SPSO NEWS

DECEMBER 2014

Monthly news from the Scottish Public Services Ombudsman

This month we are laying five reports before the Scottish Parliament – three about the NHS, one about local government and one about the water industry. We are also laying a report on 90 decisions about all of the sectors under our remit. These can be read on our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in November), we received 438 complaints. We determined 416 complaints and of these we:

- gave advice on 242 complaints
- considered 130 complaints at our early resolution stage
- decided 44 complaints at our investigation stage.

We made a total of 131 recommendations.

Ombudsman's Overview

I highlight the following matters this month:

- my concerns about the way in which the water industry assessed a couple's liability for charges for their business premises; and
- two more of my 2013/14 complaints reports – one about housing and housing providers, and the other about the water industry in Scotland.

Complaint investigation reports

In the water sector, I report on a case involving a couple who were repeatedly told that they had to pay water charges for a small building in their garden from which they operated a business (201304505). Although the building had no water connection, when Business Stream found out that the business was operating from there, they said that water charges were due. When the couple disputed the invoices they eventually received, Business Stream explained why they thought they were due to pay. However, in doing so they relied on information provided by Scottish Water, which they had not checked and which I found was not supported by water industry guidance and legislation.

Businesses regularly complain to me that they are wrongly being charged for water consumption. Some of these complaints are reported in my annual report for the water sector, which I discuss in the next section. Each case is different and is determined on its own particular circumstances. In this case, I was particularly concerned that a water provider insisted that charges were due for a building that had no water connections and for which they had already agreed no drainage charges were due. Even more concerning is the fact that they did so without exploring or testing the information and explanation that Scottish Water provided. During my investigation, Scottish Water remedied the injustice to the couple, saying that they would cancel all the charges. However, until I became involved, both they and Business Stream had maintained that charges were due, and so I continued to investigate because I believed that there was a wider public interest in doing so. I ultimately found that the charges were not in line with water industry rules. In effect, Business Stream were trying to charge the business for a service that they did not provide, which I found unacceptable. As well as making recommendations, I say in my report that I believe that Business Stream and Scottish Water should clarify a legal interpretation that they attempted to use to justify the charges.

The complaints I report on about the NHS involve failure to diagnose and treat a blood infection and to provide appropriate nursing care (201303932), a delay in diagnosis and in providing appropriate care to a cancer patient (201305802) and, as last month, a failure to risk assess a vulnerable adult in hospital (201305924). Each case involved significant distress for the patients involved and their families. I repeat my comments from last month – that NHS boards in Scotland should read these reports carefully and take steps to ensure that the failings outlined in them are prevented from happening in their board area.

The final complaint is about how a council dealt with an allegation of examination malpractice against a secondary school pupil (201303999). The pupil's father complained that the council failed to follow Scottish Qualifications Authority guidance. I upheld the complaint and made several recommendations to the council. I would urge all education departments and schools and other centres to take heed of this complaint and ensure that they have appropriate procedures in place.

Annual sectoral reports

We recently issued our annual complaints reports about housing and water for 2013/14. In both sectors the number of complaints received too early dropped, but the rate of complaints upheld rose. Both reports are available in full on our website.[1]

Housing sector – Complaints about housing rose by 16% to 797 – 56% were about local authorities and 44% about housing associations, with repairs and maintenance and complaints about neighbour disputes and anti-social behaviour topping the list. We determined 817 complaints, with the rate of cases we upheld rising from 43% to 53%. We fully investigated 93 complaints and made 106 recommendations for redress and improvement. Despite the rise in complaints received, I was pleased to see a reduction in the number of housing complaints that reached us too early – down from 52% to 43% – although this is still well above the overall rate across all complaints received (34%). A number of people told us that the reason they came to us early was because they did not know about or found it hard to complete the complaints process of the organisation concerned. This means that authorities in the sector must ensure that they make it as easy as possible for people to access their complaints process, and ensure that staff are aware of it and of how to recognise and deal with complaints at the front line.

Water sector – We received 292 complaints, with 70% of these coming from businesses, and we dealt with 314 complaints. I was pleased to be able to point to a reduction in the number of complaints reaching us about the water industry, going against the general trend of an increase in complaints about other areas. 67% of the complaints we received about water providers were about billing and charging. It remains notable that by far the most complaints received are from businesses and that we continue to see a lack of understanding among business owners of their legal obligations. We fully investigated 90 complaints and made 102 recommendations. Despite the reduction in numbers received, the rate of upheld complaints also rose in this sector, from 45% to 52%, with a very large percentage of these being about Business Stream, continuing a trend that we identified last year. We have continued to engage with the company to help them address this and to improve their complaints handling. Another feature I point out is an increase in the number of new licensed providers that have opted to come under our jurisdiction. Although this has had very little impact on the complaints we have seen so far, it indicates a change in the market place that we will monitor to identify any changes in the profile of the complaints we receive.

1 Housing report http://www.spso.org.uk/information-housing-rsl-sector;
Water report http://www.spso.org.uk/information-water-sector

Investigation Reports

Investigation report ref: 201303932

Diagnosis, clinical treatment, nursing care, complaints handling

Ayrshire and Arran NHS Board

SUMMARY

Ms A had been increasingly unwell in the weeks before she went to A&E at University Hospital Crosshouse. Her symptoms included tiredness, weakness, high temperature and a reduced appetite. Her condition was consistent with a diagnosis of infection, possibly complicated by lupus (an autoimmune condition that can damage organs), which she was known to have. Ms A was given antibiotics and admitted to hospital. The following day she was seen by a consultant, who gave her additional antibiotics and requested further blood tests. The day after that, Ms A still had a high fever and a rapid pulse and an opinion from a cardiology specialist was proposed, in case her condition was complicated by her pulmonary hypertension (raised pressure in the blood vessels that supply the lungs). However, in the early hours of the following morning Ms A was increasingly breathless and tests indicated she had a critical illness. Later that morning, she died from a cardiac arrest.

Her father (Mr C) complained to us that the board failed to take appropriate steps to assess and treat his daughter's sepsis (blood infection), and that they did not provide appropriate nursing care for her or handle his complaint appropriately. In investigating Mr C's concerns, I took independent clinical advice from a consultant in respiratory and general internal medicine, a consultant in emergency medicine and a senior nurse.

The first two advisers gave input on the clinical aspects of Ms A's care. While acknowledging that hers was an unusual, difficult and challenging case for the staff involved, the first adviser pointed to several shortcomings after Ms A was admitted. He considered that these meant her care fell below a reasonable standard. Although the hospital had recognised sepsis as probable from the start and had taken some appropriate actions, there were also omissions. The second adviser considered there were several shortcomings in Ms A's care within the emergency department, particularly a failure to measure her blood lactate level. Other failures included that Ms A was not seen by a suitably senior doctor in A&E, a prolonged stay on a trolley seemingly making her pain worse, that she was not referred for possible admission to either the intensive care or high dependency unit, and the fact that her vital signs were not monitored appropriately or often enough. Viewed as a whole, I found that the evidence indicated that the board did not take appropriate steps to assess and treat Ms A's sepsis and I upheld this complaint.

On nursing care, there was delay in admitting Ms A to a ward, and I recognise that the board faced challenges in doing this, particularly in winter. However, I considered Ms A's pain and discomfort while she awaited admission to be significant, particularly as she was neither given pain relief nor assisted in changing position while on a trolley in the emergency department. I considered it clear that a fan being used by nursing staff should have been made available to Ms A when she asked for it. In view of all this, I found that the board failed to provide appropriate nursing care for Ms A.

I also upheld the complaint about the board's complaints handling. It was clear that this was a complicated and significant matter that needed a detailed investigation and so I did not consider it unreasonable that their investigation took longer than twenty working days. However, the evidence indicated that Mr C and his wife (Mrs C) felt that it was they who were driving matters forward and that they effectively had to pursue the board. This did little to reassure them that their concerns were being addressed with reasonable transparency and efficiency. While acknowledging the complexity of their complaint, I considered it unreasonable for them to have been put in this position.

I made seven recommendations, including about protocols relating to sepsis identification, management and audit and improving access to intensive care advice for on-call clinical teams. I asked the board to write and apologise to Mr and Mrs C for the failings my report identified, and to carry out a significant event analysis, with reflective commentary, of Ms A's care and treatment and the handling of her parents' complaint. My recommendations are detailed in full in my report.

Investigation Reports

Investigation report ref: 201305802

Delay in diagnosis, clinical treatment, follow-up care

Lanarkshire NHS Board

SUMMARY

In July 2013, Mr A's GP referred him to an outpatient respiratory clinic at Monklands Hospital. The consultant there thought that Mr A's symptoms, which included breathlessness, were indicative of mild asthma brought on by a lower respiratory tract infection, for which Mr A had already received treatment. Blood was taken for routine tests, and the consultant wrote to the GP with a treatment plan and arranged a follow-up appointment for some six months later.

The next day, Mr A's blood test results showed that he had an abnormally low level of haemoglobin (a protein found in red blood cells which carries oxygen around the body). Although the board had a protocol for notifying abnormal blood results, the laboratory did not phone the consultant to highlight these as they should have done. The consultant did later review a paper copy of Mr A's blood results, but took no further action on them.

Mr A went back to his GP where he had further blood tests. In early September 2013, he was admitted to hospital and needed a blood transfusion. After further tests he was diagnosed with colon cancer with liver metastases (secondary cancer that has spread to the liver).

Mr A's daughter (Mrs C) then wrote to the consultant to ask why Mr A's blood test result was not acted on in July. The consultant apologised for the error, and said that the tests were routine and he had not chased the results as he did not expect them to be abnormal. Mrs C then complained to the board about the failure to identify the low haemoglobin level, and to treat Mr A for this in a timely manner.

In investigating this complaint, I took independent advice from one of my medical advisers, who is a consultant physician. The adviser said that Mr A's blood result was sufficiently abnormal that laboratory staff should have followed their procedures for phoning and notifying test results to the person who made the referral. Had this been done, Mr A's abnormal haemoglobin result would have been drawn to the consultant's attention immediately after it was reported. I am also concerned that the board did not spot this failure when investigating Mrs C's complaint. I would expect a failing of this significance to have been identified.

The board told Mrs C that blood results of this type can take two to four weeks to be returned. My adviser explained that one week should be sufficient time to assess routine results such as these and, in this case, I found that Mr A's blood results were available on the board's electronic records system the day they were taken, and a paper copy of the results was created the next day. To advise Mrs C about a longer timeframe for blood results to come back was, therefore, particularly misleading.

My adviser also did not consider the consultant's explanation of why he did not chase up the results to be reasonable, pointing out that any tests have the potential to be abnormal. Mr A's blood results had in fact shown a common abnormality that should have immediately alerted clinicians to consider an alternative diagnosis, organise further tests and investigations and tell Mr A as soon as they were aware of the result. Although the consultant apologised for this lack of action in his letter to Mrs C, my adviser said that both he and the board should have made more reference in their responses to the eventual diagnosis and the adverse effect of the delay in diagnosis for Mr A and his family.

continued

Investigation Reports

Investigation report ref: 201305802

Delay in diagnosis, clinical treatment, follow-up care

Lanarkshire NHS Board

SUMMARY *Continued*

During my investigation of this complaint, I did not find the board's process for tracking such results to be robust and my adviser said that, without reassurance about this, there is no certainty that such an error will not occur again. Implementing the correct protocol for abnormal test results could have avoided the errors that arose in this case, and should have resulted in Mr A getting treatment earlier and receiving an earlier diagnosis of his condition. An earlier diagnosis would have also have allowed Mr A and his family longer to adjust and plan for the future. My adviser noted that the consultant had said that the ability to check these results is dependent on his availability. It is my view that this describes an ad-hoc rather than a systematic approach to this type of work. Consultants need specific time in their jobs dedicated to checking results. This is too important a matter to be dependent on availability.

I upheld both of Mrs C's complaints and made a number of recommendations, which can be read in full in my report, including that the board conduct a review of the tracking of test results in both paper and electronic formats and the role of individuals who order tests and report their results.

Investigation Reports

Investigation report ref: 201305924

Nursing care, risk assessment

Ayrshire and Arran NHS Board

SUMMARY

Mrs A had a long history of anxiety and depression and had begun lithium treatment. When she again began to show signs of depression, Mrs A was admitted to hospital for assessment and review of her medication. Her condition deteriorated and she suffered a heavy fall. After this, Mrs A was moved to another hospital, where she died a few months later. Her daughter (Ms C) was concerned that hospital staff had failed to ensure that her mother received adequate fluids, resulting in a condition called lithium toxicity. (This is caused by having too much lithium in the system, and symptoms include slurred speech, tremors, and drowsiness.) She also complained that staff had not ensured her mother's physical safety, which led to the fall. I upheld Ms C's complaints and made six recommendations to the board to address the failings I found.

Ms C said that, during her admission, her mother developed a hand tremor, and had difficulty holding cups of liquid, even the modified cup provided by the hospital. She described how her mother deteriorated, seeming increasingly 'spaced out' and 'drugged up'. She said that after two weeks Mrs A was exhausted and frail, and needed the help of two staff or a wheelchair to help her move. She was concerned that her mother had developed lithium toxicity because staff had failed to ensure Mrs A was drinking sufficient fluid.

In investigating this complaint, I sought independent advice from one of my professional advisers who is an experienced mental health nurse. The adviser said that the monitoring and recording of Mrs A's fluid intake was ineffective, and that nursing staff failed to treat her inadequate fluid intake as a cause for concern. I was critical of these failings. I was also critical of the failure by nursing staff to identify specific fluid intake targets in Mrs A's care plan and to take account of her food and drink preferences. I upheld Ms C's complaint that the board failed to ensure that Mrs A's fluid intake was adequate.

Ms C felt that her mother's weakened state was a contributing factor in her subsequent fall, which caused Mrs A serious physical injuries. Before her admission, Mrs A was able to walk independently with the aid of a walking device, and a hospital falls assessment showed her to be at medium risk. However, Mrs A appeared increasingly tired and frail, and she fell to the floor about ten days after admission. A subsequent falls assessment also recorded a medium risk score. About three weeks later, Mrs A was discovered in the bathroom, where she had suffered a serious fall and injured her head. She sustained a fracture to an upper vertebra, severe trauma to her upper forehead, and bruising.

My adviser found that staff failed to effectively assess Mrs A's fall risk, to reassess her at appropriate intervals and to take appropriate action, in line with the board's falls management guideline for in-patients, in response to her first fall. I am critical of the failings in the falls risk assessments, which disregarded key factors that should have been taken into account. I am also strongly critical of the failure to reassess Mrs A weekly, and in response to indicators such as her first fall and her declining condition, as required by the guideline. I concluded that nursing staff failed to take reasonable steps to ensure Mrs A's physical safety.

In my report, I acknowledge that the board has identified measures to improve fluid intake monitoring and record-keeping for patients receiving lithium treatment, and to improve the regularity of falls risk assessments. Among my recommendations, I have asked them to provide me with a copy of the outcomes from the six monthly review of these measures, and any further steps to be taken. However, as I did not consider that this fully addressed the failings that my investigation identified, I made further recommendations. These were about training staff in the treatment of people on lithium therapy and on the falls management guideline, apologising to Ms C for the failings I found and raising the findings of my investigation with staff involved. The recommendations are detailed in full in my report.

Investigation Reports

Investigation report ref: 201303999

Education: secondary school pupil, policy/administration

The Highland Council

SUMMARY

Mr A sat a Higher English textual analysis National Assessment Bank (NAB) exam at school in January 2013. This was an internally verified exam, which counted towards the award of Higher English. After marking the paper and making other enquiries, the school became suspicious that Mr A might have had access to the exam's marking scheme, and the head teacher arranged to meet him and a depute head teacher. At the meeting, it appeared that Mr A admitted to having been shown the NAB and that a teacher at the school had gone over the answers with him.

Over the following months, there was a large amount of contact and correspondence between Mr A's father (Mr C), the school, the council's education department and the Scottish Qualifications Authority (SQA). In June, Mr C made a formal complaint to the council. There were delays while the council requested a written statement from Mr A. They also considered it appropriate to await the outcome of disciplinary procedures involving the teacher. Mr C wrote again in October looking for a reply to his complaint, saying that matters were totally unacceptable, Mr A was being deeply affected by the issue and the school had no written policy to deal with such situations.

Mr A was then removed from the school roll, as he had not been attending, and Mr C reminded the council that a response to his complaint was overdue. Mr A sent them a signed mandate giving them his consent to look into Mr C's complaint. The council did not uphold Mr C's complaint that they had failed to follow SQA guidelines. They also did not uphold his complaint that Mr A was deprived of an opportunity to sit his prelims and exams, saying that Mr A had not attended on the exam dates offered to him and that alternative dates had not been requested.

Mr C then complained to me. It was his view that, during the initial meeting, his son was coerced into admitting that he had cheated in an exam and that in dealing with the issue, the council did not follow SQA guidance. He believed that his son's rights (to information, advice and to provide a formal statement about the matter) had been ignored and he had been denied an opportunity to gain a qualification. Set against this, the council maintained that they followed their usual internal procedures and that these complied with SQA requirements.

In considering these competing claims, I sought information from both parties and the SQA. I was told that specific relevant documents were not only guidance, but were considered mandatory. I was also told that schools would be expected to have a system or procedure in place to record suspected incidents of candidate malpractice that could be made available to the SQA on request. Reading of the relevant documentation did not confirm the mandatory nature of the guidance. Nevertheless, I would expect written SQA guidance to be followed unless there were particular reasons not to do so, in which case I would expect these reasons to be documented. Furthermore, given the SQA's statement that information must be available on request, I would also have expected procedures to be more formally documented.

One of the documents, specifically about internally assessed exams such as the one in question, advised that candidates should be made aware of the school's policy on cheating and of their rights during and after an investigation into an allegation about it. The council and school were clear that pupils were in no doubt that cheating was unacceptable and I accepted this. However, I saw no evidence that Mr A was informed of his rights (in terms of SQA advice) before, during or after the initial meeting. This ran contrary to the guidance provided.

continued

Investigation Reports

Investigation report ref: 201303999

Education: secondary school pupil, policy/administration

The Highland Council

SUMMARY *Continued*

I noted that the head teacher could exercise discretion as to how and when an allegation of malpractice was presented but this was not claimed here. Nevertheless, the school spoke to Mr A without notice and provided their reasons for doing so, saying this was their usual practice. In my view, due to the seriousness of the matter, it would have been appropriate to try to contact Mr C for him to attend and be with Mr A. Although it has been maintained that there was always an opportunity for Mr A to provide a written statement about his version of events should he wish to (and I accept this), he did not do so. Given the guidance, however, I considered that the school should have actively requested such a statement. Thereafter, it would have been for Mr A to decide whether or not to provide it.

In the face of these shortcomings, I concluded that the council failed to follow SQA guidance and I upheld the complaint. Although Mr C believed that Mr A's failure to obtain his English Higher was a consequence of this, I did not agree. It is noteworthy that Mr A has never denied that he had access to information to which he was not entitled; and it is clear that he had the opportunity to provide other new work and to sit both his prelim and Higher exams. These were matters outwith the council's control. However, I recommended that the council should now apologise to Mr A in writing for the failures identified.

In the council's final response to Mr C's complaint they confirmed that they had asked all their secondary schools to review their internal procedures and I commend them for this. However, I also recommended that they make schools aware of the outcome of this complaint and of the importance of following available guidance. I also recommended that they liaise with SQA about the means by which they should document their procedures for dealing with such matters.

Investigation Reports

Investigation report ref: 201304505
Incorrect billing, communication
Business Stream

SUMMARY

Mr and Mrs C operated a business from a small building (the premises) in their garden. The premises were classed as a commercial property with a rateable value. A routine audit in late 2010 identified the premises as a gap site (a commercial property not being charged for water or waste water services). As the default provider in such circumstances, Business Stream were appointed as the licensed provider. In late 2012, they created an account, backdated to when the premises were first identified as a gap site, and issued an invoice for almost £1,700.

Mr and Mrs C challenged this. They explained that the premises had no water supply and the business did not use water. Whilst they would go into their house to make tea and use the toilet, any water used was already paid for through the council tax for their house. Mr and Mrs C felt that they were being charged for a service that Business Stream had not provided. They complained, but did not find the response helpful. After they complained, Business Stream said that domestic water charges were based on the domestic property's council tax banding and did not take account of any business being run from there, and that they were liable for unmetered charges on the commercial element of their property. However, they also confirmed that they had removed all drainage charges for the premises, following an engineer's report. There was a significant amount of correspondence between Business Stream and Mr and Mrs C about their complaints, much of it based on information that Scottish Water gave Business Stream.

Mr and Mrs C then complained to me that Business Stream had unreasonably charged non-domestic water and sewerage rates on the premises, and did not provide a reasonable explanation about why they did this. During my investigation I found that many of the issues raised related as much to Scottish Water as they did to Business Stream. I asked both organisations for their comments during the investigation (and I have shared my report with Scottish Water). Before I issued my report, Scottish Water said that they had decided to cancel all charges for the premises, but I continued with my investigation because I took the view that there was a wider public interest in these issues.

Business Stream and Scottish Water gave various justifications for why they thought that the premises should be charged for water, including citing health and safety guidance and water legislation. This information is outlined in detail in my report. During my investigation I asked for more detailed information about this, including whether they had sought legal advice on their view that where a commercially rated property 'has access to' a water supply it is liable for water charges. I also took independent advice from one of my professional advisers, who has considerable experience in the water industry. My adviser said that in the particular circumstances of this case he could see no justification for commercial water charges, as the premises had a separate rateable value so should be treated separately from the domestic property.

It is not for me to interpret legislation, or to arrange for an independent legal view. I can only assess whether the decisions made are demonstrably supported by relevant guidance and legislation. It is reasonable that Scottish Water should seek to apply charges for water used for commercial purposes. However, it would not be reasonable to do so for a service that had not been provided. I was not convinced by Scottish Water's evidence about health and safety requirements, as the information I saw said that the recommended actions were not compulsory. Furthermore, I could not see how some of the legislation quoted applied to Mr and Mrs C. As I was not provided with any evidence of the legal advice I asked about, I pointed out that I thought that the legal interpretation of Business Stream and Scottish Water's claim that a premises is eligible for charges if it 'has access to' the water system should be clarified.

continued

Investigation Reports

Investigation report ref: 201304505
Incorrect billing, communication
Business Stream

SUMMARY *Continued*

I upheld Mr and Mrs C's complaint, as I did not consider it appropriate to link the premises to the house just because it is located in the garden. I found nothing in the water industry rules that supports a policy decision to apply charges to a commercial property just because the owners have access to a domestic water supply already paid for through council tax. I noted that Scottish Water have already started to review their charging policies, and asked that they let me know of any changes they make as a result. I also said that Business Stream should apologise to Mr and Mrs C and ensure that their account is closed and all charges are cleared from it, as Scottish Water had already offered.

I found that Business Stream's responses to Mr and Mrs C's concerns were detailed and did try to address the issues. They reflected the situation as they understood it, largely based on information from Scottish Water. However, a reference to legislation was made in error and did not apply to Mr and Mrs C. I was concerned that Business Stream passed this on without checking its accuracy, or without challenging the clearly misleading information that they were given. As the responses contained inaccuracies and did not provide a clear explanation I also upheld this complaint and recommended that Business Stream ensure that they test the accuracy of third-party information, and challenge it where necessary, before passing this on to customers.

Complaints Standards Authority update

NHS complaints handling

We continue to engage with key partners on the Scottish Health Council (SHC)'s report of their review of NHS complaints handling 'Listening and Learning' which reported in April 2014. The report made recommendations relevant to SPSO, about developing a standardised model complaints handling procedure in the NHS as well as training, good complaints culture and accessibility for complainants. We remain in discussions with the Scottish Government and SHC on our proposals to take forward the recommendation that the CSA lead on the development of a standardised process for the NHS, with a focus on increasing early resolution. We will engage with NHS partners over the coming months to progress work on this, including participating in a Scottish Government NHS stakeholder event on 30 January 2015 which will provide a briefing on *'key national developments in encouraging and responding to feedback and complaints'*. The event will also provide an opportunity to explore best practice, share progress and learn from experience across Scotland. It is aimed towards those with executive responsibility for feedback and complaints, clinical leads with a role in feedback and complaints and those with management responsibility for complaints systems and processes.

Local government

We have reported in each of our last five updates the requirement for all local authorities to submit their 2013/14 annual complaints report to us. While we have still not seen all reports, from those we have reviewed we are encouraged to see the vast majority of complaints being handled and resolved at the frontline stage of the handling procedure (CHP). The information is providing valuable data that can be used to help finalise the sector's benchmarking of complaints performance methodology, including the agreed approach of adopting 'families' of similar local authorities.

Once again we remind all local authorities that have not already done so to provide their 2013/14 annual complaints report to **csa@spso.org.uk**

Local authority complaints handlers' network

The network met at the end of October 2014. The meeting focused on the next steps for benchmarking complaints information, including the pilot of benchmarking against the indicators and the agreed approach of adopting 'families' of similar local authorities. Members were also presented with key findings of a survey of the network, undertaken to obtain feedback from councils about the systems used across local government, processes for recording complaints, whether complaints handling was devolved to services or centralised, where complaints information was published and reported, and key areas of activity in terms of training/guidance/reporting or other functions. Details of the survey and its findings were shared through the knowledge hub. This was set up in March 2014 and is administered by North Lanarkshire Council, who provided an update on its use to date. 28 councils have now joined the hub and all other councils are encouraged to register with it, as it will be the main source for all future information for members about the network.

The complaints surgery (held at each network meeting) discussed complaints about political decisions, the handling of complaints for arms-length external organisations and school complaints. In respect of school complaints, Perth and Kinross Council reported that guidance they had produced to assist head teachers with this process would be shared with the network through the knowledge hub. We have been in correspondence with the Association of Directors of Education (ADES) to arrange further discussions around the operation of the model CHP in schools.

Other issues covered at the meeting included the forthcoming publication of the SPSO unacceptable actions guidance, research into financial redress, a proposed cross-sectoral conference for public sector complaints handlers, and the Scottish Tribunals and Administrative Justice Advisory Committee and its role in developing excellence in administrative justice in Scotland.

Further network meetings have been arranged for January and March.

Complaints Standards Authority update

Housing

The Scottish Housing Regulator (SHR) have published information on all Registered Social Landlords' (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 (SHBVN) and HouseMark.

We are engaging with the SHR to assess how we can further support the sector in improving their complaints handling and benchmarking complaints handling performance. We have also liaised with key players in the sector to explore the potential for the housing complaints handlers network to reconvene early in the new year. We will update the **Valuing Complaints web site** and contact network members when more information is available.

SHBVN are holding an event in January 2015 to outline some of their RSL members' findings on performance trends from benchmarking. This covers all elements of the Social Housing Charter including complaints and feedback. SHBVN are a national social landlord benchmarking forum in Scotland, with over two thirds of all social landlords as members. We engaged with them in developing our guidance on performance indicators in 2013.

Further education

The **'Guide to Implementation' for the further education model complaints handling procedure** (PDF, 99KB) explained that from 2013/14 colleges would be required to publish complaints handling performance information against a range of high level performance indicators related to the CHP. This is designed to help colleges assure themselves of how they are performing against the model CHP, to provide transparency and facilitate continuous improvement and benchmarking between colleges. Earlier this year, working with the further education complaints advisory group, we developed, and shared with the Quality Steering Group, further guidance on key performance indicators. The indicators provide the minimum requirement for a college to self-assess and report on performance, and to undertake benchmarking activities.

The Quality Steering Group met earlier this month and agreed that the complaints advisory group would host a benchmarking workshop in early 2015. To prepare for this workshop, colleges are asked to send their 2013/14 annual complaints performance report, which demonstrates their complaints performance against the performance indicators, to the SPSO at **csa@spso.org.uk by 9 January 2015**. Further information on the indicators and the requirements to report performance can be provided by emailing **csa@spso.org.uk**

Higher education

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 **'Guide to Implementation' for the higher education model complaints handling procedure** (PDF, 99KB). As with other sectors, we are asking all higher education institutions to provide us with a link to their published annual complaints report by sending this to **csa@spso.org.uk**

For all 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@spso.org.uk**

Training

Our next open training course for staff handling second-stage complaints (Investigation Skills) is on Thursday 26 February 2015 in central Edinburgh. For more information and to book spaces, please contact **training@spso.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 December 2014

The compendium of reports can be found on our website: **http://www.spso.org.uk/our-findings**

For further information please contact:

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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.