Public Petitions Committee
Thursday 19 November 2026
6th Meeting, 2026 (Session 7)

PE2258: Independently review NHS complaints handling for greater accountability and learning

Introduction

Petitioner	Yvette Rodgers
Petition Summary	Calling on the Scottish Parliament to urge the Scottish Government to undertake an independent review of NHS Scotland complaints handling, including the independence of investigations, how findings and failings are communicated to families, how learning and improvements are demonstrated following complaints, and whether greater independent oversight of the Duty of Candour is required to ensure transparency, accountability and public confidence.
Website	https://petitions.parliament.scot/petitions/PE2258

1. This is a new petition that was published on 16 September 2026.

2. A full summary of this petition and its aims can be found at **Annexe A**.

3. Every petition collects signatures while it remains under consideration. At the time of writing, 257 signatures have been received on this petition.

4. A SPICe briefing has been prepared to inform the Committee's consideration of the petition and can be found at **Annexe B**.

5. The Committee seeks views from the Scottish Government on all new petitions before they are formally considered.

6. The Committee has received submissions from the Scottish Government and the Petitioner which are set out in **Annexe C** of this paper.

Action

7. The Committee is invited to consider what action it wishes to take.

Clerks to the Committee
November 2026

Annexe A: Summary of petition

PE2258: Independently review NHS complaints handling for greater accountability and learning

Petitioner:

Yvette Rodgers

Date published:

16 September 2026

Petition summary:

Calling on the Scottish Parliament to urge the Scottish Government to undertake an independent review of NHS Scotland complaints handling, including the independence of investigations, how findings and failings are communicated to families, how learning and improvements are demonstrated following complaints, and whether greater independent oversight of the Duty of Candour is required to ensure transparency, accountability and public confidence.

Background information:

This petition arises from my experience following the death of my gran, whom I believe was failed during her hospital care. I pursued my concerns through the NHS complaints process and the SPSO but was left without the clear acknowledgment I had hoped for. I was not seeking compensation or punishment. I wanted someone to say, “We got it wrong, and this is what we have changed as a result.”

My experience has raised wider concerns about whether NHS complaints provide families with meaningful accountability when care falls below expected standards. I am particularly concerned about the independence of investigations, whether families receive clear findings, how learning is demonstrated, and whether there is sufficient independent oversight of the Duty of Candour.

My gran meant the world to me. I cannot change what happened to her, but I hope her experience can help improve the system for other families.

Annexe B: SPICe Briefing

Scottish Parliament Information Centre
Ionad Fiosrachaidh Pàrlamaid na h-Alba

Briefing for the Public Petitions Committee on petition PE2258: Independently review NHS complaints handling for greater accountability and learning, lodged by Yvette Rodgers

Brief overview of issues raised by the petition

The petitioner does not regard NHS Scotland complaints processes or the involvement of the Scottish Public Services Ombudsman as adequate. The petitioner is clear that she was not seeking compensation or punishment following a complaint about the care her grandmother received, but wanted acknowledgement of mistakes made and assurance that learning from the process was clearly demonstrated.

Her experience has also led her to question whether the Duty of Candour legislation ensures sufficient oversight when something goes wrong in healthcare. Her particular concerns are therefore about:

- The independence of investigations
- Adequacy of findings presented to families
- How learning is demonstrated and communicated to families
- Adequacy of oversight via Duty of Candour legislation.

NHS Complaints handling

The new NHS complaints handling procedure was established in 2016 and the National Clinical Director wrote to all health boards and other stakeholders setting out the rationale and the legislative basis: the Patient Rights Act (Scotland) 2011. The Act introduced a right for people to give feedback and comments, and raise concerns and complaints about NHS services, and it placed a duty on the NHS to actively encourage, monitor, take action and share learning from the views they receive.

The NHS Model Complaints Handling Procedure applies to all healthcare settings where NHS treatment is provided, including GP practices, and dental practices. If the person making the complaint is not satisfied with how it has been handled, then they can approach the Scottish Public Services Ombudsman.

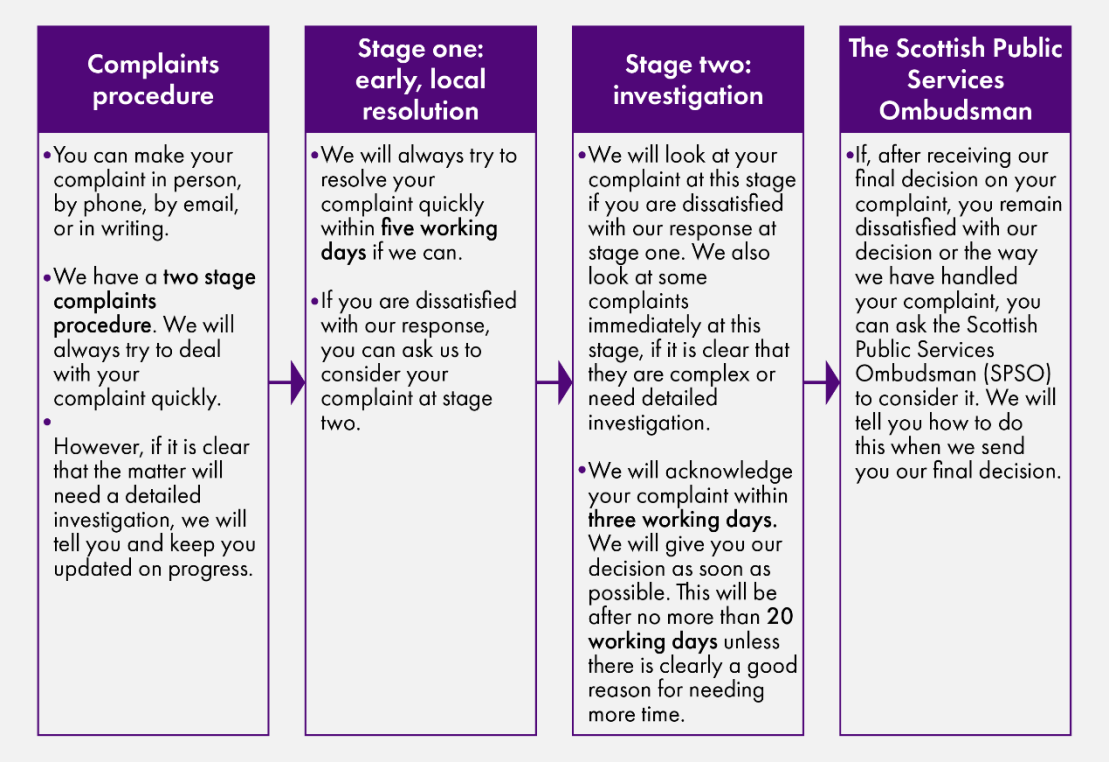
The NHS complaints handling procedure is based on the premise that effective early resolution through responsive action, listening and compassion should negate the move to a more formal complaint.

The NHS complaints procedure is a two-stage process: stage 1 being ‘early, local resolution’ and stage 2 ‘investigation’. The document explaining the process is a

long, detailed document including details of what a complaint is, the process, governance and guidance.

People are encouraged to raise a concern as soon as it arises, with the staff dealing with their care and treatment. If someone doesn't feel able to do that, or is not satisfied with the response, then they can move to stage 1 of the more formal process. The visual below provides the key stages and timings of the NHS model complaints handling procedure.

Figure 1: overview of model complaints procedure



Independence of investigations

The NHS complaints handling procedure states that everyone involved must be clear about the scope and expectations from any investigation. It acknowledges that there might be a mismatch between the complainant's expectations and what outcome might be possible, and what is possible within the 20-day response window, making a discussion essential early on.

Health Boards have dedicated complaints-handling staff teams. They will take details of any concerns or complaints and will then contact the staff involved to understand the issue from their perspective. These staff are independent inasmuch as they are not directly involved with any of the care and treatment the person has received. They will then collate the information and provide the written response to the complainant.

Some Health Boards (eg NHS Grampian) use Independent Contractors to deal with complaints in addition to their own complaints handling staff.

The procedure sets out the roles and responsibilities of the Feedback and Complaints Manager, and of Feedback and Complaints Officers.

Adequacy of findings presented to families

The findings at Stage 2 are not coming directly from the staff involved in the person's care and treatment. The procedure is set out as a 20-day process (in the case of a Stage 2 complaint). So, at Stage 2, the opportunity for a person to deal directly with the staff involved has passed and the case is taken on by a complaints handler in the dedicated team. However, a full response covering the agreed scope of the complaint should be provided to the family.

Recording, monitoring, reporting, learning from and publicising complaints

The procedure states that:

> "Complaints provide valuable feedback. One of the aims of the complaints handling procedure is to identify opportunities to improve services across [the organisation]. We must record all complaints in a systematic way so that we can use the complaints data for analysis and management reporting. By recording and using complaints information in this way, we can identify and address the causes of complaints and, where appropriate, identify training opportunities and introduce service improvements."

The procedure is a prescribed, time-bound process. Alongside the complaints handling, health boards are required to report regularly on complaints and concerns via a 'Complaints handling and learning from feedback' annual report.

These reports cover the numbers of complaints, how many were escalated to the Scottish Public Services Ombudsman (SPSO), performance in terms of timelines and complaint themes.

The reporting is through clinical governance oversight, with ultimate responsibility lying with the Chief Executive and Executive Directors, and the reports have to be published on the Health Board's website. The reports provide some examples of learning, service change and training provided, but how learning is implemented is not covered by the procedure in a prescriptive way.

Under the relevant sections, the detail is on how complaints should be recorded, how records should be kept, how they should be monitored and reported.

With regards to learning, the procedure states:

> "At the earliest opportunity after the closure of the complaint, the complaint handler should always make sure that the person making the complaint and staff of the service involved are given feedback and, where applicable, understand the findings of the investigation and any recommendations made.
>
> As a minimum, we must:
>
> - use complaints data to identify the contributory factors to complaints;
> - take action to reduce the risk of recurrence;

- record the details of corrective action in the complaints file; and
- systematically review complaints performance reports to improve service delivery.
- Where we have identified the need for service improvement:
- an action plan should be developed where appropriate;
- the action needed to improve services must be prioritised for implementation;
- an officer (or team) should be designated the 'owner' of the issue, with responsibility for ensuring the action is taken;
- a target date must be set for the action to be taken;
- the designated individual must follow up to ensure that the action is taken within the agreed timescale;
- where appropriate, performance in the service area should be monitored to ensure that the issue has been resolved; and
- we must ensure that our staff learn from complaints."

There are no explicit reporting requirements for these learning points that need to be published in the annual reports on complaints.

Scottish Public Services Ombudsman (SPSO)

The Scottish Public Service Ombudsman Act 2002, as amended, sets out the basis on which the SPSO oversees the complaints processes of public services as well as what they can investigate, their powers, and what they must not investigate.

Section 16A(2) of the Act states that certain public services must have a complaints handling procedure in respect of any action taken by them. Section 16B(1) enables the Scottish Public Service Ombudsman to publish model complaint handling procedures (MCHP) and section 16C(2) stipulates the public service must ensure their complaint procedure complies with this.

Duty of Candour – oversight and governance

Scottish Government guidance sets out:

> "The duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (The 2018 Regulations) set out the obligations on and the procedure that those providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident in providing those services that results in, or could result in, death or harm (or additional treatment is required to prevent injury that would result in death or harm)."

> "The organisational duty of candour procedure **must** be carried out by the responsible person as soon as reasonably practicable after becoming aware that an individual who has received a health, care, or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in, or could result in:
>
> - the death of the person
> - a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions ("severe harm")
> - harm, which is not severe, but which results in:
>
> a. an increase in the person's treatment
>
> b. changes to the structure of the person's body
>
> c. the shortening of the life expectancy of the person
>
> d. an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days
>
> e. the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days"

Under the legislation, a 'responsible person' needs to be identified, which can be an organisation, such as a Health board, or an individual.

There are a number of steps that must be followed:

- Identify and contact relevant persons (those affected).
- Notify the relevant person by providing an account of the incident and what actions will be taken.
- Arrange a meeting with the relevant person, and provide an opportunity to ask questions in advance. An apology should be made and the further steps being taken should be outlined, and a further opportunity to ask questions should be given.
- Carry out a review.
- An option to hold a final meeting with the relevant person.

Responsible persons are required to prepare and publish reports about the incidents, the organisation's compliance with the duty of candour procedure and information about policies and procedures and changes that have occurred as a result of the procedure.

There is a connection between the complaints procedure and the duty of candour responsibilities, although these are not explicit. What they share is a focus on process. This focus on process presents a potential risk that they are treated as separate, discrete processes, with separate reporting structures, outwith a broader organisational consideration of improvements to services, service delivery and wider clinical safety and cultural concerns. Executive Directors see reports on the metrics of these processes, but not necessarily detailed feedback on any service or other changes, and it is not clear how or whether the learning and outcomes of investigations feed into wider organisational change.

The Explanatory Notes accompanying the legislation indicate where higher responsibility sits:

> "In order to assist with monitoring the extent to which the duty of candour procedure has been followed, there is a power for certain bodies to require responsible persons to provide them with information. These same bodies are to be notified when the annual reports are published. The particular bodies with the power to require information (and who are to be notified) vary depending on the responsible person. So, for example, Health Boards are linked to the Scottish Ministers, independent health service providers are linked to Healthcare Improvement Scotland, while providers of care services or social work services are linked to Social Care and Social Work Improvement Scotland (SCSWIS, which operates under the name of the Care Inspectorate)."

Key Organisations and relevant links

- NHS Inform has public-facing information on complaints handling in NHS Scotland.

- Scottish Public Service Ombudsman (SPSO) - The Scottish Public Services Ombudsman has a wide remit, covering a variety of functions and services.

    f. the final stage for complaints about most devolved public services in Scotland including councils, the health service, housing associations, prisons, water and sewerage providers, Scottish Government and associated public bodies, universities and colleges

    g. specific powers and responsibilities to publish complaints handling procedures, and monitor and support best practice in complaints handling.

    h. Independent National Whistleblowing Officer for the NHS in Scotland (INWO) – final stage for complaints about how the NHS considers whistleblowing disclosures and the treatment of individuals concerned.

- Patient Advice and Support Service (PASS)

  "The Patient Rights Act provided for the establishment of the Patient Advice and Support Service (PASS). PASS operates independently of the NHS, and provides free, confidential information, advice and support to anyone who uses the NHS in Scotland. The service promotes an awareness and understanding of the rights and responsibilities of patients and can advise

and support people who wish to give feedback, make comments, raise concerns or make complaints about treatment and care provided." (quoted from the NHS Complaints Handling Procedure document)

Anne Jepson
Senior Researcher, SPICe
7 October 2026

The purpose of this briefing is to provide a brief overview of issues raised by the petition. SPICe research specialists are not able to discuss the content of petition briefings with petitioners or other members of the public. However, if you have any comments on any petition briefing you can email us at spice@parliament.scot

Every effort is made to ensure that the information contained in petition briefings is correct at the time of publication. Readers should be aware however that these briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

Published by the Scottish Parliament Information Centre (SPICe), an office of the Scottish Parliamentary Corporate Body, The Scottish Parliament, Edinburgh, EH99 1SP

Annexe C: Written Submissions

PE2258/A: Independently review NHS complaints handling for greater accountability and learning

Scottish Government written submission, 14 October 2026

Does the Scottish Government consider the specific ask[s] of the petition to be practical or achievable? If not, please explain why.

The Scottish Public Services Ombudsman (SPSO), which is accountable to the Scottish Parliament, has specific powers and responsibilities to monitor and support best practice in complaints handling by organisations including NHS bodies. The SPSO is the final stage for complaints about health services and provides an external independent scrutiny function for people who are dissatisfied with the handling of their complaints about NHS services.

Within this context, the Scottish Government has considered this specific ask and considers that it would not be practical for the Scottish Government itself to undertake any such review.

What, if any, action is the Scottish Government currently taking to address the issues raised by this petition, and is any further action being considered that will achieve the ask[s] of this petition?

The Scottish Government is developing and supporting a culture of openness and learning in NHS Scotland, where NHS Boards are required to act swiftly and robustly in response to complaints, or where an adverse event has occurred.

NHS complaints handling procedure

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 independent SPSO is the second and final stage in the complaints process.

The NHS Model Complaints Handling Procedure (CHP) has a statutory foundation in the Patient Rights (Scotland) Act 2011. The NHS model Complaints Handling Procedure (CHP) was developed through a partnership approach, led by a Steering Group involving the Scottish Public Services Ombudsman (SPSO) and representatives from across NHS Scotland. The independent Patient Advice and Support Service (PASS) and Healthcare Improvement Scotland (HIS) public partners were also actively involved. The CHP was adopted across NHS Scotland from April 2017.

To support transparency, the Patient Rights (Feedback, Comments, Concerns And Complaints) (Scotland) Directions 2017 placed a requirement on all NHS Boards to

publish an annual report on the feedback, concerns and complaints they have received in the preceding year. The annual reports must include a summary of actions taken by the Board as a result of feedback, concerns and complaints received in the previous year. NHS Boards must share the annual reports with Scottish Ministers, the Patient Advice and Support Service, HIS, the SPSO and, where appropriate, the Scottish Prison Service.

Organisational Duty of Candour

The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. & Care)(Scotland) Act 2016 and The Duty of Candour (Scotland) Regulations 2018 came into force on 1 April 2018 and the Scottish Government first published non-statutory guidance that year. A review of the guidance began in 2023, in consultation with a range of health and social care stakeholders, and revised non-statutory guidance was published on 4 April 2025.

All NHS Boards are required to publish annual organisational duty of candour reports. The report should articulate, in broad terms, how the local learning system identified and implemented changes as a result of incidents to which the duty has applied and reviews undertaken. These reports are intended to:

- encourage responsible persons to reflect on how the duty is being embedded and how the quality of services can be continually improved;
- provide information about the responsible person's policies and procedures, including about the procedures for the identification and reporting of incidents and the support available to staff and any relevant person affected by incidents;
- provide public assurance that the organisational duty of candour is being embedded in the sectors to which it applies; and
- contribute to the Care Inspectorate's, Healthcare Improvement Scotland's and the Scottish Government's wide evidence base about the provision of social care and health services.

In May 2024, the final report of the Infected Blood Inquiry was published. The report included a recommendation that "The operation of the duties of candour in healthcare in Scotland and in Wales should be reviewed, as it is being in England, to assess how effective its operation has been in practice." The Scottish Government has accepted this recommendation in full and undertaken a review, again with a range of stakeholders. Its findings are expected be published later this year. This review will closely inform the Scottish Government's ongoing programme of work with stakeholders including Healthcare Improvement Scotland and Public Services Delivery Scotland, focusing on organisational duty of candour, adverse events, NHS complaints and openness and learning more broadly.

Individual complaints about organisational Duty of Candour should be raised with the relevant NHS body under the terms of the CHP. Any complainant who is dissatisfied with the decision can then ask the independent SPSO to consider the complaint. The

SPSO can, and does, make recommendations in relation to organisational duty of candour and the investigation of adverse events.

Adverse events

In February 2025, Healthcare Improvement Scotland (HIS) published the revised National Framework for Reviewing and Learning from Adverse Events in NHS Scotland, which provides an overarching approach to support NHS Boards, and other health and care providers, to effectively manage adverse events.

HIS plays a key role in supporting continuous improvement and quality assurance across health and care services. HIS has led on work, in recent years, to improve adverse event investigation and to reduce variation in practice across NHS Scotland, to ensure the best outcomes for patients and staff.

A programme of joint work is ongoing , involving the Scottish Government, the Scottish Fatalities Investigation Unit of the Crown Office and Procurator Fiscal Service, and HIS to improve the quality and timeliness of Significant Adverse Event Review Reporting.

The former Cabinet Secretary for Health and Social Care, Neil Gray MSP, wrote to all NHS Board Chief Executives, in September 2025, setting out his clear expectation that all NHS Boards work with HIS to take all the necessary steps to deliver what is required to bring consistency to the:

- commissioning of adverse event reviews,
- reporting of adverse events nationally,
- timeliness and quality of SAER investigations.

The Patient Safety Commissioner for Scotland

The Scottish Government introduced legislation to establish the office of the Patient Safety Commissioner for Scotland, which was passed in the Scottish Parliament in 2023.

Karen Titchener took up office as the first Patient Safety Commissioner for Scotland on 1 September 2025. The Commissioner is an independent public advocate for patients on issues of safety, accountable to the Scottish Parliament. She will champion the value of listening to patients and hold organisations to account for their responsibility to take patients' concerns seriously. The Commissioner will bring together evidence of patients' experiences and concerns with wider patient safety data, using this to identify potential systemic patient safety issues. Individual complaints will, however, continue to be addressed under the terms of the CHP, as set out above.

The Commissioner's first annual report was published on 16 September 2026 and highlights her priorities and themes emerging from issues brought to her attention. These include the need for improved management of adverse events.

Is there any further information the Scottish Government wish to bring to the Committee's attention, which would assist it in considering this petition?

The role of the SPSO in NHS Complaints

The SPSO is independent from the providers of healthcare and Scottish Government. Their powers and responsibilities, come (predominantly) from the Scottish Public Services Ombudsman Act 2002. The Ombudsman's role includes investigating complaints about most organisations providing public services in Scotland and driving learning and improvement from complaints. The SPSO also has a statutory role in improving complaints handling and the Complaints Standards Authority provide advice, guidance and training on the application and interpretation of the CHP, to help support learning and improvement.

The SPSO publishes thematic reports in relation to the complaints it receives and has the powers to bring matters to the attention of the Scottish Parliament.

As a result of investigations into individual complaints, the SPSO may make recommendations to organisations to put things right, with a deadline to implement those recommendations. If an organisation did not comply, the SPSO has the powers to bring the matter to the attention of the Scottish Parliament by laying a special report. Since the SPSO was set up, this has not been required.

The Ombudsman's decision on a complaint is final and can only be challenged through judicial review proceedings.

Openness, Learning and Review Unit
Healthcare Quality & Improvement Division

PE2258/B: Independently review NHS complaints handling for greater accountability and learning

Petitioner written submission, 10 November 2026

Thank you for the opportunity to provide further information and respond to the Scottish Government's submission.

Having considered both the Scottish Government's response and the SPICe briefing, I remain concerned that there is a significant difference between having established processes for handling complaints and being able to demonstrate that those processes deliver meaningful accountability, transparency and improvements in patient care.

The SPICe briefing particularly stood out to me because it identifies that it is not clear how, or whether, learning and outcomes from investigations feed into wider organisational change. This is at the heart of my petition.

The briefing explains that, although complaints procedures refer to action plans, designated officers, target dates and monitoring, there is no prescriptive requirement for how learning must be implemented or explicit requirements for these learning points to be published in annual complaints reports.

The Scottish Government's submission refers to annual reporting requirements and states that reports should include summaries of actions taken following feedback and complaints. It also explains that Duty of Candour reports should describe, in broad terms, how learning systems have identified and implemented changes.

However, I believe there is an important distinction between reporting that actions have been taken and demonstrating that those actions have resulted in effective, sustained improvements. How are these changes evaluated? How is their effectiveness monitored? And how can families have confidence that learning from individual complaints has resulted in wider improvements rather than simply being addressed within the individual case?

I am concerned that the existence of reporting requirements does not, in itself, answer these questions.

I was also interested in the Scottish Government's response that it would not be practical for the Government itself to undertake the proposed review. My petition is seeking an independent review, not for the Government to assess its own arrangements. If the Government does not consider it practical to undertake this work itself, I would welcome clarification on whether it would support an independently commissioned review or another appropriate independent body undertaking it.

The Government's submission places considerable emphasis on the role of the SPSO as an independent final stage in the complaints process. I recognise the SPSO's independence from NHS providers and its powers to investigate complaints and make recommendations. However, my own experience demonstrates that the existence of an independent final stage does not necessarily mean that families

receive the acknowledgement, clarity or assurance about learning that they are seeking.

In my grandmother's case, the SPSO considered the NHS Board's investigation and response reasonable. However, I was left without the clear answers and assurance I had hoped for about what had been learned and what, if anything, had changed as a result. I am not suggesting that the SPSO has no value or that every complaint investigation is inadequate. My concern is whether the current arrangements consistently provide families with meaningful answers and demonstrable accountability.

I also note the Government's reference to the Patient Safety Commissioner for Scotland. I welcome the establishment of an independent advocate for patient safety and recognise the importance of identifying systemic issues. However, the Government's own submission confirms that individual complaints will continue to be addressed through the existing complaints procedure. I therefore remain concerned about whether the wider patient safety role adequately addresses the specific gaps in individual complaints handling, findings communicated to families and evidence of resulting improvements.

Finally, I welcome the Scottish Government's commitment to reviewing the Duty of Candour, following the recommendation of the Infected Blood Inquiry. However, I believe it is important that this work considers not only whether the required procedures have been followed, but whether they provide meaningful transparency, accountability and assurance in practice.

My intention is not to suggest that learning never takes place, nor to seek compensation or punishment for what happened to my grandmother. I want a system where shortcomings can be acknowledged honestly, families can understand the outcome of their concerns, and there is clear evidence that lessons have been learned and acted upon.

The SPICe briefing identifies uncertainty about how learning feeds into wider organisational change. I believe this is a significant issue that deserves further examination, and I hope the Committee will consider whether an independent review is needed to establish how effectively the existing arrangements work in practice.