

## **HEALTH AND SPORT COMMITTEE**

### **WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?**

#### **SUBMISSION FROM Scottish Public Services Ombudsman**

##### **About the SPSO**

1. The SPSO has a wide remit, covering a variety of functions and services. Her powers and duties come from the Scottish Public Services Ombudsman Act 2002 which gives her three distinct statutory functions:
  - 1.1. the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewerage providers, Scottish Government, universities and colleges,
  - 1.2. specific powers and responsibilities to publish complaints handling procedures, and monitor and support best practice in complaints handling,
  - 1.3. Independent Review Service for the Scottish Welfare Fund with the power to overturn and substitute decisions made by councils on Community Care and Crisis Grant applications
2. The first two of those three functions mean the SPSO is well-placed to comment on improvements to accountability that could support the changes sought by the public.
3. In 2020 the Scottish Government will introduce the new role of the Independent National Whistleblowing Officer for the NHS in Scotland (INWO). The Scottish Public Services Ombudsman will be given this as a new statutory function. The introduction of the INWO, and the duties it will place on the NHS to investigate concerns it receives (for example about patient safety) aims to give those delivering NHS services the confidence to speak up without fear. They should be able to trust the “Whistleblowing” procedures, the knowledge their concerns will be treated seriously and investigated properly.
4. The INWO will give NHS staff the ability to access an independent, external body who can review their case and bring it to a clear, final and fair conclusion.

##### **GP Practices and complaints handling**

5. In 2018/19, SPSO received 254 complaints about GP practices. This is a relatively low figure given the number of interactions GPs have with the public on a daily basis. While this suggests that many users are happy with their GP practice, we have also found that there are barriers to individuals who wish to raise concerns about either their own care or changes to services in their area. People worry that complaints may lead to a withdrawal of service or affect a relationship that is important to them. They also may feel that the issue is out of the control of their individual GP but is a broader

issue of a lack of resources. They may also be worried complaining may cause additional stress to the people who can least effect change.

6. We have also found that GP practices, particularly the smaller ones, struggle to investigate complaints that may concern close colleagues while also providing them with the support they need.
7. Finally, and as mentioned above, as we prepare for our new role as the Independent National Whistleblowing Officer for the NHS, we have been told that these barriers may be higher for GP practice staff who wish to raise concerns.

### **GP Cluster working and multi-disciplinary teams**

8. The third question asked by the committee relates to monitoring the effectiveness of multi-disciplinary teams and cluster-working. We can see many benefits to the public from such approaches and, indeed, one solution to the problems noted above could be cluster working which would allow for mutual support to small practices from their neighbours.
9. It would be critical that questions of accountability and governance are properly considered prior to the creation of such structures. This is particularly important in relation to how patients can make complaints and staff can raise concerns. How they respectively do this must be clear, understood, and impose the necessary level of accountability to ensure issues are properly addressed, escalated and learning from.
10. We have found that where joint-working exists, for example in Health and Social Care Partnerships, there can be confusion about who should deal with complaints, how that is reported, and who should be involved in investigations. We have experienced situations where it is clear when a complaint has reached us that there has been a break-down in, or lack of clear, governance systems. Indeed, at times, we have found it a challenge to identify who is responsible and who we should contact. We can only imagine how much more difficult that could be for a member of the public. This also provides a barrier to learning from complaints and to supporting staff who are complained about (a key element of any successful complaints process).
11. Considering complaints and how they will be managed and reported can provide organisations developing joint working arrangements with a useful tool to test whether monitoring and accountability structures being designed will be fit for purpose.