

## Monthly news from the Scottish Public Services Ombudsman

This month we are laying five reports before the Scottish Parliament – four about the NHS and one about a council. We are also laying a report on 80 decisions about all of the sectors under our remit. These can be read on our website at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in January), we received 475 complaints. We determined 456 complaints and of these we:

- gave advice on 261 complaints
- considered 158 complaints at our early resolution stage
- decided 37 complaints at our investigation stage.

We made a total of 109 recommendations.

## Ombudsman's Overview



I highlight the following matters this month:

- the investigation reports we are publishing
- the need for public bodies to provide accurate and complete information when responding to complaints.

### Complaint investigation reports

One of the reports we are publishing this month is about consent given on a planning application, where I found that a council placed a potentially unenforceable condition on their consent for flats to be built next door to an existing nightclub (case 201300245). Although these events took place a number of years ago, I would urge all planning authorities to note what I say in my report about ensuring that planning conditions meet Scottish government guidelines.

We are publishing four cases about NHS boards, all of which reflect issues on which I have commented before. Three of them involve late diagnosis of medical conditions, and in two cases the patient died. The first case involved a man whose heart problem was not accurately diagnosed early enough (case 201401376). When it was identified that he in fact had a tear in an artery, he was scheduled for surgery to repair this but died before he reached the operating theatre. In this case, there was a clear opportunity to identify the problem earlier, and there was also an issue with the information that the board provided to me, on which I comment further in the next section. In another case, a man with cerebral palsy also had myasthenia gravis (a condition where muscles easily become tired and weak), but this was not diagnosed until after his death (case 201304714). Because it was not diagnosed, he was not treated for it, although treatment might have improved his chances of survival. In this case, although some aspects of his care were handled well, there were also problems with the record-keeping, and there was delay in diagnosing his condition and in having him seen by a neurologist. In the third case, I found that an elderly woman's hip fracture was not identified and treated appropriately. She was also the subject of a decision that she was not to be resuscitated should her heart or breathing stop, but this was not discussed with her family, nor did staff investigate her capacity to understand this.

The final case also identifies issues of communication and the gaining of informed consent for a medical procedure. A man was left with the impression that he was having a procedure that would be done through his mouth, but instead he had an operation that involved an incision in his neck. It left him with a scar there – the very thing he was concerned might happen, and because of which he told me he had put off the operation for five years. A variety of things went wrong in getting consent and although the board had taken steps to improve their procedures, I felt that they had not gone far enough and I recommended that they do more and let me see evidence of the steps they had taken.

Each of these cases had significant consequences for the patient involved, and their family. All health boards should take note of the issues involved and ensure that in their own procedures and practices they take every possible step to avoid similar errors.

## **Providing information to SPSO**

Last month I commented on the importance of public authorities ensuring that they investigate complaints robustly and thoroughly. This is relevant again this month, and I want to focus in particular on what happens when the complaint reaches me. In the first health case mentioned above (case 201401376), the original complaint came to me in late 2012. At that time, when I asked to see the echocardiogram (an instrument for diagnosing heart abnormalities) taken at the patient's bedside on the day he was admitted, the board twice told me that this was unavailable. In the absence of this, my investigation was dependent on other records and I could not say that the actions of staff in trying to diagnose the man's condition were unreasonable. The medical adviser from whom I obtained independent advice said that the condition is rare, and that it is not unusual for it to be missed, and so I did not uphold the complaint (reported as case 201203532). In 2014, however, the board contacted me again, and said that they had located the missing echocardiogram in an electronic record which they then sent to me. I decided to reopen the complaint in light of this new information and having looked at the results, my medical adviser confirmed that there were indications of the tear in the man's aorta that should have been picked up. I have, therefore, now fully upheld the complaint (case 201401376). The board have also sent me evidence of what they have done to try to ensure that in future all relevant evidence is identified and sent to my office.

The board did absolutely the right thing in contacting me with the information when it came to light. I am, however, disappointed that they did not make sure that all the necessary sources were checked to ensure that the missing information was found and made available to me when I first contacted them. In my public report on the case I say *'It is essential that organisations ensure that all of the relevant evidence is identified when they are carrying out their investigations into a complaint. This information should then be sent to my office when we request it. ... The board's failure to do so in this case has undoubtedly added to the family's distress after Mr A's death.'* Although I believe that this is a rare occurrence, this is not the first time that I have found that a public body has not provided all the information about a complaint when I have asked for it. My complaints reviewers always pursue this issue in any case where they know or suspect that information is missing. I would stress to all such authorities the importance of ensuring that all evidence is collected and provided when responding to my investigations, and that all possible information repositories are checked if an item is found to be missing.

# Investigation Reports



Investigation report ref: 201300245

## **Planning: enforcement**

South Ayrshire Council

### **SUMMARY**

In 2000, the council granted consent for a planning application for the development of two blocks of flats, one of them next to an existing nightclub. A condition of the consent was that steps should be taken to reduce the intensity of noise in the flats closest to the nightclub. The architect had confirmed beforehand that the structure of the flats would incorporate this to reduce the noise to a level acceptable to the environmental health department. The flats were built in 2001.

In 2003 the council started to receive complaints from residents about the noise from the nightclub. When the volume of complaints increased in 2008-9 the council took steps to deal with this, including putting restrictions on the nightclub's licence and serving a noise abatement notice on them. The nightclub owners also spent a lot of money taking steps to reduce the noise levels from the club.

In 2010, the nightclub owners complained to the council that they had not enforced the planning condition that required the flats to be built with appropriate sound proofing. In 2011 and 2012, Mr C (a solicitor) complained again about this on behalf of the nightclub owners. The council told him that the planning condition had in fact been set out in a way that meant it was not possible to show if the condition had been breached. They said that because of this they could not take action and that it was in any case out of time for this to happen. Mr C was unhappy with their responses and brought the complaint to me.

Mr C's original complaint to the council was that they had not enforced the planning condition. However, because the council themselves said that it was not possible to conclude whether the condition had been breached, the complaint I investigated was that they imposed a potentially unenforceable condition on the planning application for the flats. The council disputed this, saying that they had not had the chance to consider this complaint, but I have discretion to take such a complaint under the terms of the SPSO Act 2002, and I also considered that in this case it was not reasonable to expect the nightclub owners to pursue this through other means. In responding to the complaint, the council told me that when the condition was put in place it was enforceable but that it is not now, given the passage of time and a lack of information about the existing noise levels at the time.

I took independent advice from two advisers on this case: one a planning adviser, and the other an environmental health specialist. Their advice is considered in detail in my report. My planning adviser identified failings in the way the council drafted the planning condition, which was not clear enough about what was required of the developer. He said that it would not, therefore, have been possible to enforce the condition, and also noted that the council had not taken any action to do so. My environmental health adviser found no evidence of any special measures in the design or construction of the flats that would reduce noise from the club. He also said that the Environmental Health Service had pointed out the potential for noise nuisance at the time of the original application and the council should, therefore, have required the developer to provide a noise impact assessment, and should themselves have carried out a noise survey. However, neither the developer nor the council took any noise measurements in 2000. Had this happened, the council would have had evidence of the noise levels, and would be in a position to establish if the noise from the nightclub had increased since permission was granted.

I upheld Mr C's complaint, as I found that the council put in place an unenforceable planning condition, which went against the published Scottish Government policy for imposing such conditions. During my investigation, I found no evidence to suggest that the council ever tried to enforce the condition. I recommended that they apologise to the nightclub owners, and reimburse them for the costs of the sound proofing and noise reduction measures that they have had to put in place.

# Investigation Reports



Investigation report ref: 201304714

## **Delay in diagnosis, clinical treatment, referral, record-keeping**

Lanarkshire NHS Board

### SUMMARY

Mr A, who had cerebral palsy and used a wheelchair, was admitted to Monklands Hospital with swallowing difficulties. Initial blood tests and examination did not reveal any abnormalities, but the cause of Mr A's swallowing problems could not be determined. He was eventually referred to a neurologist to find out whether this was related to his muscles or nerves. The neurology department organised additional investigations, including blood tests. However, before these could be completed Mr A died, less than a month after he was admitted to hospital. His sister (Mrs C) then complained about the care and treatment her brother received.

A blood test taken prior to Mr A's death was reported a few days after he died. However, the neurology department operates from another health board, and it was not clear from the records exactly when the hospital received the results. The blood test indicated that Mr A had myasthenia gravis (MG), a condition where muscles become easily tired and weak.

I took independent advice on this case from one of my medical advisers and my nursing adviser. Although MG is a relatively rare condition, my medical adviser said that the board should have taken steps sooner to explore alternative possibilities as to what was causing Mr A's swallowing difficulties. He said that some of the symptoms of MG might not have been immediately apparent due to Mr A's cerebral palsy. However, he was critical that Mr A was in hospital for several weeks and that this condition only came to light after he died. MG is treatable and, had it been diagnosed sooner, my adviser said that Mr A's chances of survival would have been significantly increased. In particular, he said that one course of antibiotics prescribed for an infection Mr A picked up in hospital could worsen MG. As Mr A's MG had not at that point been diagnosed, the hospital were unaware of this possibility when prescribing the antibiotic, but I am critical that the board did not diagnose Mr A's MG sooner. My adviser also said it took too long to refer Mr A to neurology and it was then too long before he was seen by a neurologist.

The blood test result was not noted on Mr A's record, even after he died. My medical adviser was particularly critical that the board did not identify this during their investigation, and he echoed Mrs C's concerns about the lack of urgency shown for Mr A's condition. In light of the board's inadequate investigation, he felt this could happen again. My nursing adviser said that as there was no available record of appropriate steps being taken to prevent pressure ulcers, the nursing care provided to Mr A was also unreasonable, as a care plan should have been in place.

Although some aspects of Mr A's care were handled well I consider that, viewed as a whole, there was a general failure to act with appropriate urgency. I have significant concerns about the board's investigation into Mrs C's complaint - given its failure to identify the blood test that diagnosed Mr A with MG - and their inability to provide copies of some of Mr A's nursing records. I recommended that they apologise to Mrs C for failing to diagnose Mr A properly, investigate the delay between referral and neurological review and provide staff with advice about how to obtain specialist neurological advice for patients when a consultant review is delayed. I also made a number of other recommendations which can be read in full in my report.

# Investigation Reports



Investigation report ref: 201304866

## Consent, clinical treatment, communication

Ayrshire and Arran NHS Board

### SUMMARY

Mr C had been diagnosed some years ago with duct stones (deposits of minerals in the ducts that drain the salivary glands) under his tongue and was due to have an operation at Crosshouse Hospital to remove them. He had previously put off having the operation as he had a fear of being left with a scar. After a pre-operative assessment with a doctor he signed a consent form for their removal, and understood that this would be done through his mouth, or if necessary by an incision under his chin. The procedure was then postponed for a short while, and Mr C was told he did not need to attend another pre-operative meeting before the rescheduled operation. After he had the surgery, he discovered that his submandibular gland (a salivary gland below the jaw bone) had been removed through an incision in his neck, and that the duct stones had not been removed. These were removed a week later. Mr C complained that the board did not obtain his consent for the procedure that was carried out, and did not remove the duct stones at that time. He said that he now has a scar, and that part of his neck is numb.

The board said that the pre-operative assessment meeting was for a day case procedure, and that no surgeon was present at the meeting. However, before the date of the planned surgery, a consultant had said that the gland should be removed as there was a large stone deep within it, and had asked for Mr C to instead be transferred to have surgery as an inpatient. However, the original plan discussed at his pre-operative assessment was not changed. On the day of surgery, Mr C was meant to go to the day surgery unit, with the surgery being done in the main operating theatre. As the unit was full, however, Mr C was admitted to a ward. This meant that he did not see the surgeon who would be operating on him, and who would have obtained his consent. A doctor was sent to get consent, but there was a lack of clarity between what the doctor discussed and for which they got Mr C's consent, and Mr C's expectations. The board said that they had taken action to improve pre-operative arrangements and to discuss Mr C's case at a clinical governance meeting. They said that the surgery carried out was appropriate to remove the large stone, and that it was highly likely that he would have needed this done at some point. They accepted that communication prior to the surgery was poor and that Mr C should have had the other duct stones removed during the operation.

I took independent advice from three medical advisers, two of them consultants in maxillofacial/head and neck surgery, and the other an experienced hospital consultant. Their advice can be read in full in my report, but they all agreed that consent was not properly obtained. One of the surgical team who was operating on Mr C should have obtained his consent for the altered procedure and discussed this fully with him. Although Mr C did have the surgical procedure to which he consented, there was a failure in the consent process as he remained under the impression that he was having duct stones removed through his mouth, rather than having the gland removed through his neck. Despite the fact that the consent Mr C gave was for the removal of the gland, I noted that the board said in their response to his complaint that the planned procedure was the removal of the duct stones alone. If this was the case, then this represented a serious failure of patient safety. My advisers also pointed out that the doctor who saw Mr C on the day of the surgery did not appear to have the required level of surgical competence to obtain that consent, and that it should not have been obtained on the day of surgery itself.

On the point about the failure to remove the stones, my advisers agreed that Mr C did not have unnecessary surgery, as it was likely that the gland would have needed to be removed eventually. However, there was a failure in care and treatment because the surgeon did not remove the stones at the time of the initial operation, and Mr C had to then undergo a further procedure to correct this.

I upheld both of Mr C's complaints. I concluded that although he signed the consent form and the process carried out was the one for which he signed, there was confusion beforehand, an acknowledged breakdown in communication, and the consent process was flawed. I made a number of recommendations, including that the board carry out a significant event analysis of Mr C's case, and provide me with evidence of what they have done to address the failures in the consent process and in the operation carried out on Mr C. All the recommendations can be read in full in my report.

# Investigation Reports



Investigation report ref: 201304903

**Diagnosis, clinical treatment, care of the elderly, adults with incapacity, complaints handling**  
Tayside NHS Board

## SUMMARY

Mrs A, who suffers from dementia, was admitted to Perth Royal Infirmary with a sudden loss of mobility. She was discharged around three months later, but it was not until later that the family learned that she had suffered a fractured hip prior to her admission. Mrs A's son-in-law (Mr C) complained that this was not properly diagnosed or treated and that Mrs A was never x-rayed during her stay in hospital. Mr C says the family have been told that Mrs A will never walk again.

Mr C and his family were also concerned that whilst Mrs A was in hospital a notice stating that she was not to be resuscitated (a DNACPR notice) was added to her medical notes. Mr C said this decision was not discussed with the family and he doubted that Mrs A was in a position to give informed consent to it, given her state of health and acknowledged dementia. This was investigated by nursing staff, and junior nursing staff apologised to the family at the time. Whilst Mrs A was in hospital, the family also met with a doctor, who explained the decision to them.

The board said that Mrs A's admission to hospital (following a visit from an out-of-hours GP) was on the basis of an underlying infection, and the GP had not been aware of any recent falls that Mrs A had suffered. Upon admission, a full physical examination of Mrs A had been carried out which did not identify any issues, and the initial diagnosis was that Mrs A had worsening dementia due to a chest infection.

In considering Mr C's complaint, I took independent medical advice from a consultant geriatrician, with experience of acute medical care. My adviser's view is that Mrs A's care and treatment fell below the standard that her family could reasonably have expected and in some areas, well below this standard. It is not now possible to say whether Mrs A would have been suitable for surgery had the fracture been diagnosed sooner, nor is it possible to be certain Mrs A would have regained her mobility had surgery been carried out. It is, however, clear from the evidence that Mrs A's loss of mobility was not appropriately investigated and that the opportunity to diagnose her hip fracture was lost. Mrs A's capacity in relation to the DNACPR notice in her medical records was not properly assessed, despite this failure being highlighted following her family's complaint. I am, therefore, of the view that the care and treatment Mrs A received was not of a reasonable standard.

Mr C also complained about the way in which the board reviewed his mother-in-law's case, as he felt the internal review process lacked objectivity and dismissed the family's concerns. Central to this was the involvement of medical staff in assessing their own actions. Evidence that Mrs A had fallen prior to her admission to hospital, and evidence that her capacity was not adequately assessed was not identified or addressed during the board's internal review. I took the view that the board's reviews of Mrs A's care were inadequate as they did not address important issues despite a lengthy process, which included meetings with the family.

I also looked at the way the board handled Mr C's complaint, as Mr C was unhappy with their responses. He pointed out that although the board apologised for any distress caused to Mrs A and her family, they did not appear to recognise the impact their failings had had on Mrs A. I acknowledge that the board gave Mr C and his family the opportunity to meet with staff and express their views. However, records of these meetings were not provided to the family upon request, nor were they told how to access them. On balance, I do not consider the board dealt adequately with Mr C's complaint.

I upheld all of Mr C's complaints, and made a number of recommendations to the board which can be read in full in my report.

# Investigation Reports



Investigation report ref: 201401376

**Delay in diagnosis, clinical treatment, complaints handling**

Grampian NHS Board

## SUMMARY

Mr A was admitted to Aberdeen Royal Infirmary with severe chest pain. He was initially diagnosed as having a serious problem with the narrowing of one or more of his arteries and was treated on that basis. However, after he had been in the hospital for two and a half days, he was found to have a different condition – a tear in the aorta (the large artery that carries blood from the heart to branch arteries). Mr A was scheduled for surgery that day but died in the anaesthetic room before this could happen. The complaint about his treatment was brought to us by an advocate, Mrs C, on behalf of his family.

In coming to a decision on whether the initial diagnosis was reasonable, the critical evidence was an echocardiogram (an instrument for diagnosing heart abnormalities that uses reflected ultrasonic waves) carried out at Mr A's bedside two days before the correct diagnosis (which was made as a result of a second echocardiogram). I was told twice that the bedside echocardiogram was not available. My adviser, therefore, only had access to the written notes and, on this basis of the available evidence, I concluded that the initial diagnosis was likely not unreasonable and there was no evidence of delay. In July 2013, therefore, I told Mrs C and the board that I could not uphold the complaint about Mr A's treatment.

In March 2014, however, the board told me that they had found further evidence. This consisted of a statement made shortly after Mr A's death, by the consultant responsible for his care. In that statement, the consultant said that the echocardiogram had clearly shown the tear. We asked the board again for a copy of the echocardiogram and they then provided this. The echocardiogram was conducted by a trainee cardiologist who had also written the report on it. The consultant's statement showed that he had accepted the report and had not personally reviewed the echocardiogram.

I took independent medical advice from a consultant cardiologist, who I asked to review the echocardiogram and the actions of the trainee cardiologist and the consultant. My adviser told me that the cardiologist, although a trainee, was relatively senior and all such trainees undertake on-call emergency work to ensure they develop the skills to diagnose a number of life-threatening but relatively unusual diagnoses, such as the one that Mr A had. Having seen the echocardiogram, my adviser considered it unreasonable that the trainee failed to make this diagnosis, as there were indications of it. He also noted that the trainee's report missed some important information. My adviser agreed with the consultant's statement that he (the consultant) had been responsible for a number of failings. He should have reviewed the echocardiogram personally and not relied on the report, and on the basis of the information given to him by the trainee, he should have arranged further tests. The consultant noted the trainee had suggested this at the time. My adviser said that it was difficult to say whether the outcome would have been different, given that the operation Mr A needed is known to be one with a high risk, but it is clear that earlier surgery would have increased Mr A's chances of survival.

I upheld this complaint in full and the recommendations I made can be read in my report.

# Complaints Standards Authority (CSA)



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## NHS – Complaints procedure

On 28 January 2015 the Scottish Government wrote to the chief executives of the NHS boards and other key NHS stakeholders to notify them of proposed changes to the NHS procedure for handling complaints. These changes will be developed by the Complaints Standards Authority who will work with boards to develop a revised NHS model complaints handling procedure (CHP) using the framework of the Patient Rights (Scotland) Act 2011, 'Can I Help You?' guidance and the model CHPs developed and implemented by other public bodies in Scotland.

The revised procedure will encourage better early, local, resolution of complaints wherever appropriate. The Scottish Government outlined the proposal to introduce a distinct five-working-day stage for early resolution, ahead of the 20-working-day investigation stage. Importantly, this will replace the existing requirement to attempt resolution within the first three working days of the 20 working day period. These changes are intended to support NHS providers to improve outcomes for people using their services, by helping them to resolve more complaints quickly at the early stages, and improve performance in meeting the subsequent 20-day target. The changes will require amendments to the regulations and directions associated with the Patient Rights (Scotland) Act 2011.

In January we attended the NHS Executive Masterclass ('Listening and learning – from Feedback to Action') jointly hosted by the Scottish Government and Scottish Health Council. We also attended the NHS Complaints Personnel Association Scotland meeting. This allowed us to share our thoughts about the development of a NHS model complaints handling procedure, and how we will work with the sector to achieve this.

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## NHS – Early resolution masterclasses

Following discussion with NHS Education for Scotland (NES) we have agreed to help develop and run a series of events for NHS middle managers on early resolution and elements of change that would be required in implementing the CHP. Dates have now been identified to hold regional events over February and March. Further details are available from NES.

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## Local government

We have now received annual complaint reports information from all councils for the year 2013/14. For the first time ever, information collected and reported in a standardised way is available to allow the sector to better understand and learn from the handling of complaints. This information, together with the other performance information reported against the SPSO's performance indicators for the local authority model CHP provides a baseline against which we can measure performance in the future.

We have agreed with the sector's local authority complaints handlers network that we need to learn from the data collection, reporting and publication process to ensure that, in future, annual complaints performance information is made available to the network at the earliest opportunity, and at least by the end of the first quarter. There may also be a need to further develop the performance indicators to ensure they provide information that is helpful to the sector. The network is undertaking further work to look at how the data collection and reporting process works in practice, and produce a summary report to use for benchmarking purposes.



# Complaints Standards Authority (CSA)

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## Housing

The next meeting of the housing complaints handlers network is scheduled for 27 March 2015 in Edinburgh. The location and time have yet to be finalised.

The network is run by the sector for the sector, and aims to identify, evaluate and share good practice in complaints handling. It also seeks to compare and contrast complaints handling performance with a view to benchmarking and sharing the learning from complaints handling. The meeting in March will reflect on the CHP in operation, performance reporting and benchmarking and possibly other issues of interest to the sector such as the application of unacceptable actions policies.

If you would like to attend the meeting on 27 March 2015, please contact us at [csa@spsso.org.uk](mailto:csa@spsso.org.uk). Further information will be provided to those who express an interest in attending.

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## Further education

The further education complaints advisory group met in January. The main areas of discussion included the requirement for colleges to produce annual complaints reports and planning for the advisory group's workshop on benchmarking complaints performance. It was agreed that the workshop will be held on Wednesday 6 May 2015, and will cover the issues of complaints handling and the reporting and benchmarking of complaints performance across the sector. The group agreed that it was important for all colleges to be represented at the workshop wherever possible, but acknowledged that for some (the UHI colleges for example) special arrangements may be appropriate, where one college attends on behalf of others.

A number of colleges have already prepared and reported their annual complaints performance information. The advisory group agreed, however, that to allow for a meaningful comparison, it was important that the data was presented in a standardised consistent way. It was agreed that the CSA would, on behalf of the advisory group, develop a template for reporting performance for use by all colleges. The template will be assessed by members of the group and completed by all colleges prior to the workshop, so that we can better understand the complaints handling performance across the sector.

The College Development Network will provide further details of the workshop directly to all colleges in due course.

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## Higher education

We would like to remind all universities of the requirement to report on their complaints handling performance annually in line with SPSO requirements, as documented in ***the Scottish higher education model complaints handling procedure Guide to Implementation (PDF, 101KB)***. We ask all higher education institutions that have not already done so, to provide us with their report, or a link to their published annual complaints report online, by writing to us at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

For all previous updates, and for more information about CHPs, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk). You can also contact the CSA directly at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

## SPSO Training Events



### **Managing Difficult Behaviour:** 1 day open course Wednesday 15 April 2015, in central Edinburgh

#### **Who should attend?**

Staff who might receive negative feedback from the public or other stakeholders.

#### **What does it cover?**

- why people complain and what they want to achieve by complaining
- how people react in situations of conflict and how this can give rise to behaviours that cause problems
- ways to de-escalate potential complaints and look at what can go wrong when concerns are responded to badly
- how an unacceptable actions policy (or equivalent) can be helpful in dealing with situations which become difficult

Participants will be given an opportunity to assess their own conflict styles and develop ways of managing their own personal 'triggers'. We will consider a number of different theories and tools that can be helpful in managing conflict. The session will include a number of opportunities to put theory into practice and participants will be able to discuss their own particular concerns.

**Price: £180 pp** To apply for the course, please email [training@spsso.org.uk](mailto:training@spsso.org.uk)

For more SPSO course information, please visit the SPSO Training Unit website:  
[www.valuingcomplaints.org.uk/training-centre/](http://www.valuingcomplaints.org.uk/training-centre/)

### **Save the date:**

### **SPSO Conference, Thursday 8 October 2015**

With a range of keynote speakers, interactive workshops and cross-sector networking opportunities, our one-day conference will focus on helping you implement improvements to your complaints handling, quality assure your complaints responses, and maximise learning from complaints using root cause analysis.

Location: **COSLA conference centre, Edinburgh (near Haymarket train station)**

Price: **delegate rate £150pp, including refreshments and conference materials**

**Spaces will be limited, but to register your early interest or for more information, please contact [training@spsso.org.uk](mailto:training@spsso.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, 18 February 2015**

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

For further information please contact:

**Alison Bennett**  
**Communications Team**  
Tel: **0131 240 8849**  
Email: [abennett@spsso.org.uk](mailto:abennett@spsso.org.uk)

## 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.



**COMMUNICATIONS TEAM**  
T 0131 240 8849



**SPSO WEBSITE**  
W [www.spsso.org.uk](http://www.spsso.org.uk)



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T 0800 377 7330  
W [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)

**VALUING COMPLAINTS WEBSITE**  
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