

January 2020

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Our findings

Complaints

Investigation report

This month we are publishing one full investigation report: [201803897 Fife NHS Board](#) relating to the unreasonable care and treatment of a woman who was admitted to hospital with a swollen leg and later died of sepsis. The report highlights failings in the way the patient's medication was assessed, the decision to stop treating her with antibiotics and a failure to ensure the death certificate was accurate. However, we found the Board's communication with the patient's family during her admission to be reasonable.

We also found that the Board's complaints handling fell below a reasonable standard. Their response failed to identify significant shortcomings and did not address all of the issues raised by the complainant.

We made six recommendations directly in relation to these findings, which the Board have accepted. These included asking the Board to apologise to the patient's family, issuing a new death certificate and reviewing the case in light of the relevant guidance on Significant Adverse Event Reviews.

We also found similar complaint handling issues with the Board in case [201602341](#). We will monitor and check that recommendations are implemented, and strongly urge all public bodies to ensure that they take steps to ensure failings are not repeated.

Decision reports

We are currently in the process of upgrading our casework management system. While there has been no impact on our casework we have decided to not publish any decision reports this month until work on our casework management system has been completed.

Learning points

We have recently seen a number of cases where complainants experienced significant delays in receiving their final, stage 2, response letter from public bodies.

When complainants call on us for help in these cases, we record the delays that they have been experiencing during the complaints process so far and ask the organisation to contact the complainant as soon as possible with an explanation for the delay and a timescale of when the final response is expected.

In cases where the issue remains unresolved, we may have to notify the organisation more formally in line with to our [Support and Intervention Policy](#).

Scottish Welfare Fund (SWF) Reviews

During December we:

- responded to 80 enquiries
- made 65 decisions:
 - 16 community care grants
 - 49 crisis grants
- changed the council's decision on seven (44%) community care grants and 17 (35%) crisis grants

Many applicants to the SWF are in situations which require urgent action. Over the holiday period, even though our office was closed, we provided a service to consider crisis grant applications. Some applicants, who were looking to make a new application with their council, contacted us during this period to advise that they were closed. We are only able to review applications once they have been through the council's application process so we signposted them to other potential sources of assistance until their local council reopened.

We also encountered difficulties associated with one council operating reduced opening hours. As we were unable to contact them for further information to carry out our independent review, the applicant experienced a delay of several days in receiving the support they needed. In the end, we were able to review the application and overturned the council's decision.

Did you know we now have a searchable directory of SWF case studies available [on our website?](#)

National Whistleblowing Standards

From July 2020 the Scottish Public Services Ombudsman is also the Independent National Whistleblowing Officer (INWO). The aim is to make sure everyone delivering NHS services in Scotland is able to speak out to raise concerns, ultimately contributing to ensuring that the NHS in Scotland is as well run as possible.

The INWO has developed a set of National Whistleblowing Standards that set out the high level principles and a detailed procedure for investigating concerns. These Standards are now being shared for information and to help prepare NHS organisations for implementation in advance of July 2020.

For further information, please visit the new INWO website at www.inwo.org.uk



Model Complaints Handling Procedure

Last year, we conducted a comprehensive review of the Model Complaints Handling Procedure (MCHP) across all sectors (except the NHS), and will be launching the updated MCHP over the next few weeks.

We will publish the new MCHP on our website and contact bodies under our jurisdiction directly to share the information.

SPSO Strategic Plan consultation

The SPSO recently sent her draft Strategic Plan 2020-2024 to the Scottish Parliamentary Corporate Body for their consideration and comment. The plan covers the SPSO's vision, values and strategic aims for 2020-2024.

We also invite comments from individuals and organisations. The consultation is open until 28 February 2020. The draft Strategic Plan and information on the consultation is available [on our website](#).

Training

Our next open training course for the public sector is:

Complaint Investigation Skills

Tuesday 10 March 2020

This course is for managers, team leaders, complaints officers and any other staff involved in the investigation of complaints. The course aims to develop their awareness of what makes the experience of complaining a good one or a bad one and explores the investigation process from initial receipt to conclusion.

[For further information and to book a place, please visit our website.](#)

SPSO Complaints Improvement Conference

Thank you to everyone for their interest in our Complaints Handling Conference in February. Please note that the event is now fully booked.

For further information contact:

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