

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid six investigation reports before the Scottish Parliament today. We also laid a report on 67 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.

Case numbers

Last month (in December 2013), we received 300 complaints, fewer than usual due to the festive break. In addition to the three reports we laid before Parliament, we determined 313 complaints and of these we:

- gave advice on 194 complaints
- handled 43 complaints in our early resolution team
- decided 76 complaints through detailed consideration
- made a total of 95 recommendations in decision letters.

Ombudsman's Overview



Investigation reports

Five of the reports I am laying today are about the NHS and one is about the water industry. The water case reflects similar failings to those I highlighted last month: mistakes in billing and poor complaints handling.

As they so often do, our NHS reports contain harrowing stories from both primary and acute care settings of the impact on patients and their families when things go wrong. The reports describe the failings; I wish here to highlight what this office does to try to put right what can be put right, and to ensure that the same issues will not recur and devastate the lives of other people using the services in the future.

After the investigation

As I see things, one of the most significant ways we 'add value' in the public sector is through our recommendations. Through our investigations, we can see where and why things have gone wrong. Failings can be down to an individual's poor performance or practice, or, more often, they can be procedural, organisational, cultural. Our recommendations are designed to support organisations in making changes that we think will remedy the problem. We issued just over a thousand of them last year, and while the word 'recommendation' may seem to lack punch, underlying this is a rigorous process to ensure change happens.

All our decisions and investigations are made public (<http://www.spsso.org.uk/our-findings>) including the recommendations. This transparency helps hold organisations to account. Each recommendation is issued with a deadline for completion and we monitor completion times closely.

We are rigorous in asking organisations for evidence of implementation. Examples of evidence we may require include:

- copies of the new policy/procedure or review/audit we have asked for with action plans for implementation and the outcomes of these
- documentation showing that the staff training we asked for has been carried out
- proof that credits/payments we have asked for have been made
- copies of apology letters demonstrating that they satisfy our **guidance on a meaningful apology**.

With any of our recommendations, but particularly where we have identified systemic issues, where appropriate we will ask one of our independent advisers to assess the evidence as well. If we find that an organisation has not provided what we consider robust evidence, we go back to them until we are satisfied that the recommendation has been implemented.

There is a longer account of the kinds of recommendations we make and the evidence we require to satisfy ourselves that the organisations concerned have taken into account the findings of our investigation in our **recent briefing to the Local Government and Regeneration Committee**.

Investigation Reports



Investigation report ref: 201204018

Nursing care; record-keeping; complaints-handling

Lothian NHS Board

SUMMARY

Miss C and her siblings complained about the care their late mother (Mrs A) had received while in hospital. Mrs A had been admitted with lower abdominal pain and because she had been passing black, tarry stools with fresh blood. She had a history of chronic obstructive pulmonary disease (COPD) and bladder cancer. A few days after admission, Mrs A asked to use the commode. She was left unattended and fell and fractured the neck of her femur. She died a few days later.

Miss C complained that her mother's medical conditions were not taken into account when staff assessed Mrs A's risk for falls. Miss C said that if a proper assessment had been made, her mother would not have been left alone on a commode. She also complained about how the board handled her complaint about her mother's care.

The board said that a FALLS risk assessment (an assessment tool for the prevention of falls in older people) had been completed for Mrs A on her admission to hospital and every day afterwards. They said that on admission, Mrs A was rated 1. A different assessment which was also carried out on the day of admission clearly stated that Mrs A had poor vision as a consequence of cataracts and noted that Mrs A self-reported 'dull hearing' as a problem.

The independent nursing advice that I obtained found no evidence of any further FALLS assessments being carried out on the two days following admission. My adviser said it appeared to him that the first assessment was presumed to be correct and carried forward with no account taken of the visual impairment recorded. He did add that as long as Mrs A's condition showed no marked deterioration, there would not have been a requirement to carry out a full FALLS assessment on a daily basis. However, he also said that there was no evidence, apart from a mobility assessment, that the interventions and prevention measures that should have been carried out with a risk score of 1 had been carried out.

The adviser further said that in his view Mrs A's FALLS assessment should have been scored at admission not at 1 but at 2, that is 'at risk of falls'. In accordance with the board's policy, this would have initiated a more intensive care-plan including several interventions and prevention measures. The adviser pointed out that along with the sight problems which were not properly taken into account there were other issues that should have been included in the assessment of Mrs A's FALLS risk. Her

blood tests on admission showed that she was clinically anaemic, and this and her end-stage COPD would have increased her risk of fatigue, weakness and dizziness. He noted that on admission Mrs A complained of dizziness, but this did not appear to have been considered in the assessment. His view was that staff were 'blinkered' by the criteria set out in the FALLS assessment and the initial score of 1 and he concluded that they did not exercise clinical judgement in relation other factors which may have increased the risk of a fall.

In their response to Miss C's complaint about the fall, the board maintained that the reason for leaving Mrs A alone on the commode was to allow her some privacy and dignity. Mrs A was assisted to the commode and left with a call buzzer in her hand. They said that she did not call a nurse but tried to return to her bed independently and staff were informed by another patient that she had fallen.

My investigation found that there was no contemporaneous record of the fall and the medical staff's description of the circumstances surrounding the fall were ineffectively recorded. The board's critical incident review (CIR) of the fall took the view that the assessment and actions taken afterwards were appropriate with the exception that Mrs A should have been wearing more suitable footwear. I found that the CIR should have looked at other issues.

I also found that the board failed to address Miss C's concerns adequately. I agreed with Miss C that the board did not describe events in sufficient detail. It also appeared that, as part of the CIR, the FALLS coordinator overlooked the fact that Mrs A had been incorrectly scored. As a consequence of this, the board did not provide any information about what should have occurred had Mrs A been correctly scored as having a FALLS assessment score of 2. Clearly, had she been correctly scored, in accordance with the board's own policies and procedures, a number of interventions would have been prompted, including the development of a falls prevention care-plan.

In upholding both complaints, I recommended that the board make formal apologies to Miss C and her siblings for their failure in this matter and for the omissions in their correspondence; look again at the FALLS assessment to ensure that staff exercise clinical judgement when assessing risk; and emphasise to staff the importance of keeping accurate and timely records which would be fully adequate for the purposes of later scrutiny.

Investigation Reports



Investigation report ref: 201300692

Clinical treatment

A Medical Practice in the Greater Glasgow and Clyde NHS Board

SUMMARY

Miss C had asked for a house visit for her mother (Mrs A), who had a very swollen stomach, was constipated and appeared very ill. Miss C was unhappy that during the house visit, the GP failed to examine Mrs A or ask her whether she was in pain. Miss C said that the GP disregarded the symptoms she reported, refused to give Mrs A anything to help her sleep and called her mother by an incorrect name.

The day after the house visit, Miss C called the practice and spoke to the GP asking for advice, as her mother was being sick. She phoned again the next day after which Mrs A was admitted to hospital, where she died two days later. The discharge letter subsequently sent to the GP practice referred to Mrs A's initial examination on admission to hospital. It said that she was dehydrated and cachectic (suffering general ill-health with emaciation); her abdomen was grossly distended and generally tender; an x-ray showed faecal loading; and a CT scan taken later showed massive constipation with dilation of the small and large bowel. The letter confirmed Mrs A's cause of death as being due to bowel stasis (stoppage or reduction of the flow of bowel contents) and dilation. Miss C complained that had Mrs A been examined and told treatment in hospital was necessary, the outcome for her could have been different.

In responding to Miss C's complaint to the practice, the GP maintained that she had examined Mrs A while Miss C was out of the room but admitted that she had not checked Mrs A's pulse or blood pressure, nor had she assessed her further. The GP said that she should perhaps have reassessed Mrs A after the telephone call the day after the house call. The practice completed a significant event analysis (SEA) three months after Mrs A's death. This concluded that more time could have been spent with Mrs A and on explaining the diagnosis and 'red flag' symptoms to look out for. The report said that, with the benefit of hindsight, Mrs A should have been reviewed after the telephone call the day after the house visit.

I took independent specialist advice on this case. My adviser reviewed the notes about the house visit and said that it was likely from the records (and

confirmed by the SEA), that a 'cursory' examination had been performed by the GP. He said that abdominal pain in patients over the age of 70 should always be taken seriously. In this case, however, no rectal examination was performed which, particularly in a case of a lower bowel problem, should have been mandatory, nor was there any evidence that bowel sounds were listened for.

The adviser also considered whether the outcome for Mrs A could have been different if the GP had acted as he would have expected. He said he could not be certain whether Mrs A would have accepted the need for hospitalisation on either the day of the house visit or the day after. Nevertheless, he said that had the GP revisited, rather than dealing with the call the day after the house visit as a telephone consultation, this may have stressed the potential seriousness of Mrs A's condition. The adviser went on to say, however, that when Mrs A was finally admitted to hospital she was initially observed overnight, and very little active clinical management was undertaken during her hospital stay.

The adviser also pointed out that it was unusual for patients of this age to die from bowel stasis and from the information available to him it was unclear whether there was any underlying condition. In his opinion there would probably have been no difference to the outcome for Mrs A had the GP carried out a full examination or acted in any different way. Nevertheless, he said it may well have speeded up her hospital admission and reduced Miss C's concern. The adviser was also critical of the SEA, saying that it took place too long after the events, inappropriately referred to understaffing and contained no view from a representative from the community care providers.

I upheld the complaint and made two recommendations: that the practice ensure that the GP makes a formal apology to Miss C for her failure in this matter and that they ensure that the GP completes appropriate professional training so that she is fully appreciative of the seriousness of abdominal pain in the elderly and the importance of conducting a thorough history and examination.

Investigation Reports



Investigation report ref: 201204479

Diagnosis; clinical treatment; record-keeping; communication; complaints handling A Medical Practice in the Greater Glasgow and Clyde NHS Board

SUMMARY

Ms C, an advice worker acting on behalf of Mrs A, complained about the care and treatment provided to Mrs A's husband (Mr A) by his GP and about the GP practice's response to her original complaint.

Mr A was 63 and had no significant previous medical history other than being monitored for an irregular heartbeat since 2009. He had also suffered a 'mini stroke' in 2011 and he was taking warfarin (a blood thinning medication). Ms C said that in April 2012, Mr A was feeling very unwell with excruciating headache, dizziness and disorientation. His GP told him he had a build-up of ear wax and treated him for that. Mr A's symptoms worsened to include vomiting and he was unable to work or leave home due to the dizziness. Ms C said that as the GP was reluctant to attend Mr A at home, he called NHS 24 several times and visited the A&E department of his local hospital over the next few weeks. After experiencing his symptoms for a period of some six weeks, Mr A attended A&E for the third time and was diagnosed as having a large bleed on the brain. He died in hospital two days after presenting to A&E.

Ms C's complaint was only about the GP practice, and the actions of NHS 24 and the A&E department are not the subject of this investigation.

My investigation looked at the relevant Scottish Intercollegiate Guidelines Network guidance (SIGN 107 – Diagnosis and Management of headache in adults) and the General Medical Council (GMC)'s guidance on good medical practice and the standards and ethics expected of doctors. I also took independent advice from my GP adviser, who examined all the notes and records.

I concluded that the practice failed to provide appropriate care for Mr A's reported symptoms. The GP had continued to prescribe aspirin to Mr A, who was already on warfarin, despite advice from the anticoagulation clinic in 2009 that once the warfarin reached the therapeutic range, additional aspirin should be stopped. My adviser said that the results sent to the GP in December 2011 by the anticoagulation clinic showed that the warfarin was within the therapeutic range at that time. However, the GP continued to prescribe aspirin and advised Mr A to continue with this drug regime a few days before his death. My adviser said that the continuation of the aspirin would have made any bleeding on the brain suffered by Mr A worse and while it was not possible now to say whether this would have made any difference to the eventual outcome, the adviser was of the view that it would have made Mr A's death more likely.

It is clear from the out-of-hours (OOH) GP practice service records that Mr A was suffering from clear 'red flag' symptoms and was in two of the risk groups identified under SIGN 107 that should have prompted further investigations. While the GP records do not state that Mr A actually reported these symptoms to the GP, there is evidence that he was reporting symptoms of persistent headaches and nausea to other clinicians at the time through the OOH service, and given this, I consider it implausible that he was not suffering from these symptoms when he saw his GP. The GP either failed to record these symptoms or failed to take a full clinical history. In addition, the OOH service was reporting their encounters with Mr A to the GP as per the normal practice so the GP should have been aware of these symptoms. I am, therefore, critical of their actions in this regard.

It is also of concern to me that the standard of the clinical records are such that it is not clear what history was taken; whether requests for home visits were adequately and appropriately triaged; what examinations or investigations were carried out; nor indeed if the GP had come to any specific diagnosis other than a build-up of ear wax. This is contrary to the guidance issued by the GMC.

I also upheld the complaint about how the practice handled the complaint. It was clear that the practice's complaints procedure was out of date and that their response failed to meet the timescales that they should have met. Their response letter to Ms C's original complaint did not address most of the specific issues raised. However, my main concern is that even with the benefit of hindsight, the practice do not appear to have gained any insight into the failings in their care and treatment of Mr A.

To address these failings, I made several recommendations, including that the practice conduct a Significant Event Analysis of these events and that any learning outcomes are discussed at the GP's annual appraisal. I also asked them to conduct a review of a sample of clinical records to assess whether they meet the standards recommended by the GMC, and that any learning outcomes are addressed at the GP's annual appraisal and/or with appropriate training. Further, I recommended that they conduct a review of the practice's monitoring protocol for patients taking warfarin to ensure that it is fit for purpose; conduct a review and revision of their complaints procedure to ensure it complies with current NHS complaints handling guidance; ensure that all staff have received appropriate training on handling complaints; and issue a written apology to Mrs A for all the failings identified in this report.

Investigation Reports



Investigation report ref: 201204379

Clinical treatment; communication; record-keeping Grampian NHS Board

SUMMARY

Mrs C raised a complaint on behalf of Ms B about the care and treatment provided to her late mother (Mrs A). Mrs A had a history of heart problems and had been referred for coronary artery bypass surgery on a priority basis. Less than a month later, she experienced severe chest pains and attended hospital. It was identified that she had suffered a heart attack. Mrs A died two days after admission and the complaint, which I upheld, was that staff failed to provide appropriate care and treatment. Mrs B's family was also very unhappy about the communication and information disclosed between doctors, nurses and relatives.

As part of the investigation all the information provided by Mrs C and the board (including Mrs A's relevant clinical records and the complaints correspondence) was given careful consideration. I also obtained independent specialist advice from a consultant interventional cardiologist.

The board maintained that appropriate care and attention was delivered to Mrs A in a timely manner throughout. My adviser, however, said that, while the hospital's medical team correctly diagnosed and treated Mrs A's acute coronary syndrome, they failed to timeously diagnose that she was suffering from fluid accumulating in her lungs (pulmonary oedema) despite her high breathing rate and relatively low oxygen saturation, documented on her observation chart. There was no evidence that Mrs A's chest was examined over a specific period of time and I accepted the advice I received that this failure led to the gradual worsening of her pulmonary oedema for several hours until it was eventually identified.

My adviser was of the view that, having failed to timeously treat her pulmonary oedema for several hours after her heart attack, the board had deprived

Mrs A of her best chance of survival. In addition, had the pulmonary oedema been identified earlier, the decision to move her to another hospital would have been made sooner. While I recognised that Ms B maintained that her mother died prematurely due to a catalogue of events that occurred at the hospital and, in particular, the delay in being transferred to another hospital, I also accepted the advice I received that it is uncertain whether the delay in transferring Mrs A had actually led to her death.

Mrs C also raised concerns about the adequacy of communication with the family. While the board explained why they would not provide details about a patient's condition by telephone and that they aimed to protect the confidentiality and dignity of patients, I concluded that the level of communication in this case did not meet the family's needs during this extremely difficult and distressing period. I found that there were failures in the level of communication with Mrs A's family, although I was mindful that the board had already accepted that some of the communication with the family was not of a high standard, and had apologised and taken action. This is reflected in the recommendations.

I made several recommendations for redress and improvement, including that the board apologise to Ms B for the failures identified; reflect on the failure to examine Mrs A's chest and ensure that measures are in place to prevent a similar occurrence in the future; undertake an audit of record-keeping in the ward to ensure medical records are completed timeously and comprehensively and report back to the SPSO; and bring this report to the attention of relevant staff during their appraisals to ensure lessons have been learned from this case.

Investigation Reports



Investigation report ref: 201204933

Clinical treatment; nursing care; communication Grampian NHS Board

SUMMARY

Mrs C complained on behalf of her mother (Mrs A) about the care and treatment her father (Mr A) received in hospital. Mr A had been admitted to the hospital's Acute Stroke Unit after suffering a stroke at home and he died in the hospital around seven weeks later. Mrs C complained about failures in relation to her father's clinical and nursing care, and in how staff communicated with the family, in particular, when Mr A's condition deteriorated and on the day he died. She said that on a number of occasions, nursing staff failed to take account of Mr A's dignity by leaving him in a state of undress. Mrs C said that the family were also distressed by errors in relation to the completion of Mr A's death certificate.

In investigating this complaint, I sought independent advice from two of my advisers, a hospital consultant and a nursing adviser. The records, notes and responses from the board and Mrs C were examined and I also considered a number of policies and guidance including about record-keeping, the management of patients with strokes and the Nursing and Midwifery code of conduct. I found that there were a number of failings.

On the issue of clinical treatment, my hospital consultant adviser said that there was no discussion of an end of life care process being adopted for Mr A, even though it was clear to the medical staff that he was very unwell, further treatment options were limited, and he was deteriorating. The adviser said that the care of Mr A was halfway between active care and palliative care with neither of these being done well. He said that, if Mr A was being actively treated by the medical staff, then he should have had a further review on the day before his death rather than nothing being done. Alternatively, if the medical staff had decided that further medical treatment was likely to be futile, a more active palliative care approach should have been pursued and this would have led to a clearer discussion with the family. I also found that

there was a lack of consistent supervision of a junior doctor who treated Mr A and of consistent consultant care for Mr A.

I also criticised Mr A's nursing care. Respect for the dignity of a patient should be of paramount concern at all times. I did not consider the board's reasons for removing Mr A's pyjama bottoms were justified and I took account of the criticisms of my nursing adviser in relation to the board's response which my adviser considered to be unacceptable.

There were also failings in the communication with Mr A's family. There was a lack of documentation about this and senior medical staff failed to provide systematic and regular information to them. It appeared that Mr A's family had to make contact with medical staff to find out about his condition and treatment rather than it being initiated, as it should have been, by the medical staff treating him. Further, given the complexity of Mr A's health, consultant level staff should have spoken to the family so that they were clearly made aware of Mr A's treatment and his poor prognosis, particularly when his condition deteriorated in the days leading up to his death. In addition, further distress was caused to the family when errors were made in the completion of Mr A's death certificate.

I made several recommendations for redress and improvement, including that the board draw this report to the attention of all senior medical staff involved in Mr A's care; take steps to put in place an action plan to address the failings identified in this report; ensure that staff document relevant discussions they have with a patient's family or their carer; act on my adviser's comments about introducing of a policy on the certification of a patient's death; draw to the attention of relevant staff the importance of providing evidenced based complaints responses; share with relevant nursing staff my nursing adviser's comments about maintaining a patient's dignity; and apologise to Mrs A and her family.

Investigation Reports



Investigation report ref: 201204157

Billing and charging Business Stream

SUMMARY

When Mr C took occupancy of a small rented industrial unit, he said that the factor of the property made him aware that he would be contacted by a water service provider direct about his water bill. Mr C told us that water was provided to the premises through a single pipe and the supply was metered. He said that the first indication he had from Business Stream that they were the provider was a reminder four months later. Mr C queried the issue of a reminder when he had not been invoiced, and questioned whether the meter which had been read was for the premises he rented because the number of the meter appearing on the invoice was wrong, as was the reading. Business Stream told Mr C that they would investigate.

Business Stream did identify the correct meter. However, Mr C complained to us he had to pursue the issue unsuccessfully over many months and despite being repeatedly told that his account was on hold received a letter from a debt recovery agency notifying him that Business Stream were pursuing him for payment of an outstanding balance. It took a number of telephone calls, complaints and time before the situation (Business Stream referring to three meters over this time) was resolved, and Mr C complained that he had been put to unnecessary expense.

Mr C believed that the original invoice he had received related to charges for the toilet block, which was a shared facility and the responsibility of the factor, and that Business Stream should have been able to resolve the matter following his initial telephone call to them when he received the reminder for the wrong meter.

My investigation found that the evidence did not make clear why this was such a complex issue to resolve. It took over nine months and involved more than one visit to the premises, before it was confirmed which meter served Mr C's business. It was also evident that Business Stream's enquiries were prompted by Mr C contacting them to ask for updates, and because he had received demands for payment, rather than that Business Stream were pursuing the matter.

Business Stream accepted there was a delay and made reductions to Mr C's bill to reflect their failings. However, I did not consider that the payment to date adequately reflected the failings which occurred. In upholding the complaint about the delay, I recommended a further payment be made because of their poor handling of the matter. I also recommended that they provide my office with evidence that there is a robust system in place or proposed, to ensure that the errors which resulted in the delay in resolving this case do not recur. I agreed with Mr C that it was inappropriate that Business Stream call in debt collectors on an unresolved issue which it was in their hands to resolve, and I recommended that that they formally apologise to Mr C for their error.

Complaints Standards Authority update



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

The model complaints handling procedure (CHP) for all organisations in this sector was published on 28 March 2013 and they are required to have implemented it by 31 March 2014.

Engagement with organisations in this sector have been positive and we are aware from our contacts with a range of bodies that most are on target to achieve implementation by the deadline. Where organisations would benefit from support, advice or guidance in implementing the CHP, including on the range of training that we can provide, we would encourage them to contact our CSA team at csa@spsso.org.uk.

Local authority complaints handling network – reporting and publishing complaints information

The model CHP requires public bodies to publish, on a quarterly basis, information on outcomes, trends and actions taken. This is a requirement which is over and above the requirement to internally report on complaints information and the aim is to help ensure awareness and transparency of the range of issues raised and considered through the complaints process and the fact that organisations have responded positively to any service failures identified. There should be a strong focus on how the organisation has responded to learning.

To assess compliance with this requirement we recently asked a sample of local authorities to confirm the arrangements they had in place for the quarterly publication of outcomes, trends and actions taken. We are grateful to the 15 councils that provided us with information. We are still assessing the returns against this but have identified some good examples of communicating complaints information and have found that all councils responding had measures in place for internal management reporting. Several councils had experienced difficulties in publishing the information required by the model CHP for various reasons but are taking positive steps to address this. The outputs of our review, including learning on what works well and areas for improvement, will be discussed at the local authority complaints handlers network at its next meeting on 28 March.

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 complaints handling performance against the SPSO performance indicators, which were developed in partnership with the local authority complaints handlers network. At the next network meeting we will be considering progress in this regard and discussing how information should be presented and reported. We will also be discussing 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.

continued

Complaints Standards Authority update



Housing

We reported our assessment of the sample of registered social landlord (RSL) compliance in last month's newsletter and are continuing to assess the information provided. The sample is on reporting and publishing complaints information.

We note that the Scottish Housing Regulator's deadline for submitting the first Annual Return on the Charter (ARC) is approaching (May 2014) and that the SHR recently published revised **technical guidance** providing full information on the data social landlords should provide in their ARC. This includes information on the indicators related to complaints. A summary of progress against the Charter can be found **here**.

We would also remind RSLs of the SPSO's high level indicators for monitoring complaints handling performance under the SPSO's model complaints handling procedure (CHP). These indicators provide the basis for self-assessment and benchmarking activities and should provide the basis of public reporting to tenants in line with the model CHP. The indicators can be accessed at http://www.valuingcomplaints.org.uk/wp-content/media/RSL_performance_indicators1.pdf.

Further education

Working closely with Colleges Scotland and sector representatives, we have received expressions of interest to form the new complaints handling network for the sector. We hope that, depending on availability, the first meeting of this group will take place in March. Learning from the success of the local authority complaints handlers network, we expect this group to enable complaints practitioners to share information and best practice in complaints handling and to shape future complaints handling arrangements on behalf of the sector, including in terms of reporting, publishing and benchmarking information.

If you are interested in joining a network group, please contact the CSA team directly at CSA@spsso.org.uk

NHS

We are entering the final phase of our programme of training and education about feedback and complaints, which we developed and delivered with NHS Education Scotland (NES). Following the launch of the e-learning modules for frontline NHS staff, our training unit has developed an e-learning module on investigating complaints for NHS complaints officers and managers which is currently being piloted and will be launched shortly. We have also recently delivered direct delivery training to over 200 GP and dentist practice managers which will help provide significant reach in improving complaints handling skills across primary care.

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, 29 January 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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VALUING COMPLAINTS WEBSITE

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