SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

Scottish Public Services Ombudsman – our role and the NHS 2025-2026

Ombudsman Overview

I welcome the opportunity to engage with the Health, Care and Sport Committee in my role as Ombudsman and Independent National Whistleblowing Officer (INWO) for the NHS, offering an independent, evidence based perspective on how Scotland's health system is experienced in practice.

Reporting directly to Parliament, my role provides independent oversight, evidence-based challenge, and assurance that lessons from failings are identified and acted upon. I have been in post since the end of October 2025, having taken up the role at a time of heightened pressure on public services and unprecedented demand for SPSO's help.

In health and social work, Parliament has given me enhanced powers to assess the quality and reasonableness of clinical and professional decision making. This allows me to provide insight that goes beyond administration, compliance or process. Through complaints and whistleblowing cases, we see the system as patients, families, and staff experience it, often identifying risks and failures not visible through routine performance reporting.

Demand for our service is at record levels (up 31% in 2025-26 compared to 2024-25) and continues to grow. We continue to significantly increase our own productivity year on year, closing 30% more public service health complaints in 2025-2026 than we did in 2019-20[1]. However, this unprecedented and growing demand is placing pressure on the complaints system with growing backlog and timescales to respond, raising questions about capacity, accessibility, and fairness. Looking forward, careful decisions will be required about how we address a growing gap between demand and capacity and prioritise SPSO's resources in the face of this strained capacity.

[1] Across all public service complaints cases this figure was 48%

The themes in health complaints are consistent and systemic: persistent delays, unsafe staffing levels, poor communication, and weaknesses in record keeping and follow-up. These are not minor operational issues; they are risks that contribute to harm, dissatisfaction, and loss of trust.

Our perspective is distinctive because it connects lived experience to systemic pressures and real world consequences. Our recommendations are targeted, evidence based and grounded in individual cases. However, our impact is constrained by outdated legislation, limits on information sharing, and static funding that does not reflect rising demand or complexity, particularly in health.

I intend to report regularly to this Committee, sharing key data, themes, and emerging risks. The insight we hold is directly relevant to your scrutiny and policy role, and this report is intended to support informed challenge and meaningful improvement.

SPSO and the NHS

SPSO's role in relation to the NHS is unique.

As Ombudsman and INWO, we have a dual mandate:

- We can consider complaints both from those receiving and those providing NHS services (whistleblowing).
- We have the power to directly assess and comment on clinical decision making, extending to all decision making for whistleblowing.

This goes beyond our standard remit across wider public services meaning our perspective on health is broader and deeper than in other areas of our work.

Key facts

- SPSO has the same power as the Court of Session to obtain evidence ensuring our investigations have access to the best available evidence.
- We take independent advice from clinicians to ensure we are not reliant on the medical views of the body complained about, last year we took clinical advice 931 times.
- We report to Parliament, sharing key findings and evidence directly with MSPs.
- While there are legal limitations on what we can share, we do not work alone, we work closely with other bodies to drive systemic improvement.
- We set the standards by which NHS whistleblowers should be treated and whistleblowing concerns investigated.
- We have worked with the Scottish Government, who are responsible for establishing NHS complaints procedures, to establish a Model Complaints Handling Procedure for health complaints.

Beyond the NHS

This briefing focuses on our relationship to the NHS and insights from our work in 2025-26. Other aspects of our work which are also relevant to the remit of the Committee:

- We can directly assess the professional judgements of social workers meaning we can probe those complaints more deeply.
- As the independent reviewer of Scottish Welfare Fund decisions on Crisis and Community Care Grants, we help support preventative spend that aims to support vulnerable people to stay in their community.
- Those that use our service are disproportionately likely to be disabled with 56% telling us they have a long-term condition that impacts on their daily life.

Reporting in the public interest and for systemic improvement

We lay two types of case reports before parliament in a monthly compendium. This allows us to keep Parliament and the public informed of our work and broader learning and scrutiny of public services.

Public interest reports[2]

Public interest reports focus on cases where we consider there is significant public interest in our findings and wider learning for organisations. They are designed to inform improvement and prompt change. Last year, we laid seven public interest reports before Parliament. *Four came from public complaints* and *three from whistleblowers*. All related to the NHS.

Casework example: Whistleblowing [3]

Concerns were raised about staffing levels in a maternity service, including risks to timely, safe care and sustained pressure on staff. Our investigation found staffing was not always safe or consistent, with insufficient cover at times leading to delays accessing labour wards and theatres, and inadequate out-of-hours support for midwives. We also found that the Board had not handled the whistleblowing concerns in line with National Whistleblowing Standards, and previously agreed actions had not been fully implemented.

We upheld the concerns and published a public interest report. Our recommendations require strengthened safe-staffing processes, improved planning and prioritisation, clearer out-of-hours escalation, and proper follow-through and communication on whistleblowing actions. The Board must now evidence improvement, which we will continue to monitor.

[2] All public interest reports are available here: *Investigation Reports | SPSO* and *Our findings | INWO*
[3] *Greater Glasgow and Clyde NHS Board | INWO*

Casework example: public service complaint[4]

We received a complaint from the family of C who had been admitted to hospital for palliative care. We found significant failings which meant that we issued a public interest report. These included that C had been in unnecessary pain during their time in hospital.

We also discovered advice from consultants was not acted up on and there were lengthy gaps in pain assessments. On at least one occasion the ward had run out of pain relief medication, keys could not be accessed for opening the drug cabinet, and there were instances when C took the wrong medication.

Recommendations were made to make significant improvements.

Decision reports

The second category of reports we publish are reports of decisions. These include key information to enable the Parliament and others to understand what we are seeing in cases which, while important, do not require the full, personal detail to be in the public domain.

We published and made public summary decision reports of 119 NHS public service complaints[5] and 20 whistleblowing decisions. This reporting helps us to ensure we provide:

- transparency and accountability of our own work
- a data source about the work that we see
- tools for broader learning

[4] *Investigation Report 202308705 | Borders NHS Board | SPSO*
[5] *Decision Reports | SPSO*

What we see: SPSO's insight on health complaints

Public service complaints

If we analyse the health related public service complaints reported last year, some common themes emerge:

- **Delays** in recognising symptoms, acting on test results, or initiating treatment and referrals which can contribute to deterioration or reduced treatment options.
- **Failure to recognise and respond to deterioration** as a result of poor monitoring and escalation processes, where deterioration was either not identified or not acted upon.
- **Breakdowns in communication**, this is a common issue across our casework and can affect patient understanding, consent, and family involvement.
- **Inadequate record keeping** remains a recurring theme across health boards with poor or incomplete documentation at times preventing continuity of care and accountability.
- **Complaint handling failings**[6] leading to delays in families and loved ones receiving meaningful explanations, acceptance and apology when things have gone wrong and assurance that improvements will be made. In addition, organisational learning processes were often ineffective, with inadequate investigations and responses.

At times of increased pressure, there is a need to ensure that we continue to focus on the fundamentals of care and work with scrutiny bodies and NHS governance systems to quickly identify and solve these issues.

[6] Some of these cases also feature in the themes outlined above, as failings in complaint handling and organisational learning often arose following incidents involving underlying clinical failings.

Whistleblowing

Our whistleblowing casework too often reveals a gap between identifying issues and implementing effective, timely improvements. This means:

- the system can identify problems but can fail to act quickly
- delays are a systemic risk
- governance is not consistently delivering accountability
- systems exist but are not reliably ensuring ownership, oversight, and delivery of change
- systems and processes in place for vulnerable groups are not consistently prioritised or actioned

As our INWO function now has five years of experience, later this year we intend to publish and share with the Committee a report which highlights in more detail what we are seeing, what is working and where the NHS whistleblowing system and speak up culture needs to improve.

Ensuring impact, driving improvement

We follow up all of our recommendations and our work is only concluded when we consider these have been completed. Our work helps Boards complete overdue actions, strengthen oversight, and make sure concerns led to meaningful change.

Casework examples

In response to our findings and recommendations from separate investigations about nursing care, particularly wound care, a Health Board last year commissioned a two year Board wide improvement programme focusing on nursing care, particularly skin integrity. This will bring together a range of activities into one improvement programme to support the fundamentals of nursing care and wound management including person centred planning; risk assessments; the use of specialist equipment and timely documentation.

In a different Health Board, our findings and recommendations from investigations into three separate complaints have led to a wide scale independent audit of the service area. The purpose of the audit is to ensure there is no systemic or individual issue that may have affected other patients being treated for similar conditions.

A key finding of our whistleblowing work across 2025-26 was that important patient safety actions identified locally from concerns had not always been carried out. Our interventions required Boards to implement these actions, close gaps in governance, and improve how risks are monitored, especially for vulnerable patients and in pressured services.

Our recommendations resulted in:

- safer care through earlier identification and management of risks
- stronger speak up cultures, with targeted support for teams where concerns had not been handled in line with the whistleblowing standards
- better planning and support for pressured services, improving sustainability and reducing delays
- clearer escalation routes, especially for out-of-hours services
- more consistent communication with whistleblowers, including apologies and better updates
- stronger governance, including equality impact assessments and oversight of contracted services

Casework examples

One NHS Board undertook a variety of actions to improve the speak up culture within their Women and Children's Directorate, including initiatives aimed at listening to staff and following up on their feedback.

In another case, where we found that a Health and Social Care Partnership did not fully engage with the potential risks to patients associated with a service change, the partnership completed a health needs assessment. The assessment, which included consultation with the patient group involved, was completed to better understand the current and projected needs of the patients and make recommendations aimed at improving health outcomes for that population.

Resolving cases – Adding value

In our public service complaints work, we handle, assess and investigate cases prior to the formal investigation stage. Last year, we closed 993 cases at Preliminary Investigation (in addition to the 131 cases we closed at Triage and Early Decision).[7]

This allows us to:

- make good use of limited resources
- recognise where the NHS may have already conducted a good investigation and put appropriate measures in place
- focus on outcomes to resolve matters whilst preventing the need for more in-depth and lengthy investigation

The, at times extensive, preliminary investigation work we undertake at this stage helps us to ensure that:

- we have evidence that the NHS investigation has made the right decision
- where action is required, it has been acknowledged by the NHS and is already under way

This approach allows us to provide reassurance to the person bringing the complaint while also recognising where good practice has already occurred in the

[7] More information about our process is available here: *How we handle complaints | SPSO*

complaints process before our involvement. While there are legislative limitations on what we can report about these cases (we can report statistically and very anonymised examples), we are actively considering how much more information about our important work at this stage of the process we can put in the public domain within those limits.

Doing it well

Casework example: public service complaint

In response to a concern about a fall during transfer, the Board:

- undertook a thorough investigation, seeking statements from all relevant staff
- invited the family to visit hospital to demonstrate how people are transferred
- sought input from an expert clinician not directly involved in the case
- informed the family when that expert clinician had raised concerns that were not directly complained about

And ultimately, provided a thoughtful and respectful complaint response.

We took our own expert advice to ensure that nothing had been missed and found that this case did not need further action.

Restoring relationships and trust

In whistleblowing cases, we recognise the key importance of restoring relationships and trust. We will be reporting on our process in more detail in our five-year overview later this year but wanted to highlight our monitored referral process[8]. We use this process if a whistleblower has had difficulty accessing the process or concerns about doing so, and we also have concerns. In such cases, we will monitor the local response, to help ensure the NHS organisation, in their investigation, is acting in compliance with the National Whistleblowing Standards.

[8] *Monitored referrals | INWO*

Another innovative approach taken in response to whistleblowing concerns is the use of a resolution agreement which allows us to ensure that the process concludes with a restoration of the relationship. This builds on our public service complaints work, where resolution is also a potential outcome.

Casework examples: whistleblowing

Supporting the process

An NHS worker approached the INWO as they were dissatisfied with how their concerns had been handled under business as usual processes and had limited confidence in the local whistleblowing process. We used our monitored referral process to support them to access the NHS whistleblowing procedure and get a response to their concerns.

Restoring trust

We facilitated discussions between the complainant and the Board to resolve a complex complaint about treatment within critical care. The complainant was satisfied that the agreed outcome addressed the patient safety risks they had raised.

Our INWO casework also contains evidence of good practice:

An NHS worker complained to INWO that the Board had not taken their concerns about fire risks seriously and that the recommendations made following the whistleblowing investigation were not being progressed. We did not uphold the complaint as we found evidence of good complaints handling. We found that the concerns had been taken seriously, that each concern was sufficiently and impartially investigated and the response contained adequate information relating to proposed actions to address the concerns. The Board was also able to provide evidence that the recommendations had been progressed.

Using data for insight

Individual cases are the heart of what we do. The stories provide real life examples of care that can tell us what people are experiencing. They can help us to highlight where we are seeing red flags that may indicate broader or wider systemic problems.

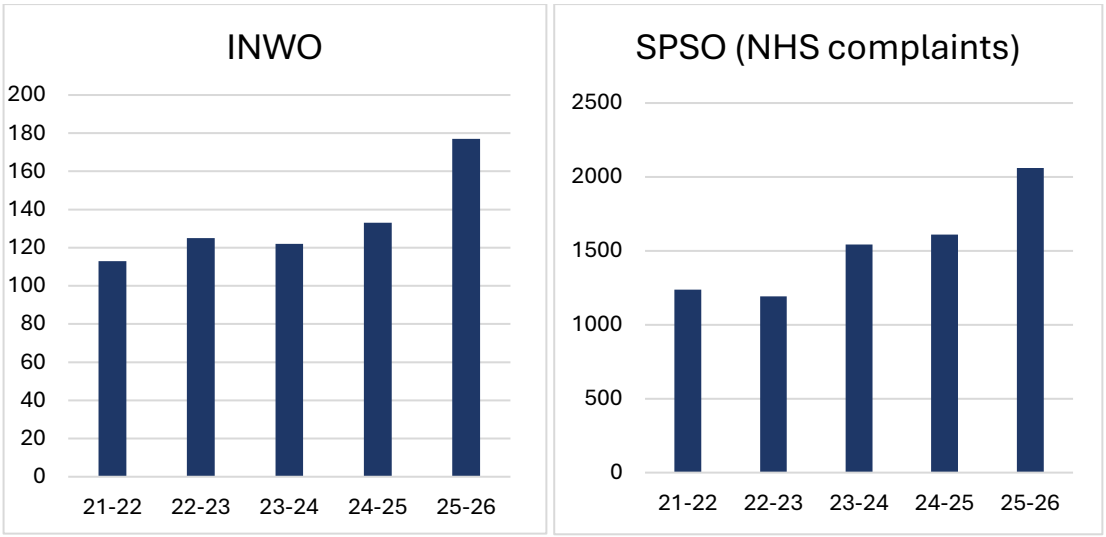
We analyse, share and publish data. Our annual statistics include data in an open source format that allows for others to use it. They can be found here *Statistics 2025-26 | SPSO* and *Statistics | INWO*. We also provide analysis in our annual reporting:

Numbers and data

2025-2026 saw:

- 28% increase in NHS complaints
- 33% increase in whistleblowing complaints

Graph of five-year trend for both INWO and Public Service NHS complaints



Fundamentally, the data is telling us that people are using the complaints and whistleblowing process more.

Some of this may be for positive reasons. For example, we know that people have been historically reluctant to complain about the NHS and some of the barriers to that may be shifting.

However, the increase is dramatic and likely reflects some deterioration of experience.

The themes we have identified in the investigation cases can be used alongside our statistical data to develop a picture of what is likely driving concerns to us.

- delays in the provision of care, making improvements, and responding to complaints or concerns
- issues with documentation and record keeping
- a lack of communication and issues with the quality of that communication

These are system wide issues and they lead to individual harm both for patients and for staff who are unable to provide the quality of service they would wish.

We also analyse data at a more micro-level, by NHS organisation for example:

Table with top five sources of complaints from last year

GP and GP Practices	450
Greater Glasgow and Clyde NHS Board	297
Lothian NHS Board	223
Lanarkshire NHS Board	168
Tayside NHS Board	120

The relatively small volume of our casework, compared with the volume of NHS interactions, means it can be harder to identify trends at service level (i.e. below Board level). However, we share any findings or concerns arising from even small increases or changes with scrutiny organisations, so this information can be combined with other intelligence.

GP whistleblowing complaints are low

What we do not see in data can also be important. The numbers of complaints about GPs remain low in comparison to the volume of patient contacts[9] they have and we receive fewer whistleblowing concerns from this sector.

The NHS complaints procedure is ultimately the responsibility of ministers and we would need to work with them to better understand what is driving this and make any significant changes to policy.

Barriers to complaining for some are significant

We are also aware that there are some for whom vulnerability means they are unlikely to complain, they are too reliant on the NHS or are overwhelmed by the impact of ill health or other vulnerabilities. In whistleblowing, NHS staff may be reluctant to raise concerns in the absence of a positive, supportive speak-up culture. We know that particular groups within the NHS, may be less likely to raise concerns.

Raising standards in complaints handling and whistleblowing

In addition to our individual casework, we have a statutory remit to set and monitor standards in complaints handling and whistleblowing. We have a small team that seeks to help public bodies improve their complaints handling by responding to requests for advice about the application and interpretation of the Model Complaints Handling Procedures and the National Whistleblowing Standards, providing training and other resources, and sharing best practice.

Last year, we received 194 such requests from those handling NHS complaints and those handling NHS whistleblowing concerns. These requests cover an extensive range of subjects, from complex whistleblowing cases, appointing external investigators, the overlap between complaints/whistleblowing concerns and other

[9] Estimates based on figures from Public Health Scotland show primary care contacts could outnumber secondary care by around 7 to 1.

processes, matters appropriate for the complaints handling procedure/ whistleblowing process and managing difficult engagement in the complaints process.

INWO

Speak Up Week

Speak Up Week is an annual campaign designed to promote a culture where staff feel, safe, supported and empowered to raise concerns with the NHS in Scotland.

During last year's campaign, which focussed on the theme of **Listen, Act, Build Trust,** we showcased the positive work being carried out by NHS Boards, sharing learning from organisations that have taken steps to improve their speak up cultures and build trust with staff.

NHS Boards contributed actively throughout the week by hosting local events, sharing resources and publicly pledging their support.

This year Speak Up Week will take place from Monday 28 September to Friday 2 October 2026 and will mark a key milestone of five years of the National Whistleblowing Standards.

Support and intervention Policy

We also systematically track repeat issues we experience when considering complaints and concerns such as delays and failure to respond through our Support and Intervention policy.

The policy sets out a framework of up to six levels of intervention where, taking a risk-based and proportionate approach, we offer support to organisations or intervene directly when required. This policy enables us to focus our resources on public bodies who require support to help them improve their complaint handling practice or address poor performance.

Each year we publish the details of all the interventions level 3 and above in our Annual report.

In 2025-26 the majority of intervention action was in relation to non-completion of recommendations, or overdue requests for the organisation to take action. We know that organisations continue to face significant challenges, particularly in relation to resourcing, which will impact on their ability to respond to us on time.

Public service complaints – a shared responsibility

For NHS public service complaints, our role in setting standards is more limited than in other areas because the Patients Rights legislation places this responsibility on the Scottish Government. We intend to engage with the new government to seek support for taking forward modernisation and improvements.