PE1844/G
Petitioner submission of 18 February 2021

The Patient Advice and Support Response

- *"The Patient Advice and Support Service recognises that the SPSO does provide an element of external oversight and has the power to investigate complaints against the NHS by service users and their families and issue recommendations."*

This statement that the SPOSO only have an element of external oversight is not good enough and the reason for the petition. They can only investigate what the said NHS board choses to share with them hence investigations are only as good as the information provided to them by the perpetrators.

- *"There therefore appears to be an absence of checks and balances for problems encountered with primary health care."*

This statement speaks for its self and this should never be the case.

- *"The Patient Advice and Support Service, recognises that at the initial stages an internal NHS complaint and investigation can be the most effective way to identify issues, seek an apology and hope that learnings are absorbed by the NHS and disseminated, but also recognises that the Duty of Candour and a culture of no blame has yet to make significant inroads into the NHS."*

This statement is the reason that an external complains body is needed as no family should ever under any circumstances need to rely on hope that learning has been absorbed by said NHS board. This is a disgrace that this has been put in writing however not surprising as this is the current state of affairs which is completely unacceptable.

- *"The Patient Advice and Support Service would therefore see a value in the central collation of the complaints received by both the Health Boards and Care Opinion, and an independent review of these complaints, potentially though an extension of the remit of the Patient Safety Commissioner. There also appears to be no centralised dissemination of the learning from the complaints process or Care Opinion, and therefore would advocate for a formalised process across the Health Boards, with potential oversight by an independent body such as the Patient Safety Commissioner*"

This statement is extremely valid and would also seem very logical however again this is fully reliant on the said health boards providing an accurate account of the complaints they have received which is not acceptable. A centralised collation of the complains should be in place but by external bodies not populated by the boards in which the complaints were raised against. This makes absolutely no sense and again is completely open to boards emitting systematic failings with no one knowing the actual number of complaints registered. Essentially you are asking the NHS Boards to volunteer all their failings.

Health Improvement Scotland Response

- *"HIS does not have a remit to investigate individual complaints from members of the public about care and services received from NHS boards. However, HIS does use a wide range of data and intelligence, including complaints and feedback data, to inform its work, for example, inspections and reviews."*

Health Improvement Scotland as they stated cannot investigate complaints from the public which is exactly what this petition is about. Their view on this is irrelevant as they have nothing to do with the current complaints handling system in place. The data and intelligence that they are referring to is again the intelligence received from the said NHS boards in question. This is based on biased information and their knowledge is very limited to what the said NHS choose to share or emitted. The NHS hold all the cards and only share what they decide with no consequences or anyone to prove otherwise. (unless you or others have first-hand experience of this and the emissions that frequently occur)

- *"We also receive notifications from Boards when they commission a Significant Adverse Event Review for a category I adverse event. We do not routinely review the handling of individual adverse events."*

This is also inaccurate based on personal experience of not only myself but numerous other families. This information is often "miss placed" or not sent. This is only pursued or highlighted to HIS by the families involved in the adverse event (which is something that not everyone will be aware of or in fact emotionally capable of given the grief they will be suffering). This set up again relies solely on the NHS board in question volunteering this information with no consequence or checks that this is ever done. This again is completely out of anyone else's control other than the perpetrators who hold all this information. Families should not have to force the NHS to share this information and ensure and triple check that all the information has in fact been shared and also edited prior to being shared.

SPSO Response

- *"This power would improve trust in the SPSO by enabling us to pursue areas where we are seeing potential systemic failings, particularly for vulnerable groups. Changes are also needed to improve access to SPSO as the final stage*."

If the current set up and process works correctly why would the SPSO be seeing areas of potential systemic failings? This itself highlights that not only do the SPSO need further power to intervene but also highlights that this system is far too open to interpretation by the NHS boards investigating their own failings. There should never be areas where there are systemic failings if the complaints process is working correctly and the learning and improvements are being monitored correctly. This being noted particularly for vulnerable groups. Which essentially means that in non-vulnerable groups where people are able bodied to communicate and speak up for any ill treatment this isn't as prevalent however, in vulnerable groups failings are more accepted when individuals are unable to communicate what is happening. This statement again highlights the need for consistent care across all areas of the NHS.

- *“There is a single NHS procedure which organisations are required to follow. The process can be adapted locally (in a limited way) to ensure organisations take ownership of the process. For example local branding on documents so it is clear that this is the procedure they operate. This may have caused some confusion that there is more than one procedure but we can confirm that there is only one NHS complaints procedure in Scotland*.”

This is also incorrect. There may be one procedure however, this is completely different within each NHS Board. This I know personally as I have dealt with NHS Forth Valley, NHS Lothian, NHS Arran and Ayrshire, NHS Lanarkshire and NHS Orkney and have this in writing from the consultants that this is one of the inconsistency between health boards. I can provide the names of consultants that have confirmed each NHS have their own procedures and some are better than others. This is the current state of affairs. This is clearly not the understanding that the SPSO have on this situation which is also extremely concerning as again this is something which is clearly in no way being monitored if this is SPSO understanding of the current situation and each complaint will be handled differently depending on the NHS board to which is raised.

Thank you so much for allowing us the opportunity to response to these. The responses provided highlight contradictions, biased shared information and a huge lack of impartially which therefore proves that an Independent External Complaints Regulator is most definitely required to ensure complaints are dealt with and corrective actions are implemented and monitored. If this does not happen these failing will be allowed to continue again and again. I fully appreciate that there can be improvements made in each of these areas however, that does not remove the fact that the current process and the ones suggested by the above all rely on the NHS Boards providing correct unbiased data which is not acceptable. Self-regulation should never be an option in any business let alone within the NHS which has enormous budgets and is essentially left to their own devices.