

Monthly news from the Scottish Public Services Ombudsman

This month we are laying seven reports before the Scottish Parliament – all about the NHS. We are also laying a report on 78 decisions about all of the sectors under our remit. These can be read on our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in October), we received 498 complaints. We determined 472 complaints and of these we:

- gave advice on 280 complaints
- considered 99 complaints at our early resolution stage
- decided 93 complaints at our investigation stage.

We made a total of 101 recommendations.

Ombudsman's Overview



I highlight the following matters this month:

- my 2013/14 complaints report about the NHS in Scotland;
- the evidence I provided in my submissions on the Scottish Welfare Funds (Scotland) Bill; and
- repeat issues identified within NHS complaints ranging from poor communication and failure to gain informed consent, to delayed diagnosis, and failure to care properly for vulnerable individuals.

Health report

At the end of October, we issued our annual health complaints report for 2013 – 14. During the year, complaints about the NHS in Scotland made up nearly a third of all the complaints we received, and covered a wide range of services, including GP and dental practices, pharmacists, nurses and hospital care. In the report I pointed to an 11.5% rise in health complaints, and an increased rate of upheld complaints. I also drew attention to my continuing concern about the time it is taking for coherent complaints procedures to be put in place for services delivered under the integrated health and social care models, and the barriers that some individuals have faced when trying to complain about NHS care in prison.

During the year, we made 684 recommendations for redress and improvement in the NHS – over half of the recommendations we made across all sectors during the year. The case studies in the report highlight how the learning from complaints can be used to make far-reaching changes in individual practices and across health boards. Those case studies, and the experiences of the people on whose complaints I report today, demonstrate the continuing need for vigilance and improvement in the NHS in Scotland. We will continue to work to ensure that the needs of people using the NHS are central to how they are cared for, and that they are able to express how they feel about the service and quality of care they receive.

The report, along with supporting information such as my annual letters to health boards with their individual statistics, is on our website¹.

¹ <http://www.spsso.org.uk/information-health-sector>

Update on Welfare Funds (Scotland) Bill

I reported on this Bill² in some detail in my July commentary. I have already provided the Welfare Reform Committee with written evidence on the proposals and, earlier this month, I attended the committee to give oral evidence³. In the Bill, the Scottish Government propose that the SPSO take on a new role as the review body for Scottish Welfare Funds (SWF) decisions. As I have explained, if this goes ahead, it would mean an extension to our jurisdiction – the ability to review and, crucially, to change these decisions. It would mean adapting our current remit, processes and procedures to provide this service.

We have actively discussed with the Government and Scottish Parliamentary Corporate Body how we could manage and carry out this work. Throughout these discussions, the fact that people asking for review will need a quick decision and may be particularly vulnerable individuals has been a key focus for us.

Complaints about the NHS in Scotland

This month, I am again highlighting issues about communication, both with patients and their families and between health boards or health professionals, and the assessment of risk. Some of the patients involved were particularly vulnerable. In one case I have decided to draw the attention of the Scottish Government to my report and am sending them a copy to consider.

All the cases in this compendium involved distress and considerable extra concern for patients and their families at what were already difficult times for them. All NHS boards in Scotland should read these carefully and take steps to ensure that the failings outlined in the reports I lay before Parliament today are prevented from happening in their board area.

² Welfare Funds (Scotland) Bill

³ Scottish Parliament – official report of Welfare Reform Committee meeting

Investigation Reports



Investigation report ref: 201300451

Diagnosis, clinical treatment

Lanarkshire NHS Board

SUMMARY

Mr C had bowel problems and went to Monklands Hospital where he was examined by a consultant colorectal surgeon. The following week, he went back for a CT scan (a specialised type of x-ray using computers to give a detailed image of internal organs). At a follow-up appointment, the consultant told Mr C that he had cancer of the large intestine (colon cancer). Mr C had a colonoscopy (where a tube carrying a camera is inserted into the intestine), then investigative surgery. There was no evidence of cancer, but Mr C's intestine was punctured during the operation, leaving him with ongoing and debilitating symptoms. Mr C complained to me that the board's actions in diagnosing him were unreasonable.

In looking at Mr C's complaint, I took independent advice from a consultant colorectal surgeon, as well as looking at national guidance which sets out the ways in which colon cancer should be confirmed. The intention of the colonoscopy was to take a tissue sample (biopsy) for analysis. However, a sample was not taken because it was not possible to reach what the consultant thought to be a suspicious mass identified in the scan. Taking into account the national guidance on colon cancer, my adviser said that without a biopsy it would not have been possible to be certain that Mr C had cancer. The board acknowledged in their complaint response that he was given this diagnosis before all the investigations were carried out. I was very critical that the consultant gave a cancer diagnosis before obtaining this information. There did not appear to be any review of the scan findings or any attempt to use other less invasive diagnostic methods before proceeding to surgery. I found no evidence, however, that Mr C's intestine was punctured because the surgeon did something wrong, and it is a known risk of such surgical procedures. Whilst it must have been a relief for Mr C to find out that he did not have cancer, it is unfortunate that he was left with ongoing symptoms affecting his daily life.

In responding to Mr C's complaint, the board said that the clinical team noted he had an abdominal mass on repeated occasions, which led to the initial diagnosis of colon cancer. However, my adviser said that no evidence of this mass was recorded in Mr C's notes when he was examined; this information came only from statements made after Mr C complained.

I upheld his complaint and made a number of recommendations, which can be read in full in my report. These included that the consultant involved should discuss this case at their annual appraisal and that the board review their diagnostic process for colon cancer.

In addition to the clinical failings I identified, I found that the board did not respond to Mr C's second letter of complaint. Because of this, I exercised my discretion to look into his complaint even though it had not completed their complaints handling procedure, and said that they should review their monitoring process for complaints.

Investigation Reports



Investigation report ref: 201301767

Risk assessment, care of the elderly, communication

Lothian NHS Board

SUMMARY

Mrs C complained that two hospitals provided inadequate care and treatment to her late mother (Mrs A). Mrs A had a number of medical issues including a degree of cognitive impairment (a condition affecting the ability to think, concentrate, formulate ideas, reason and remember). She was admitted to the Western General Hospital with pneumonia and confusion. She fell that night and fractured her leg, and was transferred to the Royal Infirmary of Edinburgh early the next morning for surgery. She did not have the surgery until some five days later and was in hospital for about seven weeks altogether. A few days after being discharged she was admitted again, but became very unwell and died the next day. Mrs C told me that the weeks following Mrs A's fall were horrific and believed that her mother would not have died if the hospitals had acted properly. She felt her mother was discharged too early and endured repeated fasting when her surgery was postponed. Mrs C also said that staff in the second hospital did not communicate adequately with the family, including about a decision on whether Mrs A should be resuscitated if her heart or breathing stopped.

I took advice on this case from two nursing advisers, one of whom specialises in mental health, and a medical adviser specialising in care of the elderly, after which I upheld both complaints. The advice I received was that when Mrs A was admitted to the Western General her mobility was not adequately risk-assessed or her degree of cognitive impairment taken into account in terms of her risk of falling. Although it was not possible to eliminate this risk, reasonable and appropriate falls prevention planning would have minimised it. She was not adequately supervised, particularly as she had impaired mobility and confusion. I did not, however, find her discharge home inappropriate as although there were risks associated with this, it was clearly planned and there was no evidence to indicate it was unreasonable.

After Mrs A fell and was moved to the Royal Infirmary, I found that her operation was repeatedly postponed for various reasons. This meant that she had to fast over a number of days and became very weak. The nursing notes for the days before her operation were very sparse and showed that Mrs A was clearly in pain. She was starved of food for 36 hours, which I found unreasonable. Current advice is that patients need only fast for six hours before surgery and my nursing adviser said that the approach adopted in Mrs A's case was based on antiquated practice and lacked individual care. Communication with the family was poor, with much of it prompted by them, and documentation of it was inadequate. While the initial decision about resuscitation was reasonable, it would have been better if doctors had discussed it with the family beforehand. We noted, however, that this decision was later reversed and that this was clearly recorded and communicated.

I made seven recommendations, which can be read in full in my report. These included that the board ensure that they properly assess and provide appropriate care for people with dementia in future, take steps to ensure that they communicate appropriately with the families of such patients, review their practice about providing nutrition and fluids before an operation and raise the failures identified with relevant staff.

Investigation Reports



Investigation report ref: 201302139

Consent, communication

Greater Glasgow & Clyde NHS Board

SUMMARY

In 2004, Miss C was admitted to hospital to have her pregnancy terminated for medical reasons. This was a very difficult decision for her and she was very upset about it. On the day of the procedure, she signed forms that she thought were for her consent to the termination. More recently, however, she became aware that she had signed forms allowing the hospital to arrange for her baby to be cremated, and that she could have chosen differently, for example, by arranging a private burial rather than cremation. She complained to me that the board did not explain her rights, or what she was signing, and that they asked her to sign while she was sedated and before the delivery of her baby. She also said that in their response to her complaint the board gave incorrect information about the dates on the forms.

In their response, the board had said that the records showed that she was provided with clinical and pastoral support and that it was normal practice for the midwife to discuss all the issues with the patient, including a discussion on the hospital's arrangements for cremation. They said these discussions happened before Miss C gave birth and that she was not in established labour at the time, some 33 hours before her baby was delivered. They also said that just after the procedure the midwife had not noted her as being sedated, although Miss C did receive pain relief on the labour ward after that.

I took advice on this case from one of my medical advisers, who said that the health records showed that the board did provide appropriate clinical and pastoral care, as well as some discussion about what would happen. He also said, however, that the capacity to give consent can change depending on events. The medical records showed that at some point before the forms were signed Miss C was given medication that had the potential to make her less capable of taking an informed decision. He, therefore, thought it probable that she might have still been affected by this and unable to give her full and complete informed consent. He also pointed out that staff had not followed much of the board's guidance about looking after women in this sort of situation. It was also clear that information in the board's response to Miss C's complaint (about when the forms were signed) was wrong, which was not helpful as the timing of this was pivotal to her complaint.

I upheld all of Miss C's complaints. She should not have been asked to make such an important decision when, potentially, she lacked the ability to fully understand what it involved. I was also extremely concerned both that Miss C was (in my view unnecessarily) asked to sign cremation forms at such a distressing time, and that I found no evidence that she was given other options. This is of particular concern because the need for this was specified in the board's guidance.

I made six recommendations, which can be read in full in my report. As well as apologising to Miss C, these included that the board ensure that staff follow the correct guidance and tell me how it will make sure that parents are aware of the choices open to them in such circumstances. I also recommended that forms are fully explained and that the patient is asked for their consent at an appropriate time.

I received this complaint and began my investigation prior to the publication of the Report of the Infant Cremation Commission. I will send the Scottish Government a copy of my report, and invite them to consider sharing it with the National Committee on Infant Cremation or the National Cremation Investigation.

Investigation Reports



Investigation report ref: 201302798

Risk assessment, clinical treatment, communication

Forth Valley NHS Board

SUMMARY

Mrs A, who had no previous psychiatric history, took her own life after a period of depression. She had gone to her GP with numerous symptoms and at first it was thought she might have multiple sclerosis (MS), but this was ruled out after tests. Mrs A's health problems continued and she started to make a serious suicide attempt, but stopped and told her husband what had happened. She was referred as an emergency to mental health services, who noted that Mrs A believed that she had a severe illness and was having suicidal thoughts. She was placed under the care of the intensive home treatment team (IHTT), kept under close review and advised to stay in the company of family members because of her suicidal thoughts. She saw several IHTT staff over the next four weeks, but a final appointment with them was postponed because none of the team was available that day. Mrs A did not tell anyone about the postponement. This meant that she was alone on the morning of the original appointment, which is when she took her own life. Her mother (Mrs C) then complained about the diagnosis and about her daughter's care and treatment, as the family felt that signs of ongoing or increased risk were missed.

The board replied to Mrs C saying that staff who had cared for Mrs A were shocked and saddened by her death, and that all staff took risk assessment very seriously. They said that the IHTT had over time built up experience enabling them to assess the risk posed by patients with suicidal thoughts. They explained Mrs A's diagnosis (which they told me was of a severe depressive episode without psychosis) as well as her medication and the rationale behind her treatment. My mental health nursing adviser said that Mrs A was thoroughly assessed when she was first seen by the IHTT. I did not uphold this complaint as I found no evidence that the diagnosis was inadequate, or that elements of Mrs A's condition were not diagnosed.

I did, however, uphold the complaint about Mrs A's care and treatment. Mrs C had expressed concerns about various aspects of this, including risk assessment and monitoring. The board had told me that the IHTT saw her regularly, every day at first and then twice a week. They considered her to be at medium risk, which was fairly quickly reduced to low risk as she appeared to be improving. My mental health advisers were, however, concerned about the way that Mrs A's risk was assessed and monitored. Their advice is noted in more detail in my report, but it is clear that Mrs A displayed several factors associated with risk of suicide. The risk in such situations is dynamic and may change in line with a person's mental state and social circumstances. Mrs A had made a serious suicide attempt. The change in the level of risk assessed was of concern and was at odds with the view that she should remain in the company of family members at all times, and the approach to the review of risk lacked structure and transparency. I found no evidence that this was discussed between the professionals involved before the risk was reduced.

I, therefore, found that although Mrs A was initially assessed appropriately there were then a number of failings in her care and treatment. I am very concerned that there is no evidence that her risk of suicide was comprehensively assessed before staff reduced her risk level. Medical and nursing staff appear to have taken different views about her condition, and this was not communicated to the IHTT team or Mrs A's family. My advisers have said that Mrs A's suicide would have been difficult to predict, and that the level and intensity of treatment was generally appropriate. However, given the failings outlined in my report, I found that her care and treatment was not of a reasonable standard.

I made a number of recommendations, which can be read in full in my report. These included that the board review the IHTT's approach to assessing risk and the processes for communicating patient medical reviews to IHTT staff and discharging patients from the IHTT, as well as reminding medical staff of the importance of accurate and signed contemporaneous notes.

Investigation Reports



Investigation report ref: 201302928

Delay in diagnosis, referral

A medical practice in the Tayside NHS Board area

SUMMARY

Mrs C was diagnosed with bowel cancer late in 2012. She had been regularly attending her medical practice with a number of symptoms for some time, and had been diagnosed with irritable bowel syndrome in the August of that year. Mrs C told me that she had to request a referral to a specialist, and when her GP then made the referral, they classed it as routine and not urgent. Her symptoms then got worse, and the practice tried to speed up the referral. After she was seen as a result of the referral, Mrs C was diagnosed with cancer, and needed surgery.

Mrs C complained that the practice had not provided adequate care or made appropriate referrals. The practice told me that when they were making decisions they considered that the combination of Mrs C's symptoms and her relatively young age (she was in her forties) did not indicate a more serious diagnosis or the need for an urgent referral.

I took advice on Mrs C's case from one of my medical advisers, who is an experienced GP. My adviser was critical of the care provided, and I accepted that advice and upheld Mrs C's complaints. National guidance is available, which identifies risk factors and 'red flag' (warning) symptoms. Mrs C had a number of these symptoms but the practice did not respond to them appropriately. My adviser also pointed out that for over three years GPs in Scotland have been encouraged to pursue an early diagnosis of cancer if a patient over the age of 40 is displaying red flag symptoms. Given Mrs C's age and her symptoms, I accepted my adviser's view that she should have been urgently referred by no later than September 2012. Instead there was a non-urgent referral by late November 2012. I was also concerned that I could not assess properly whether it was Mrs C or the GPs who suggested a referral when this finally happened, as the overall quality of the clinical records was poor – they lacked detail and did not include clinical findings. I made a number of recommendations to ensure that individual GPs reflect on their actions, and that the practice sample and review case notes to ensure these meet required standards. These recommendations can be read in full in my report.

Investigation Reports



Investigation report ref: 201303786

Clinical treatment, palliative care, record-keeping, communication

Greater Glasgow & Clyde NHS Board

SUMMARY

Mrs A was admitted to Vale of Leven Hospital with difficulty in swallowing and keeping any foods or liquids down, including her oral medications. She was diagnosed with terminal oesophageal cancer five days later. Mrs A remained there for nearly three weeks, before being transferred to Royal Alexandra Hospital, where she died a few weeks later.

Mrs A's son, Mr C, complained to me that the board failed to ensure that his mother received adequate fluid and nutrition when she was a patient at Vale of Leven Hospital, and that she did not receive any palliative treatment for nearly three weeks. He told me that his mother had entered hospital mobile, self-caring and independent, but due to her physical and mental deterioration she was reduced to a state of near-total dependence on nursing staff. He described the stress of witnessing this as 'unbearable' and said he felt the health service seemed to view elderly people as problems, rather than people. In considering Mr C's complaints, I took independent advice from a consultant general surgeon with experience in oesophageal cancer and an experienced nurse.

My nursing adviser noted that difficulty in swallowing is a distressing symptom in the later stages of oesophageal cancer (for both patients and their relatives). I was satisfied, however, that nursing staff took appropriate steps to assess and refer Mrs A's difficulty in swallowing. They also encouraged her with fluid and diet intake, as well as taking reasonable steps to ensure that she continued to receive her medication, while waiting for her palliative treatment plan. However, I found that the board failed to monitor and record Mrs A's fluid intake for a ten-day period.

Shortly after Mrs A's diagnosis, hospital staff told Mr C that her condition was terminal, and that palliative care would be considered. However, nothing happened for three weeks. Mr C then raised his concerns with the consultant on the ward, who contacted the Royal Alexandra Hospital and arranged for Mrs A to be transferred there that day. Mrs A was transferred, and had a procedure to attempt to expand her oesophagus. This procedure was unsuccessful, as was a further procedure to insert a stent (a tube placed in the oesophagus to keep a blocked area open so the patient can swallow soft food and liquids) ten days later. Six days after that, a stent was successfully fitted. However, Mrs A contracted an infection, and died three days after the stent was inserted. My surgical adviser said that once Mrs A was transferred to the second hospital there was not an unreasonable delay in treating her. He also noted that it was unlikely that the delay in placing the stent would have affected the outcome for her. There was, however, a delay in initially transferring Mrs A to start treatment, due to a failure in communication between the two hospitals.

After Mr C complained, staff from the board met with him twice. In these meetings, they expressed their condolences for his loss and apologised for the experience that he and his late mother had gone through. They acknowledged that Mrs A should have been transferred to the surgical ward sooner, and explained that there was a delay because a meeting to consider her case had been cancelled in each of the two weeks after her admission. Although the board admitted these failings and apologised to Mr C, I found that they failed to clearly acknowledge where responsibility lay for the delay in his mother's treatment. They have since made a number of improvements to their processes to try to ensure that lessons are learned and that treatment plans are in place for patients in Mrs A's position. I upheld both Mr C's complaints and made recommendations to ensure the action taken by the board fully addressed the failings my investigation identified.

Investigation Reports



Investigation report ref: 201304325

Delay in diagnosis, referral

A medical practice in the Grampian NHS Board area

SUMMARY

Mrs C was diagnosed with bowel cancer as a result of an emergency admission to a local hospital. She had been attending her medical practice with symptoms for about ten months and complained about the delay in diagnosis. There were initial concerns that Mrs C's symptoms could have indicated ovarian cancer but once this was excluded her case was treated as routine. The practice accepted that a referral could have been made earlier and that they should have arranged the hospital admission. They also told me that they conducted a significant event analysis (SEA) to ensure that they learned from this experience. The SEA, however, took place in April 2014, some three months after I told the practice that I was investigating the complaint.

I took expert advice from both a GP and a nurse, as Mrs C was seen by several GPs and a nurse practitioner. Both experts were critical of the actions taken. The GP adviser criticised the practice for taking an approach that assumed a low risk explanation. He said that in order to diagnose cancer early there needs to be an assumption that 'red flag' (warning) symptoms are treated as suspicious. He was concerned that the practice failed to support the nurse practitioner in appropriately identifying these and knowing when to seek help. I also had concerns about the time taken and the way the SEA was conducted. There was a considerable delay in holding this and I was not convinced by the explanation that this was because it was difficult to arrange an appointment for all team members to be present. Such meetings should be a matter of routine.

Given the clear criticism of the actions taken both before and in response to the concerns raised, I upheld this complaint and made a number of recommendations to ensure an improved service in the future. As Mrs C had died before my investigation was complete, I asked the practice to apologise to her husband, Mr C. It is particularly poignant to note that, although my GP adviser was cautious about the impact the delay had on Mrs C's prognosis, he did say that in a best case scenario she could have been diagnosed nine months earlier and that logic would suggest this might have resulted in a better prognosis.

Complaints Standards Authority update



NHS Complaints Handling

We continue to engage with the Scottish Government and other key partners on the Scottish Health Council's (SHC) 'Listening and Learning' report on NHS complaints handling. In line with the SHC recommendations, we are discussing the potential to develop an NHS model complaints handling procedure (CHP) for the sector, increasing focus on encouraging early resolution of complaints as recommended in the SHC report. Further information for NHS stakeholders will be available soon.

Local government

The local authority complaints handlers network met on 31 October to progress arrangements for benchmarking complaints performance. Discussion focused on the pilot arrangements taken forward from the previous meeting, including discussion within the agreed 'families' of local authorities. The SPSO performance indicators for the local authority model complaints handling procedure were also covered, with discussion on specific requirements around reporting learning and outcomes. The information from councils' reports on these indicators will be used to benchmark councils' complaints handling performance. The network's complaints surgery also considered commonly arising issues in dealing with complaints, for example political and elected member decisions, complaints about arm's length external organisations (ALEOS) and complaints about schools.

Local authority – reporting performance

In October we issued our annual letters to local authority Chief Executives. These provided annual statistics for each local authority about complaints to SPSO. In his letter the Ombudsman outlined the fact that the statistics reflect the first full year of operation of the standardised model complaints handling procedure. As part of that he highlighted that each council is now required to report and publicise complaints information on a quarterly and annual basis, including annual reporting on how they perform against the agreed performance indicators, and that the statistics provided by SPSO in the annual letters are part of the detailed complaints picture that each authority is responsible for gathering and publishing, and using to benchmark through the local authority complaints handlers network.

We would remind local authorities that have not already done so to either send us (or send us a link to) their report of their annual complaints handling performance, in line with the SPSO performance indicators within the **CHP implementation guide** (PDF 90KB). On the basis of these, we will continue to discuss with the sector how they can ensure that they report consistent and comparable information, including demonstrating the learning from complaints, and ensuring this is shared both within and across local authorities.

Health and Social Care Integration

As previously highlighted, SPSO responded to the Scottish Government's consultation on regulations to support the Public Bodies (Joint Working) (Scotland) Act (on health and social care integration). We highlighted the absence of consideration of complaints arrangements, which we have also noted as a key concern in our annual report and the local government report. We are keen to engage with the new integrated joint boards to discuss their plans for developing complaints arrangements in this area and met recently with the Care Inspectorate to discuss our arrangements in this area.

We are continuing to discuss the recommendations of the Scottish Government's social work complaints working group with the Scottish Government's team on Integration and Reshaping Care. The working group recommended the alignment of the internal social work complaints procedure with the local authority model CHP (subject to some flexibility in extension timescales) and SPSO taking on the role of the existing Complaints Review Committees. Timescales and legislative changes for implementing the group's recommendations have still to be confirmed.

Complaints Standards Authority update



Audit Scotland – Developing excellence in administrative justice in Scotland

The Scottish Tribunals and Administrative Justice Advisory Committee (STAJAC), with Audit Scotland, SPSO and key local government partners, including SOLACE, SOLAR, COSLA and the Improvement Service, are developing a project to support more effective decision-making by local authorities in areas of administrative justice, and better understanding of the costs of administrative justice.

STAJAC and Audit Scotland are currently seeking to identify a selection of case studies to model the user journey for administrative justice, to help better understand the impact on users and on decision makers of not getting decisions right first time. The aim is to deliver a methodology/approach to help councils to assess the impact of administrative justice processes and provide best practice guidance to help councils 'get it right first time'. This will include support for councillors and others involved in scrutinising administrative justice.

STAJAC and Audit Scotland are seeking views from local authorities on relevant work already undertaken by the sector in this area, suggestions for case study areas where work would be of most benefit and potential sources of data, particularly cost, process mapping and outcome data. Any councils or others who would like to contribute their views can contact the CSA in the first instance (CSA@spsso.org.uk).

Housing

The Scottish Housing Regulator (SHR) have published information on all Registered Social Landlord (RSL) Annual Returns on the Scottish Social Housing Charter. This provides all of the data from each RSL on how they are performing against the outcomes of the Charter as outlined in the SHR's indicators, including in relation to complaints volumes. RSLs should also report on their complaints handling performance in line with SPSO model CHP requirements and self-assessment complaints indicators for the housing sector, developed in association with the Chartered Institute of Housing, the Scottish Housing Best Value Network and HouseMark. We are engaging with the regulator to assess how we can further support the sector to benchmark complaints handling performance and welcome engagement with the sector to understand how existing approaches may be developed further to meet the reporting requirements of the model CHP.

Higher education

Earlier in October we attended a higher education complaints practitioners meeting at Heriot-Watt University, Edinburgh. This gave us the opportunity to update sector representatives on our work and to discuss and clarify a range of issues on operation of the model CHP and good complaints handling more widely. We were encouraged by the progress this group has made in sharing good practice on complaints handling, and reaffirmed our view that the sector would find benefit in the group benchmarking performance and seeking to share learning from complaints across the sector. We will attend further meetings of the group to further update members on the work of SPSO, and look forward to working more closely with the group to ensure best practice across the sector.

As with other sectors, we remind all universities of the requirement to report on their complaints handling performance annually in line with SPSO requirements, as documented in the **CHP implementation guide** (PDF, 101KB).

Complaints Standards Authority update



Further education

Working closely with the sector's complaints handling advisory group, we are developing further guidance on the performance indicators that will form the basis of benchmarking complaints performance information. The indicators against which colleges are required to publish information for the last academic year are outlined in **the implementation guide accompanying the model CHP** and published in 2013 (PDF 99KB). The FE network have agreed to arrange a cross-sector benchmarking forum on annual complaints performance through the College Development Network, supported by the CSA. This will focus on annual performance reports and potential areas of improvement in complaints handling performance and the CHP. Details will follow in due course from the College Development Network.

Prisons complaints

We had a helpful meeting with the Scottish Prison Service (SPS) complaints managers in October. In addition to a number of key complaints topics, we discussed the value that can be obtained from an increased focus on consistent recording and reporting of complaints, and the opportunity for the SPS to develop a complaints handlers network – like that for the local government sector – to identify, evaluate and benchmark good practice in complaints handling.

For this and previous updates, and for further information in relation to CHPs, visit our dedicated website www.valuingcomplaints.org.uk. The CSA can also be contacted directly at CSA@spsa.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, 19 November 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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