms C complained that her sister was not diagnosed or given an oncology appointment quickly enough. She asked the board to re-check the chest x-ray, and the board then told her that in fact a spinal x-ray was done at the same time. This showed that the cancer had returned and spread to Ms A's spine, but the radiology department had not reported the results of it. The board could not say whether Ms A was told about this at the time. They also said that the consultant did not make the referral when he said he would, but that one of his team did so two weeks later.

My investigation found that the board's explanations and investigations were inadequate and did not tell the full story of what happened. Their file suggested that the spinal x-ray results might not have been reported because of a delay in the images going onto the system. When I asked my medical adviser to look at the evidence, however, he said that radiology should have reported on the spinal x-ray, even if there was a delay in the system. He also said that because the A&E technician failed to correctly interpret that x-ray, and radiology did not report on it, there were serious failings in care. The board did not pick up on this when they investigated Ms C's complaint.

On the matter of the delay, I found that the consultant did not refer Ms A to oncology when he said he would, and my adviser said this was another significant failing. In my report, I point out that Ms A was told she would be given an appointment to discuss treatment, but this did not happen, adding unnecessarily to the distress that she and her family suffered in the weeks before she died. Again, I found the board's investigation to be inadequate. They incorrectly assumed that the referral that was eventually made came from the original consultant, when in fact it came from a different consultant after Ms A's GP requested this. I described the board's investigation as 'narrow and restrictive', as they did not seek comments from the consultant who should have made the referral in the first place.

I have several concerns about the findings from my investigation. These include that a scan with a positive result for cancer was missed, radiologists who discovered this did not appear to have done anything to stop it happening again, and the board did not properly investigate this when they learned about it through Ms C's complaint. I was also concerned about the time taken to refer Ms A to the appropriate team, and that again the board did not properly investigate. I upheld both complaints and recommended that the board apologise to Ms C and her family, discuss this case and my findings with the consultant at their next performance appraisal, and review their complaints handling procedures in detail to try to make sure that similar failures do not happen again.

# Investigation Reports



Investigation report ref: 201402431

## **Diagnosis, clinical treatment, referral, record-keeping**

A medical practice in the Lothian NHS Board area

### SUMMARY

Mr A went to his GP practice complaining of chest pain. He saw a nurse practitioner (NP – a specially qualified senior nurse) who assessed him. He was prescribed medication to reduce stomach acid. Two days later, Mr A had a heart attack and died.

His sister (Mrs C) complained that the practice did not provide him with appropriate medical care. The practice told Mrs C that her brother did not regularly attend the surgery and had never reported any cardiac (heart-related) symptoms. They said that, after he died, they carried out a significant event analysis (SEA – an analysis of adverse clinical events), and concluded that the NP had acted appropriately and that GPs at the practice would not have acted differently.

I asked two of my advisers to provide me with advice on the evidence in this case, and both were critical of what had happened. My medical adviser said that the type of pain Mr A was describing can be a common cardiac symptom, depending on how the patient describes it and any known risk factors that they have. The NP, however, had noted that there were no cardiac symptoms. My medical adviser was particularly concerned that the records the NP had made did not show information that one might normally expect to be recorded – such as symptoms, the type of pain, and any family history of heart problems – and was not reassured that the NP asked all the appropriate questions. She also said that Mr A showed enough risk factors that the NP should have considered that there might have been a cardiac reason for his pain.

My nursing adviser said that an NP would act in a wider role than a registered nurse, and should have the same competence as a GP in that role. She was critical of the NP's actions, as was my medical adviser, and I concluded that the level of service provided to Mr A was not reasonable. I took the view that the NP should have referred him to another health professional for further assessment, and possibly for a test to check that his heart was not the cause of the problems. Both advisers were also critical of the SEA, saying that it was not completed to a reasonable standard, and did not reflect the failings that there clearly were (for example, my medical adviser found the NP's assessment and record-keeping to be inadequate, but the SEA said that the NP had taken a full history and made comprehensive notes.)

I upheld Mrs C's complaint and made a number of recommendations, including that the practice apologise, review the level of education and training needed for the NP role, and review the assessment, supervision and appraisal requirements for the NP involved.

# Investigation Reports



Investigation report ref: 201304549

**Nursing care, clinical treatment, care of the elderly, record-keeping, discharge planning**  
Lothian NHS Board

## SUMMARY

After falling in her care home and fracturing her hip, Mrs A was admitted to the Royal Infirmary of Edinburgh for surgery. She needed help with eating and drinking, but was fully mobile before she went into hospital. After her operation, she became dehydrated, and developed a pressure ulcer. She died a week after being discharged from hospital, and her daughter (Mrs C) complained that her mother was not treated or cared for properly and that her diabetes was not managed appropriately.

The board told Mrs C that a fluid chart was started for Mrs A the day after she was admitted, and was monitored accurately, with fluids being given as and when they were prescribed. A food chart was started three days later. They also outlined what they did in respect of Mrs A's care, including reviews by a dietician and speech and language therapist, and said that she was prescribed supplements, although she refused them. Mrs C was unhappy with their response and complained to me about her mother's care. Although her main complaint was about nursing care, about which I obtained advice from my nursing adviser, I also obtained advice from one of my medical advisers, a consultant geriatrician (a specialist in care of the elderly), on a number of related medical issues.

One of my nursing adviser's main concerns was that there was a failure to follow national guidelines and to refer Mrs A to a dietician when she experienced weight loss. Food charts were not always completed, and those that were made suggested that Mrs A's intake varied, and her fluid intake and output were not always totalled. My nursing adviser said that it is essential that how a person's fluid and food intake will be managed is written down in a robust care plan, and that accurate fluid charts are maintained so that staff can make informed decisions. She found no evidence of a specific care plan to meet Mrs A's needs.

My medical adviser was very critical of Mrs A's care, and that she became dehydrated. He said that guidelines suggest that her fluids should have been regularly monitored (which, in his opinion, meant at least every other day). Mrs A was not monitored at this level, and a lack of good medical notes made it difficult for my adviser to comment on medical decisions. She had been started on intravenous fluids, but my adviser found no evidence of these being administered over the next four days, and noted that prescribed medication that encouraged urine production would have been better discontinued. Management of Mrs A's diabetes was poor – her blood glucose levels were normal when she was admitted but deteriorated to a dangerous level while she was in hospital. She was eventually referred to the diabetes team, but staff did not recognise the need for this early enough. In terms of the care of Mrs A's skin, my nursing adviser said that Mrs A was at high risk of developing pressure ulcers, and was assessed frequently enough. My medical adviser noted, however, that the pressure ulcer she developed was not a trivial one and said more consideration should have been given to Mrs A's dehydration when assessing her. Both advisers agreed that the standards of care provided to Mrs A fell well below a reasonable level in several respects.

I concluded that, although she had dementia, Mrs A was generally in a good state of physical health before being admitted to hospital after her fall. She did not, however, receive appropriate care there in terms of nutrition or the provision of a specific care plan. She did not receive appropriate treatment for dehydration and her diabetes was not monitored appropriately. I also found that Mrs A's discharge was not properly planned in a number of respects, and that the board did not adequately investigate Mrs C's complaint about the standard of care provided to her late mother. I upheld the complaint, and made a number of recommendations to the board, taking into account those that I have already made to them in previous reports about their treatment of pressure ulcers. My recommendations in Mrs A's case can be read in full in my report – they included that the board remind staff of the requirements for record-keeping and referral, ensure appropriate assessment of elderly patients for rehabilitation (including review by a consultant geriatrician), and review procedures for the care and management of patients with diabetes admitted to such wards.

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# Complaints Standards Authority (CSA)



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## Local government

We have now received annual complaint reports from most councils for 2013/14. We are considering the information to better understand the complaints handling performance and analysis of learning across the sector. Early indications suggest that the adoption of the model complaints handling procedure (CHP) has added value for both organisations and customers, with a high reported average of complaints across the sector being closed at stage one of the CHP. We also undertook a high level analysis of councils' annual complaints reports. We are pleased that, for the first time ever, we now have some comparable data to allow us to better understand performance across the sector and have established a baseline against which to measure future performance.

The local authority complaints handlers network met in January to consider benchmarking of complaints information contained in council's annual reports based on initial analysis. The network also considered the use of IT systems for complaint recording and reporting, with a demonstration being provided by Fife and North Ayrshire Councils. The 'Complaints Surgery', which is a feature of all network meetings, discussed issues around the handling of complaints about council policy and the application of a council's unacceptable actions policy.

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## NHS Complaints Handling

Following the Scottish Health Council's recommendation that the CSA develops a standardised model complaints handling procedure for the Health sector we have been liaising with Scottish Government officials to agree the way forward for this work. Discussions are ongoing regarding methodology, timescales and stakeholder engagement, however we expect to progress this work during the first half of 2015/16 and expect further information to be available to stakeholders soon.

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## Housing

We attended the Scottish Housing Best Value Network (SHBVN)'s 'Partners Event' on January 14. The SHBVN is a national social landlord benchmarking forum in Scotland that has over two thirds of all social landlords as members. They provided very helpful presentations about the performance trends of social landlords across Scotland, including in relation to complaints, using their benchmarking data and the data provided by RSLs and councils in their annual reports to the Scottish Housing Regulator.

We have arranged to meet with key stakeholders from the sector in early February to plan future meetings of the housing complaints handlers network. Our experience confirms that complaints handlers network groups add great value in terms of sharing best practice and comparing performance in complaints handling.

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## Further education

We have received a number of annual complaints reports from colleges. We ask colleges that have yet to submit their annual complaints report to now do so. The next meeting of the complaints handling advisory group will be held in late January to finalise the arrangements to hold a benchmarking workshop for the sector in the near future. At that time, we hope to provide feedback on what the college annual complaint reports are telling us about complaints handling performance in the sector. Arrangements will be communicated through the complaints handling advisory group to the Quality Steering group and then to individual colleges.

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## Higher education – performance reporting

The higher education complaints practitioners group met in January at Glasgow Caledonian University. As with other sectors, we remind all universities of the requirement to report on their complaints handling performance in line with SPSO requirements, as documented in **the Scottish higher education model complaints handling procedure Guide to Implementation** (PDF, 99kb). We ask all higher education institutions to provide us with their report, or a link to their published annual complaints report online, by writing to us at [csa@spsa.org.uk](mailto:csa@spsa.org.uk)

For all previous updates, and for more information about CHPs, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk). You can also contact the CSA directly at [CSA@spsa.org.uk](mailto:CSA@spsa.org.uk)

# Complaints Standards Authority (CSA)



## SPSO Training Events

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Thursday 26 February 2015 in central Edinburgh. This is open to staff from all sectors under the SPSO's jurisdiction.

**For more information and to book spaces please contact [training@spsso.org.uk](mailto:training@spsso.org.uk)**

And did you know that we can run courses specifically for your organisation, at a location convenient to you? If this is of interest, please contact us at [training@spsso.org.uk](mailto:training@spsso.org.uk) to discuss this.

## 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 £150pp, 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](mailto: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, 21 January 2015**

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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