**PE1844/A**
Scottish Government submission of 15 December 2020

The Scottish Government view is that the Scottish Public Services Ombudsman (SPSO) effectively provides the role of the external independent regulatory body for NHS Complaints as called for in this petition. Details of the NHS Model Complaints Handling Procedure (CHP) and the role of the SPSO in NHS Complaints are set out below to inform the Committee.

Please see submission below for the Committee in relation to this petition.

The NHS Model Complaints Handling Procedure (CHP) has a statutory foundation in the Patient Rights (Scotland) Act 2011. It was developed through a partnership approach, led by the Complaints Standards Authority. The Scottish Public Service Ombudsman (SPSO) issued the CHP with detailed guidance and support that was adopted across every Health Board from April 2017. The SPSO anticipate the CHP will be reviewed again by 2022/23.

The Patient Rights (Scotland) Act 2011 and supporting legislation, provides a specific right for people to make complaints, raise concerns, make comments and give feedback. The Act also places a duty on NHS Boards to thoroughly investigate and respond to any concerns raised, to take improvement actions where appropriate and to share learning from the views they receive. When a person (or a third party authorised by the person to act on their behalf) has concerns about their treatment or care, this should be addressed at a local level through the NHS complaints procedure. When that is not possible, the SPSO is the second and final stage in the complaints process.

The revised procedure brought the NHS into line with other public service sectors by introducing a distinct, 5 working day stage for early resolution, ahead of the 20 working day stage for complaint investigations. Around half of complaints are resolved at the early resolution stage. Complaints investigations can be more complex and the regulations make provision for extensions to the timeline in these circumstances. The latest NHS Scotland Complaints statistics (2019/20) can be found here.

The Scottish Public Services Ombudsman (SPSO) is independent from the providers of healthcare and Ministers. Their role, set out in statute, includes investigating complaints about most organisations providing public services in Scotland and driving learning and improvement from complaints. The SPSO makes independent and impartial decisions. The SPSO will seek to resolve a complaint where possible. Where resolution is not achieved, and once the SPSO have completed an investigation and made a decision, they will write to both the person who made the complaint, and the organisation involved, setting out reasons and recommendations. Recommendations have implementation timescales attached and are always followed-up.
Recommendations cover actions needed to put things right, improvement and learning and effective complaint handling. SPSO decisions are final and can only be challenged through the Judicial Review Process.

The role and function of the SPSO is set out in legislation Scottish Public Services Ombudsman Act 2002

- Schedule 1 confirms the SPSO' s independence;
- Section 2 sets out their power to investigate or resolve complaints
- Section 13 provides them with the same power as the Court of Session to obtain evidence when they are investigating
- Regulation 16G of the Scottish Public Services Ombudsman Act 2002 confirms the SPSO' s statutory duty to improve complaints handling.
- Section 16 sets out the powers of the SPSO to lay a special report before the Scottish Parliament when an investigation report finds someone suffered injustice or hardship because of maladministration or service failure, and this has not been, or will not be, remedied. Notably, the SPSO has never had to lay such a report.

The Scottish Government and NHS Scotland have a shared vision for an open and learning culture. The NHS CHP reflects the broader ambition for the NHS in Scotland to be an open, learning organisation that listens and acts on feedback when unintended harm is caused. Health and social care organisations need to learn effectively from experience and how to feed this learning into improvements in the delivery and management of care.
Our commitment to this is strongly demonstrated in the development of our approach to openness and learning and a number of systems are already in place that focus and emphasise the requirement for Boards to act swiftly and robustly when things go wrong. These include adverse event reviews, the Scottish Mortality and Morbidity Programme and The Duty of Candour (DoC) provisions that complement the CHP.

When these processes identify where improvements should be made, service providers need to implement them and demonstrate how these changes have been monitored to provide assurance and public confidence that the necessary changes have resulted in improvements.

Healthcare Improvement Scotland's (HIS) role is to enable the people of Scotland to experience the best quality of health and social care. They do this by encouraging and supporting continuous improvement in healthcare practice, and providing public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services, and independent healthcare services. The Cabinet Secretary for Health and Sport has asked HIS to ensure NHS Boards notify them of any Significant Adverse Event Review commissioned in response to a category one event. This will provide a more comprehensive national overview of adverse events across Scotland and highlight opportunities for learning at a national level.

Legislation underpinning the CHP;
The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Amendment Regulations 2016 ; and
The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2017