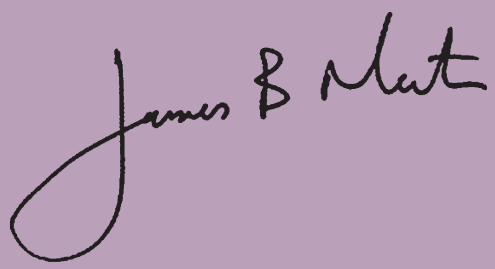
Transforming Scotland's Complaints Culture

SPSO Scottish Public Services Ombudsman

SPSO ANNUAL REPORT 2013 – 14

Laid before the Scottish Parliament by the Scottish Public Services Ombudsman in pursuance of section 17(1) and (3) of the Scottish Public Services Ombudsman Act 2002.



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Ombudsman's overview

Welcome to our 2013/14 annual report.

Last year, we helped over 4,400 people in Scotland. We provided independent advice and support, investigating where we could the issues people brought us. We made final stage decisions on almost 900 complaints, providing individual justice to people failed by public services.

We also improved public services by rigorously following up nearly 1,200 recommendations. And by publishing our decisions, we made public authorities more transparent and accountable to the people their services are for.

We achieved this against a background of receiving a record number of complaints, up 8% on the previous year. 2013/14 is the fifth consecutive year we have seen an increase.

At the same time, we continued to successfully put in place simple, accessible, standardised and effective complaints handling procedures across more areas of the Scottish public sector.

Complaints are a key way for public authorities to learn about services that are not working well and to use that feedback to make improvements. Thanks to our complaints standards work, for the first time members of the public and others will soon have access to clear, transparent and consistent information on the volume of complaints service providers received and how they handled these. There is also much evidence that, as well as providing accountability and other clear benefits for service users, getting things right early saves money for the public purse.

Our work directly contributes to the Scottish National Performance Framework, in particular the national outcome of ensuring that public services are high quality, continually improving, efficient and responsive to local people's needs.

Balancing demands on our service

As in so many businesses that are demand-led, there is an inherent tension in balancing service user and other stakeholder needs. SPSO has multiple goals – efficiency, effectiveness, quality, accessibility, impact and public service improvement. Each year the demands on us change, and we need to be flexible and creative in finding new ways to carry out our different functions.

Our productivity kept pace with the increased demand, thanks primarily to the extraordinary commitment of SPSO staff. Their dedication and hard work allowed us to keep our heads above water as complaint numbers increased again and resources remained static. I am grateful to the Scottish Parliamentary Corporate Body for recognising the challenge of the increase in complaints and their complexity, and giving us temporary funding in 2014/15 for more staff to carry out investigations.

How does the SPSO make a difference?

I think individual stories are a powerful way of illustrating how a complaint can have an impact on an individual and also lead to wider change. I recognise the courage and stamina it can take to make a complaint about a public service and we work hard to put things right and to bring about learning and change through the complaints that we see.

An example of such a case is what happened to a 60 year old man who was taken into hospital after a seizure. He had early onset dementia, and sight and hearing difficulties. He had a stroke in hospital and was discharged to a care home, where he was given no physiotherapy care. His wife felt that he was left to vegetate and said that, despite her having welfare power of attorney for her husband, the hospital had not included her when making decisions about his care and treatment. Among other failings, my investigation found that the man's care needs had not been adequately assessed, there were no meaningful attempts at rehabilitation or to discharge him home, and his dignity was not respected.

This case raised important issues under the Charter of Rights for people with dementia and their carers in Scotland. As well as the significant injustice that the man and his wife suffered, we identified failings not just in his treatment but also in hospital staff's understanding of peoples' rights under the relevant legislation (the Adults with Incapacity (Scotland) Act). To redress the personal injustice in so far as was possible, I recommended that the board apologise to the couple and that, if his wife agreed, they thoroughly assess the man to find out whether he would benefit from physiotherapy and if so, arrange this. It is also our role to ensure that processes are changed so that failings are not repeated. To address the failings in this case, I made recommendations to improve staff training in the care of people with dementia including asking the board to audit the ward's compliance with the legislation. We shared the outcomes of the complaint through our communications channels, adding to the intelligence that the Scottish Government, Healthcare Improvement Scotland and others use to drive their scrutiny, regulatory and improvement activities.

Recommendations like these do make a difference. We follow up each one, and require the organisations to provide us with evidence that they have implemented them. We check the hundreds of apologies, policy reviews, action plans and training programmes that we ask public bodies to carry out, to make sure that they have done what they said they would. The results of our recommendations mean real changes in real services delivered to real people.

Ombudsman's overview

Person-centred public services

Rising complaint numbers is one challenge; another is changes in how public services are delivered. We need to be proactive and responsive to policy proposals and make sure we share our unique perspective on services in a way that reflects the experiences that people using those services bring us through their complaints.

In one particular policy area – integration of health and social care, including social work – I am concerned about the time it is taking for simple, coherent and effective complaints procedures to be put in place. I have commented on this before, for example in my evidence to the Health Committee in October 2013, when I said '... If we are serious about integration, all aspects ... should be looked at, which should include complaints. It is a matter of some urgency. I would not want a system to be put in place and then have a lag on the complaints side that causes people to become frustrated with the system and begin to lose confidence in it. I urge people to think carefully about that.'

My concern is all the stronger because people using health and social care services can often be vulnerable. This is also the case for people using social work procedures, where the pace of reform has been slow. Back in 2008, Douglas Sinclair highlighted the need for simplification in social work complaints pathways, saying that the complexity of the arrangements was putting people off complaining. People still have to use those arrangements, and it is now 2014.

One further issue I wish to highlight is that it is clear from discussions with some health boards that access by prisoners to the NHS complaints process remains problematic. It is worth noting that the number of complaints received by SPSO remains well below the levels escalated to Scottish Ministers under the previous complaints system. Again, this is an issue I have raised in various ways throughout 2013/14.

Complaints on the increase

We saw complaint numbers rise in most areas of the public sector. This most likely relates to greater public awareness of complaints (and hopefully of the benefits of complaining) resulting from media coverage of problems, particularly in the NHS in the wake of the Francis Inquiry. Another possible factor is the more streamlined processes now operating under the standardised complaints procedures. I explained in last year's report that a possible unintended consequence of more accessible systems could be that more complaints come to us because people are getting through the local procedure quicker, finding their complaint easier to pursue, and are being appropriately signposted to us. This may also explain the continuing drop (of 6% on last year) in the rate of premature complaints (complaints that reach us before the organisation's own process has been completed). It is early days though, and we will continue to monitor this.

We upheld more complaints (overall 4% more than last year) which tells me there is still work to do in supporting organisations in getting things right when people complain to them.

Ombudsman's overview

Making complaints more effective

In 2013/14, we supported public authorities in putting in place model complaints handling procedures (CHPs) in three new areas: further education, higher education and the sector made up of the Scottish Government, Scottish Parliament and associated public bodies. Our support includes providing advice and guidance tools, sharing best practice, facilitating networks of complaints practitioners and delivering extensive training activities.

Customers benefit from the standardised approach because, increasingly, anyone using a public service now knows what to expect when making a complaint. For organisations, there is clarity and consistency about stages and timescales. There are opportunities for learning and improvement to services through increased responsiveness, transparency and oversight. There is also a developing performance culture in complaints handling. I have been keen to drive this over the past year, in part through delivering master classes on the fundamental importance of complaints in terms of corporate governance and responsibility, taking on the lessons of the Francis Inquiry into the Mid-Staffordshire NHS Foundation Trust.

2013/14 is the first year for which the sectors that have already implemented model CHPs are required to report their annual statistics. This is a true turning point for the public sector in Scotland, in enabling complaints to help drive service improvements across organisations and sectors.

The Scottish model

The efficiency and quality of our casework and the benefits brought about by improved public sector complaints handling procedures attracted a great deal of interest from other ombudsman offices and other countries. I detail some of this below. While highlighting our growing reputation for getting things done and done well, I want to emphasise that we are by no means resting on our laurels. I recognise that there remains a great deal to be done.

I gave evidence to a Westminster inquiry into the Parliamentary and Health Service Ombudsman (PHSO). The PHSO is the final stage for complaints about UK government departments and agencies and the NHS in England. The inquiry's report recommended consulting on creating a single public services ombudsman for England. It also called for new legislation that would give the PHSO the power to oversee complaints processes across its jurisdiction and a formal role in setting complaints standards and training in complaints handling. This would draw on the Scottish legislation that enabled us to set up our Complaints Standards Authority (CSA), a body that is unique among UK ombudsmen (and as far as I am aware is unique outside the UK as well).

I was also asked to contribute to an external evaluation of the Local Government Ombudsman (LGO) for England, which made recommendations to help ensure the consistency of decisions, strengthen corporate governance and assure the public of its independence.

Ombudsman's overview

We hosted a large number of visits from Scottish organisations and other ombudsmen and complaints handlers, who wanted to find out more about our casework process and the CSA. Visitors came from Scotland's Commissioner for Children and Young People, the Scottish Legal Complaints Commission, the Legal Ombudsman, Ombudsman Services (which handles complaints about communications, energy providers and property in England and Wales), the Housing Ombudsman, the LGO, the Public Services Ombudsman for Wales and the Northern Ireland Ombudsman. The Office of the Independent Adjudicator, which handles complaints about higher education in England, has decided to use our model complaints handling procedure as the basis for developing a framework for a standardised procedure across its jurisdiction, and University College Dublin has unilaterally already done so. We also hosted visits from Australia, China, Ireland and Norway.

Our quality assurance (QA) process, which ensures that our decision-making is robust and consistent, was nominated by our ombudsman peers as an example of best practice innovation. I was invited to speak at a European Ombudsman conference about our QA and the other ways we continuously build quality into our work. We were also heavily involved in the activities of the Ombudsman Association, where we are on the Executive Committee, chair the First Contact and HR working groups and are represented on the legal and communications groups.

Our expertise in delivering training and developing e-learning modules in complaints handling was sought after. We delivered over 50 courses across Scotland and expanded our e-learning platform. We developed complaints handling training materials with NHS Education for Scotland, specifically for NHS staff, and the NHS in England are adapting these to train their entire staff. Our training materials have also been requested by local authority staff in New Zealand.

It is worth noting that our training unit is run by one person, with support from SPSO colleagues. Indeed, our entire staff number only around 50. I think the expansion of activities and the interest in what we have achieved is a reflection of the excellent work done by what is a relatively small team of people at SPSO. I am pleased to recognise an outstanding year for the office and hope that this annual report does justice to the huge effort they have made, the innovations and solutions they have come up with and the ongoing dedication they demonstrate to making a difference.

Jim Martin, SPSO

"This is a true turning point for the public sector in Scotland, in enabling complaints to help drive service improvements across organisations."

Casework performance

This section highlights:

- casework volumes and outcomes
- how we managed the increased demand
- timescales
- how we ensured the quality of our service and our decisions
- stakeholder involvement

Case volumes

Although our level of investigation resource remained the same in 2013/14, we were able to achieve an 8% rise in productivity and manage the 8% increase in complaints to us. We did this by continuing to focus on performance management and quality assurance, and by carrying out a successful pilot project that introduced expertise earlier in our process.

There is a detailed table with all the outcomes of the complaints we dealt with in 2013/14 at the end of this report. Below we identify some key points.

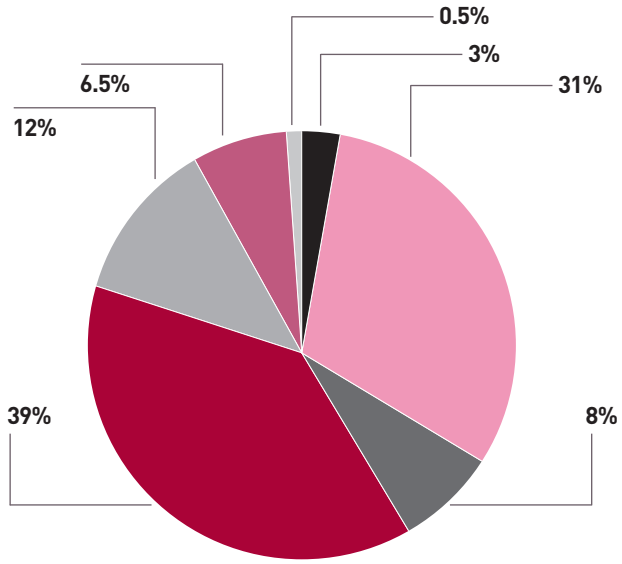
Cases received

The number of complaints people brought us continued to rise for the fifth year in a row. In 2013/14, we received 4,456, an increase of 8% on the 4,120 we received the previous year. We handled 8% more complaints, 4,408 compared with 4,077 the year before.

Enquiries went down to 363 from 531 the year before. There is a breakdown of enquiries at the end of this report. It shows the organisations to which we most frequently signposted people, the top two being Citizens Advice Scotland and the Financial Ombudsman Service.

Most of the increase in complaints received came from the two sectors that make up 70% of our workload, local government and health. Local government complaints received rose 16% from 1,505 in 2012/13 to 1,750 last year. Health complaints rose 11.5% from 1,237 to 1,379. Other sectors saw rises and falls in complaints received (for example housing associations up by 7% and water providers down by 17%) but on less statistically significant volumes.

Complaints received by sector in 2013/14



SECTOR	COMPLAINTS	% OF TOTAL
Further & higher education	125	3%
Health	1,379	31%
Housing associations	351	8%
Local authority	1,750	39%
Scottish Government & devolved admin	535	12%
Water	292	6.5%
Other	24	0.5%
Total	**4,456**	**100%**

Casework performance

Changing profile of complaints

The main positive for service users from the 2013/14 figures is the further drop in the number of complaints we saw that were premature (ie that reached us before they had completed the public organisation's own complaints procedure). Four years ago the rate of premature complaints was 51%. It has fallen gradually since then, and in 2013/14 it was 34%, a 6% overall decrease on the previous year.

Every sector under jurisdiction saw a decrease in premature complaints, the percentage drop being more pronounced in those sectors where we saw fewer complaints.

Reduction in premature complaints over past 2 years by sector

SECTOR	2012 – 13	2013 – 14	% DIFFERENCE
Further and higher education	44	27	**-39%**
Health	356	350	**-2%**
Housing associations	175	163	**-7%**
Local authority	750	692	**-8%**
Scottish Government and devolved admin	156	140	**-10%**
Water	133	117	**-12%**
Other	11	6	**-45%**

The fall suggests that there is more effective signposting about when to refer complaints to us. This is good news for complainants, as it can be very frustrating for people to have to return to the organisation they were first complaining about. The lower rate of premature complaints suggests that people are getting their complaint dealt with at the right place and using the SPSO properly as the final stage in the process.

Primary responsibility for this lies with the public authorities that are dealing with the complaints. Consistency in achieving this effectiveness may have been helped by the explicit guidance on how and when to signpost to us, contained in the model complaints handling procedures.

This welcome reduction in premature complaints also means that more of the complaints we see are ready for us to consider. Clearly, however, investigating a mature complaint takes more time than providing support and advice on a premature complaint. It is also worth noting that the sector in which complaints usually present the most complexity is health, and this is where the premature rate has dropped least. The added complexity within health complaints is that here, uniquely, we have powers of clinical judgement. This means that we are able to consider what the health professional did and whether it was reasonable in the circumstances, so we will often be examining medical records and other clinical evidence and seeking independent specialist advice. This can be particularly resource and time intensive compared with most complaints about other areas.

This changing profile puts greater pressure on the later stages of our process where we look at what we may be able to achieve for people whose complaints are mature. In 2013/14, we successfully applied for temporary funding for two additional complaints reviewers, and these posts were filled in April 2014.

Casework performance

Pilot project – giving people answers earlier

We are always looking for ways to maximise the efficiency and effectiveness of our process. In 2013/14 we introduced a six month pilot project where a small team of complaints reviewers worked closely with our advice team. This enabled us to better manage expectations early on as to what we could achieve for the person making the complaint.

The pilot introduced a much earlier triage of complaints, enabling complaints reviewers to let many complainants know more quickly whether we could achieve what they were looking for. This meant that people were getting an answer sooner and this was of course a positive outcome. Given the success of the pilot, we decided to continue it into 2014/15.

While the number of cases moving on to be investigated remained at the same level as in 2012/13, this project led to a rise in the number of complaints determined in one category, that of people who withdrew complaints, did not 'duly make' their complaint or wanted an outcome that we could not achieve for them. These increased from 1,017 last year to 1,436. In these cases, we often reached no final decision and invited these complainants to come back to SPSO if they wanted us to look at their issue in more detail or to provide more evidence that might allow us to take it further.

We analysed the complaints that contributed to this increase and found these were mainly local authority complaints. Initial indications are that these represent an underlying dissatisfaction with discretionary decisions made by the local authorities concerned, which we cannot look at where there is no evidence of maladministration or service failure. We will, however, continue to analyse these complaints to identify any common themes that we could pass on to the appropriate local authority and other stakeholders to help inform their work.

Complaints by sector

Complaints dealt with by sector 2012–13 and 2013–14

SECTOR	2012 – 13	2013 – 14
Further and higher education	138	**111**
Health	1,197	**1,324**
Housing associations	316	**360**
Local authority	1,507	**1,747**
Scottish Government and devolved administration	527	**528**
Water	347	**314**
Other	45	**24**
Total	4,077	**4,408**

Case decisions

In 2012/13, we dealt with around 60% of our cases at the advice stage. In 2013/14 this rose to 64%, thanks to the pilot project described above.

In 2013/14, 1,579 cases were passed on from the advice stage for further detailed review, compared with 1,601 in 2012/13. At this stage, we try to talk to the complainant to make sure we understand their complaint and the outcome they want. We aim to see if there is a resolution that can be achieved, and in 2013/14 we resolved 63 complaints at this stage compared with 47 the previous year.

We also decided a further 622 cases at this stage. These were premature, out of jurisdiction, or we were unable to take the matter further because the complainant did not provide us with enough information, withdrew the complaint, or wanted an outcome we could not achieve for them.

Casework performance

Key figures 2013–14

The number of complaints received rose by **8%** on last year

We handled **4,408** complaints, **8%** more than last year

The number of premature complaints fell to **34%** of our caseload (**6%** less than last year)

People who received advice, support and signposting: **3,192**

Number of cases decided following detailed consideration pre-investigation: **685**

Complaints fully investigated: **894** with 895* publicly reported to parliament

We made **1,197** recommendations for redress and improvements to public services (**19%** more than last year)

The overall rate of upheld complaints was **50%** (up from **46%** last year)

* Some of the cases published in 2013/14 will have been handled in 2012/13. In a small number of cases we do not put information in the public domain, usually to prevent the possibility of someone being identified.

Casework performance

Investigations

We gave our decision by letter in 850 cases, compared with 895 in the previous year. We also published 44 full detailed investigation reports, the same number as the previous year.

Upheld complaints

Of all the complaints that were 'fit for SPSO' (i.e. ready for us to look at and about a subject that we could look at), we upheld or partly upheld 50%, up from 46% in 2012/13. 'Upheld' includes fully and partly upheld complaints. Much of the rise was due to small increases in upheld complaints in the two sectors about which we receive most complaints, local authorities (up 2% on last year to 49%) and health (up 3% on last year to 55%).

As we reported last year, we have been working with a number of individual organisations that we identified as having both high volumes of complaints reaching us and high uphold rates after investigation. Having analysed the reasons for these last year, we are continuing to work with a small number of those organisations where we feel a greater focus on good complaints handling will help them reduce both the volume of complaints and their uphold rates.

We uphold complaints wherever we find fault, even if this has already been recognised by the organisation. We do this to recognise the validity of the complainant's experience. People come to us for an external, independent judgement about what happened and if we find that something went wrong it is important for the complainant that we acknowledge this. We also include in our reports how the organisation responded to the original complaint and any action that they took, or plan to take, to put things right. Where an organisation has responded well, while we will uphold the complaint, we may also publicly commend them for acknowledging the mistakes that happened and the action they took to resolve this for the complainant, and we are unlikely to need to make recommendations.

"People come to us for an external, independent judgement about what happened and if we find that something went wrong it is important for the complainant that we acknowledge this."

Casework performance information for 2013/14 is available on our website at **www.spso.org.uk/statistics**

Casework performance

Sharing learning

Our reports are intended to raise wider public awareness and support learning. Full detailed investigation reports have particular potential to do this and we take care to highlight them in our e-newsletter. As is the case each year, the majority of these are about the health sector, usually because of the severity of the individual injustice or because there was a particular issue we wanted to highlight. In 2013/14, these issues included mental health, pressure ulcers, care of vulnerable adults, barriers to prisoners accessing the NHS complaints process and record-keeping. We will give more detail of these in our dedicated health complaints report later this year.

We also published two detailed reports about a water industry licensed provider because we identified serious systemic issues in their complaints handling. We published one report about the tendering process for a ferry route, where we recommended that as a matter of urgency the government agency responsible continue to look at measures to reduce weather related ferry cancellations and to increase the reliability of the route for passengers. Finally, we published a report about a commissioner's handling of a complaint about the actions of a councillor.

There is much more about how we share learning in the next chapter on 'Impact'.

Timescales

Clearly, the time taken to handle complaints will vary significantly from case to case, depending on the level of advice, resolution work or investigation required. We have, however, set average timescales for staff to work towards in these different areas, which we publish on our website. Despite the increase in case volumes, we met two of our three internal timescales, as detailed below:

- **PI-1 99%** (target: 95% of advice stage complaints handled within 10 working days)
- **PI-2 70%** (target: 95% of early resolution complaints decided or moved to more complex investigation stage within 50 working days)
- **PI-3 96%** (target: 95% of investigation complaints decided within 260 working days)

We anticipate that the pilot described earlier and other initiatives underway will enable us to make progress against our second internal performance measure in the coming year.

We publish reports of almost all of our investigations online and they are searchable at **www.spso.org.uk/our-findings**

Casework performance

Quality of service and decisions

We have an internal forum that considers all the information we receive about our service, to ensure that we are learning and improving as a result of what users are telling us. The forum meets quarterly to consider the various sources of intelligence: quality assurance, reviews of decisions and customer service complaints. It shares learning and recommends and implements improvement initiatives. We publish statistics on our website about reviews of our decisions and customer service complaints about SPSO, and we share key findings, areas for improvement and good practice, both with individuals and across our office for wider learning and development.

On customer service, research we have carried out previously tells us that people need us to listen properly to their concerns and be empathetic. They want us to be upfront with them about what we can and cannot achieve, and provide information in plain English and by the means of communication they want. Once we take a complaint on, people expect us to use our investigative skills to make an independent, impartial examination of anything that went wrong and make recommendations to put things right. Whether or not we find in their favour, people should be satisfied that we have heard their concerns, considered the evidence and carried out a thorough investigation.

Quality assurance (QA)

In addition to senior level review of decisions, we ensure quality through our QA process. This is a constantly evolving tool and our current process involves randomly testing a 10% sample of our work at different stages in our process. We look carefully at the lessons from each quarterly QA review, and this helps us determine our focus for each year. In 2013/14 we concentrated on reviewing and expanding the criteria we use and linking more closely with our customer service standards.

We did not change any decisions following QA in 2013/14. We did give careful, closer consideration to a small number of decisions and found some instances where we could have given a clearer explanation or where we could have obtained more evidence to support our conclusions. We were, nevertheless, satisfied with the decision reached in these cases. Senior staff thoroughly examined any case that raised such questions, involving the staff member who considered the complaint in order to share in a positive way any learning identified.

We also identified many examples of good practice, which we always highlight in our quarterly reports, to celebrate the good work of colleagues and to demonstrate what we should aim for.

In 2014/15 we will further develop our service standards so that they more clearly express the link with our QA process, so that our customers, other stakeholders and staff know what should be expected when they are in contact with our office.

"Whether or not we find in their favour, people should be satisfied that we have heard their concerns, considered the evidence and carried out a thorough investigation."

Casework performance

Reviews of our decisions

We also carefully analyse requests for reviews of our decisions to check that we are getting things right and take action in any where we have not.

Before we issue a decision, wherever possible we phone complainants to explain our decision and give them the option to discuss it with us. When we send a decision letter, we remind complainants and organisations that they can ask for a review if they think there is new evidence about the complaint, or that there are factual inaccuracies in our decision. This is a process we set up ourselves, which is non-statutory (i.e. we are not required by law to have it). It includes decisions not to look at a complaint, as well as the decisions we give after an investigation.

When people ask us for a review, they are disagreeing with our decision. However, we often find that the information they provide does not fall within our criteria for a review. Even so, their request may give us the opportunity to address their concerns about what we have said and, in some cases, to provide further explanations about our powers and the reasons for our decisions. This also helps us feed back to our staff how they could have communicated a decision more thoroughly or clearly.

In 2013/14 we received 260 requests for review (5.7% of our caseload) and closed 276 (some cases received at the end of 2012/13 were dealt with in 2013/14). We changed the original decision in five of these. In these cases we either did not feel we had enough evidence to reach the original conclusion, or felt we could have exercised our discretion to consider the complaint. We re-opened eight complaints in light of new information received (i.e. entirely new and relevant information that we did not have during the original investigation).

We have a separate process for full detailed investigation reports. Before we publish the final report, we send the complainant(s) and organisation involved a draft copy and ask for any comments.

All our decisions are subject to judicial review. There were, however, no judicial review challenges in 2013/14 by either complainants or public organisations (this has been the case since 2007).

Customer service complaints

We have a separate process for people who are unhappy with our service. This is our customer service complaints scheme, which is also non-statutory. It has two internal stages, followed by referral to an external Independent Service Delivery Reviewer (ISDR). We report on complaints about our service in more detail in a later chapter, where the ISDR also provides a report of his findings. We share the learning from these complaints internally and publish reports on our website to assure our customers that complaining to us does make a difference and to let them know what we have done to address any failings that are identified.

"We share the learning from these complaints internally and publish reports to assure our customers that complaining to us does make a difference and to let them know what we have done to address any failings that are identified."

Casework performance

Stakeholder involvement

Customer sounding board

We want to involve the public in helping us improve our service and with this in mind we set up a customer sounding board which met for the first time in December 2013. Members are representatives of different public service user groups including:

- Age Scotland
- Alliance Scotland
- A prison visiting committee
- Citizens Advice Scotland
- Consumer Futures
- Patient Opinion Scotland
- Scottish Independent Advocacy Alliance
- Tenant Participation Advisory Service Scotland

We welcomed the sounding board's input on the information we give customers about our service and on initiatives such as our proposed revised service standards. The sounding board also discussed more general themes such as social media and other routes for feedback and complaints; people's experience of health and social care integration complaints pathways; the Scottish Welfare Fund and prisoner access to complaints processes.

We also discussed different ways in which organisations gather feedback from service users. This ongoing conversation is proving very useful as we prepare to issue our next survey to users of our service in 2014/15.

Impact

This section outlines what we have done to ensure that the outcomes of our consideration of complaints, in particular our recommendations, were relevant, joined-up and drove improvements in public services. We highlight how we used communication channels to ensure accessibility and how we developed new ways to help us hear from our stakeholders.

Sharing strategic lessons

Through our recommendations we try to fix things for people and ensure that public authorities learn lessons from complaints and monitor improvements. While it is ultimately for the organisations themselves (supported and driven by regulators and other improvement and scrutiny bodies) to bring about change on the ground, our recommendations represent significant tools that can help make that change.

We see our role as identifying failings and making recommendations that put organisations back on the right track. We see it as the role of other scrutiny bodies to regularly review processes and ensure that organisations stay on that track. To put it another way, our investigation is a red flag that makes the organisation sit up, take notice and make changes; regulators and other improvement and scrutiny bodies carry out green flag checks in a continuous and systematic way that show that the organisation is acting properly.

There are three main ways in which we share learning:

- putting information, including analysis and trends, into the public domain;
- working alongside regulators and other improvement and scrutiny bodies to ensure that people's concerns are fully addressed and do not fall between the cracks; and
- encouraging regulators and other improvement and scrutiny bodies to build key aspects of good complaints handling into their work where possible to help drive a valuing complaints culture across the public sector.

Providing information

We share learning from the complaints we see through:

- publishing a significant volume of decisions and statistics about sectors and individual service providers on our SPSO website
- e-newsletters, sectoral reports, annual letters and our Valuing Complaints website
- consultation and inquiry responses
- providing written and oral evidence to parliamentary committees and others
- participating in working groups
- conferences, meetings, presentations and visits.

In a later chapter we describe how the new requirement on public sector organisations to publish consistent complaints data will support improvement.

Maximising the impact

We are keen to strengthen links with regulators and other improvement and scrutiny bodies and we recognise the value of our different roles. An example of the inter-relatedness of our work was highlighted in our April 2013 commentary about the care and treatment provided to a young man before he committed suicide. The **Mental Welfare Commission for Scotland** (MWCS) had conducted a review into the man's death and used the case to raise broad concerns about how services respond to young people with multiple problems. When we investigated the case, we did so from our specific standpoint of looking at the individual experience of the person who had brought the complaint, in this case the father of the young man.

Given our different roles and remits, the MWCS review and our investigation examined some different areas. However, the two reports complemented one another in many ways, and several of the conclusions were similar.

Impact

Our annual letters provide details of the complaints received and dealt with about a relevant organisation or sector along with premature and uphold rates, compared with the previous year. Organisations use these statistics to help assess and benchmark complaints performance.

In 2013/14 we published eight individual sectoral complaints reports, and we received very positive feedback on their usefulness and user-friendliness. We will be publishing similar reports again this year, building up an increasingly detailed picture of the issues arising within and across sectors.

We have a duty to alert the appropriate authority if we see serious failings and will also do so if our investigation points to the possibility of a systemic issue. In these cases we may pass on information to professional regulatory bodies such as the **General Medical Council**.

We also shared relevant cases with the **Scottish Human Rights Commission**, for example investigations where we found a failure to maintain dignity and respect in someone's healthcare. The Ombudsman sat on the Commission's Advisory Panel that developed the Scottish National Action Plan on Human Rights that was launched in December 2013. He welcomed the plan's emphasis on helping organisations embed a human rights approach in their work.

We worked closely with **Healthcare Improvement Scotland** (HIS) in 2013/14, taking part in their working group looking at new guidance for adverse incident reviews. There are clearly areas of mutual learning in this work. For example, the group noted the significant overlap in the skills required to undertake complaints investigations and to review adverse events, and looked at supporting NHS boards to translate learning into service improvement and to share outcomes across services and boards.

HIS also invited SPSO to be represented on their Healthcare Intelligence Review group. This group will help members share the different types of information they hold to identify the key early signs of problems and help HIS to react promptly to those.

Following the transfer to the NHS of responsibility for healthcare in prisons, we identified some barriers to prisoners raising complaints. In a May 2013 investigation we found that a prisoner had been unreasonably denied access to the process. We were pleased to be able to report that the Scottish Government was being proactive but also commented in our e-newsletter and subsequent evidence to the Health Committee that: *'It is now 18 months since the transfer of responsibility and it is high time that these issues were fully addressed.'* We highlighted the same issues appearing in a different health board in October 2013. And in written evidence to the Health Committee we said that while we appreciated there would be a time lag while problems were ironed out, we would be very disappointed if we were continuing to report on access issues into 2014.

Our arrangements with regulators and others are set out in protocols and MoUs; see www.spso.org.uk/memoranda-understanding

Impact

Driving a culture that values complaints

The key elements that we encourage regulators and other scrutiny and improvement bodies to ensure are built in are:

- clear accessibility and visibility of the complaints procedure and related information. This includes clear signposting and support for those with needs or difficulties in accessing the system, as well as ensuring that real or perceived barriers to complaining have been identified and removed.
- a focus on resolving things early at the frontline, including ensuring apologies are given freely and action taken where things go wrong
- recording all complaints and reporting this regularly in line with model complaints handling procedures or other requirements such as the Patient Rights Act
- learning from service failures, with systems in place to analyse and report on complaints outcomes, trends and actions taken. This would include seeking opportunities to share learning across the relevant sector.
- ensuring that processes are in place to identify and respond immediately to critical or systemic service failures or risks identified from complaints
- strong, visible leadership on complaints from senior staff, including support and training and a recognition of the importance of effective complaints handling to good governance.

Consumer Ombudsman

In 2013/14, we were invited to contribute to the Scottish Government's discussions about consumer protection and the possible creation of a Scottish Consumer Ombudsman. We offered our experience on a range of matters such as a single portal advice centre, common standards of complaints handling, consolidating the complaints handling landscape, financial redress, the pros and cons of recommendations versus binding decisions, how complaints link to improvement, and the role of mediation. The roundtables we attended were also useful for discussing the possible implications of the European Directive on Alternative Dispute Resolution, which requires there to be access to dispute resolution for consumers.

Other areas

We responded to a wide range of other inquiries, work plans and consultations. Given our complaints standards improvement role, and our focus on streamlining complaints processes, we responded in particular to changes that would affect users of public services and their access to complaints. These included section 70 of the Education (Scotland) Act 1980, the Revenue Scotland and Tax Powers Bill, draft standards for the inspection of prisons in Scotland, petitions on whistleblowing and an independent examinations regulatory body, the Children and Young People (Scotland) Bill, proposals relating to the delegation of local authority functions and the Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000, tax management, a guide for board members of public bodies in Scotland and the new housing panel for Scotland.

See our consultation responses at www.spso.org.uk/consultations-and-inquiries

Impact

Tracking and follow-up on recommendations

In 2013/14, we issued 1,197 recommendations on cases we closed (up from 1,003 last year) and while the word 'recommendation' may seem to lack punch, we do drive each one to completion under a rigorous process. We issue each recommendation with a deadline for implementation, and we monitor completion times closely. In 2013/14, of 1,171 recommendations due for implementation, 74% were carried out within the agreed timescale and 98% within three months of the target date.

While we work hard to engage with public authorities to meet the timescales wherever possible, ultimately it is down to each individual organisation to implement the recommendations on a timely basis. There is some variation between sectors in the percentage of recommendations not being implemented on time. There may be structural or operational reasons for this, for example in the way that different authorities take decisions, which can slow down implementation. And in cases where recommendations are more complex, implementation may sometimes take longer than first anticipated.

Where we find that policies and practices are inadequate we can recommend that they are reviewed and changed. We can also have professionals include discussions in their appraisals about failings that we have identified. This happens most often in the health sector. In all cases, we require organisations to provide evidence of implementation, for example:

- copies of the new policy/procedure or review/audit we have asked for, with action plans for implementation, and the outcomes
- documentation showing that the staff training we asked for has been carried out
- proof that credits/payments we have asked for have been made
- copies of apology letters, demonstrating that they satisfy our guidance on meaningful apology.

Where appropriate we will ask one of our independent advisers to assess the evidence as well. This can happen with any of our recommendations, but we do this particularly where we have identified systemic issues. If we find that an organisation has not provided robust evidence, we go back to them until the recommendation has been implemented to our satisfaction.

Examples of recommendations:

- a college review a disabled student's application for a place
- a council meet with a woman to explore her options for rehousing
- a council consider paying a landlord an amount equivalent to one month's housing benefit payment
- a housing association offer a man a redress payment in line with that offered to other neighbours
- a GP practice review a sample of their patient records to ensure that clinical note taking complies with the relevant standards
- a hospital carry out a significant event analysis of the circumstances that led to a man's death, and use this to improve their future practices
- a dentist refund the cost of treatment that a man had to get from another dental practice
- a prison ensure staff are aware of the procedure that should be followed when searching a prisoner's cell
- a water company adjust charges on an account, to credit it with half of the fees that were disputed.

Impact

Using communications tools effectively

We want organisations to learn from their and others' complaints and we make public as many as possible of our decisions and investigations, including the recommendations. This transparency helps hold organisations to account, and the possibility of reputational damage can sometimes be a useful lever for ensuring improvements are made. We are mindful of this in managing press interest in our work. The press are an important facilitator of information about SPSO, and our media reach expanded significantly in 2013/14, most likely in response to journalists' heightened interest in health stories.

As well as making almost all of our decisions public on our website, we have continued to publicise the key learning from them through our monthly e-newsletter which has around 2,000 subscribers. We produce targeted information for different stakeholder groups, and in 2013/14 this included an updated guide for MSPs, MPs and parliamentary staff. We also produced new materials in partnership with Citizens Advice Scotland (CAS) as part of our ongoing project to strengthen our links with advisers and advocates. We developed a guide to all our key information leaflets for CAS bureau managers and an e-learning module about the SPSO for bureau staff and Patient Advice and Support Service advisers. This material is also available through the Scottish Independent Advocacy Alliance.

We recognise that people increasingly use social media and digital services to access public services and we continue to measure and monitor the impact and value of our online services. We use Twitter regularly and our followers increased by 130% in 2013/14 compared with the previous year.

In the final quarter of the business year, we visited a number of prisons and were able to assess the visibility and usage of our printed and audio materials. We are now working to make further materials available to ensure we are as accessible as we can be, especially for people who have low literacy levels. This project is part of our continuing aim of raising awareness among hard-to-reach or typically excluded users and potential users of our service.

Listening to stakeholders

We now have three sounding boards through which we seek stakeholder views. As we highlighted in the casework section, we set up a customer sounding board whose members include representatives of advice, advocacy and support groups. One of the projects we are discussing with them is how to gather user feedback on our service in preparation for our next customer survey.

In 2013/14, our NHS sounding board met twice, after its inaugural meeting in March 2013. It is made up of senior NHS professionals from across Scotland, including representatives of chairs of boards, chief executives, medical and nursing directors and complaints handlers.

A new local authority sounding board was also set up, following a joint invitation from the chair of SOLACE (local authority chief executives) and the Ombudsman. Members include representatives of SOLAR (local authority lawyers), ADES (directors of education), ADSW (directors of social work), heads of planning, CIPFA (accountancy in public service), the Improvement Service and the chair of the local authority complaints handlers network.

The sounding boards allow for frank, two-way discussions about our role and effectiveness. They help us listen to where we can improve our service and provide a constructive environment for discussion and better understanding of issues relevant to each area, away from the consideration of individual cases. They meet two to three times a year and details of membership and minutes are on our website.

Case Studies

This is a selection of case studies from investigations we published in 2013/14. Some illustrate the double injustice that can happen when a poorly delivered service is compounded by poor complaints handling. Other case studies are included to show some of the positive actions that organisations take in response to complaints. To share this good practice, in the report on our website we normally highlight where an organisation has taken such action. Still other case studies summarised here are included as examples of where organisations have delivered a service and investigated the complaint properly.

Health: dementia; capacity for decision-making

A 55-year old woman, who has since died, was often in hospital. She had learning difficulties and dementia and could not make her own decisions. Although she didn't have a formal welfare guardian, she had an independent advocate to help protect her rights. In 2011, the woman was in hospital several times. She couldn't feed herself, and was fed through a tube. Hospital doctors decided that she should not be resuscitated if her heart stopped, and staff decided to remove her feeding tube during one admission to hospital. The woman died later that year, and her advocate complained to us about these decisions.

We found that the decision to stop feeding was taken before the woman's dementia status was assessed, and was unreasonable. The medical records did not support some of what the board said about the background to that decision. The doctor in charge had the final say on the resuscitation decision, but no-one spoke to the advocate or the woman's carers about it to explain it or find out what she might have wanted.

The board have made several positive changes since this happened. However, we were very concerned about how they decided about treatment and how they dealt with the woman's decision-making capacity. They knew they were dealing with a very vulnerable person, but there were significant delays in acting on legal safeguards that should have protected her. We recommended that the board use the woman's case to review their practices when caring for patients with learning difficulties and suspected dementia, particularly in decision-making. We also asked them to improve their record-keeping in a number of areas. Because of our concerns, we highlighted her case to the Mental Welfare Commission for Scotland.

Case **201104966**

Case Studies

Local government: additional support needs in school

When a child with severe and complex additional support needs was enrolled in a school, the enrolment process and the child's experiences at school meant there were real challenges for everyone involved. An advocacy worker complained on behalf of the parents about some of what the school had done. The council eventually accepted that some actions had been unreasonable, and upheld some of the complaints. We looked at how the council had handled this, and found that they had taken far too long, had not apologised and hadn't told the parents what had happened as a result of these complaints. We said they should apologise for this, and review their complaints handling process. We also said they should look at any learning – including on equality and diversity – arising from the complaints, and review how they handled them to find out why such serious issues were not upheld earlier in their complaints process.

Case **201205187**

Health: ambulance; patient transfer, complaints handling

A man, who had been out for a drink with friends, fell downstairs at home. His wife found him unconscious and finding it very hard to breathe. When an ambulance arrived she said the crew didn't seem to want to take him to hospital and she overheard them talking about 'drunks'. She said they only took him because his blood pressure was low. The crew transferred the man to a wheelchair to take him to the ambulance. He ended up paralysed, and his wife thought that this had something to do with the way the ambulance crew transferred him.

We couldn't say whether what the ambulance crew did had any effect on what eventually happened. But we found that once they realised how he had fallen, and that he had been unconscious, they should have immobilised him as soon as possible, and they didn't do that. The ambulance service's response to the complaint also didn't reflect the seriousness of this allegation, and it seemed from this that the staff involved weren't interviewed. Much later, we were told that one of them had in fact left the service and the other had been disciplined. We were very concerned that the service did not send us all the information at the start, and that they gave us the missing details so late. We said they should have their complaints process externally audited to make sure it was fit for purpose. We also said they should apologise to the man and his wife because he wasn't properly immobilised and because of their poor investigation.

Case **201301204**

Case Studies

Higher education: appeals processes

A student appealed his academic results saying that in the circumstances there were good reasons why he had not done well. His appeal was partly upheld, and his student representative then asked for a review of that decision. This was refused as the university said that his evidence was not valid, so the student could not continue his studies. We found that the university had not taken into account all the information that would have provided a complete picture of the student's circumstances and given his appeal fair consideration. We said that they should apologise for this and reconsider his appeal.

Case **201304371**

Housing: right to buy

A man and his father exchanged their rented houses. The man then found that he couldn't buy his new home through the right to buy scheme, as the scheme was suspended before he exchanged. He also found out that the suspension had since been extended for a further ten years. The leaflet the housing association gave him when he exchanged did not mention the suspension at all. It said that although one type of right to buy would be lost when the properties were exchanged, someone in his position would qualify for the modernised right to buy scheme. As the association could not show that they had told the man about the suspension, we upheld his complaint, and also thought that they could have alerted him to the possibility that the suspension might be extended. We said that they should apologise and consider making him an ex-gratia payment. We also said they should make sure that all of their paperwork is correctly updated, and that staff understand what they should tell people.

Case **201300633**

Transport: ferry routes

An action group were campaigning for a frequent, safe, reliable vehicle and passenger ferry service. Transport Scotland had tendered for that service and had awarded a six year contract on a passenger-only basis. The action group felt the service provided was inadequate, and pointed out evidence of significant numbers of cancellations and of a considerable drop in passenger numbers. We looked at the tendering process in detail, including a European Commission decision on state aid for ferry services. We did not find anything wrong in the process and did not uphold the complaints. However we recommended that Transport Scotland urgently look at ways to reduce the number of cancelled ferries related to weather conditions, and to increase the reliability of the route for passengers.

Case **201202798**

Case Studies

Prisons: visits from children

A man arranged for his children, who were 16 and 15, to visit him in prison. When they got to the visit room, they were not allowed in and were told this was because they were not with an accompanying adult (a person over 18). The man complained that the prison allowed them to book in for the visit, have their identities checked and go through the metal detector before being told that they both needed to be with an adult. The younger child had been searched during the process, and had told staff then that the adult accompanying her was her older brother.

The prison policy said that a person under the age of 16 would not be allowed in unless they were accompanied by a person who was at least 18. Mr C's younger child was, therefore, not accompanied by an appropriate adult, according to the prison policy, and was searched there without an appropriate adult being present. After we asked the prison service about this several times, they confirmed they did not have a specific national policy. They also checked on local policies and found that prisons were not operating consistently, with some allowing the accompanying adult to be 16 or over, and others 18 or over. We said they should explain what they had done to put a consistent policy in place, consider discussing this with Scotland's Commissioner for Children and Young People and, once they had a policy, take immediate steps to make their staff fully aware of it.

Case **201101687**

Water: billing and charging

A man rented an industrial unit, which had a water meter. He told us he heard nothing about water charges until he got a bill reminder about four months after moving in. He said he hadn't received the bill and in any case the meter number and reading were wrong. The water company said they would investigate, and eventually sorted this out, but only after he had chased them about it for nine months. A debt recovery agency also tried to get payment for the disputed amount from him, even though his account was meant to be on hold. We couldn't see why this was so difficult to sort out. The water provider had not followed this up, and only did so when the man contacted them. They had already reduced his bill because of the delay but we didn't think that they reduced it enough in the circumstances. We recommended a further payment, an apology and that they send us evidence of what they had done to stop this happening again.

Case **201204157**

Case Studies

Local government: antisocial behaviour

A couple were having problems with their neighbours' behaviour. Their sleep was often disturbed and they were worried about the safety of their family and property. They complained to the council about their neighbours but were unhappy with the way their complaints were handled.

We found that the couple had complained about this for nineteen months. The council had recorded a number of the incidents, and had taken action after the first few, but didn't follow up on later complaints. The couple had kept a diary of what happened, but the council had not followed up on this either. It was clear from what we saw that the council knew things were getting worse but they took several months to get it sorted out. They didn't tell the couple what was happening and didn't respond to their complaints properly. We said they should apologise to the couple, and that they should make sure their staff know what to do in cases of antisocial behaviour, what records they should keep and the importance of replying to complainants quickly.

Case **201200725**

Housing: repairs and communication

A woman told us it took too long for her housing association to fix damp and drainage problems. She had contacted them many times on behalf of herself and her neighbours and felt she wasn't getting anywhere. The association had told her that the problems were significant, and they'd found it difficult to provide a timescale for fixing them as they had to investigate in detail. They'd accepted that they could have communicated better, offered her a voluntary payment as an apology, and explained that they'd introduced a new customer care centre to improve communications.

We found that it took around nine months for the problems to be addressed, but the association had clearly been working on this during that time. The problems were considerable and affected the whole building. We agreed that these were exceptional circumstances, and that their actions about the repairs were reasonable. On communication, although their responses became more helpful as work progressed, we upheld this complaint as sometimes the woman had to ask for information rather than this being provided as it should have been.

Case **201204216**

Case Studies

Health: prisoner access to complaints process

A prisoner was unhappy with how his complaints about his healthcare were treated. He had sent the board a lot of feedback forms and a complaint form. We found that the board's complaints handling had been poor and said they should apologise for this.

Of even more concern, however, was a wider issue – we found that prisoners' access to the complaints process was restricted. Although the board said that they thought forms were available to those who wanted to complain, and that prisoners could write directly to the board with a complaint, we found that prisoners normally had to complete a nurse referral form, then ask for a complaints form. Even then, they sometimes only received a feedback form, unless they said that they didn't want one. This meant that in some cases the feedback process was used as an extra level of the NHS complaints process. NHS users don't have to complete a feedback process before accessing the complaints process, and it should be the same for anyone in prison. We recommended that the board make sure that prisoners could in future have easy access to NHS complaint forms.

Case **201203374**

Health: fertility treatment

We heard from a couple who'd had an unsuccessful first cycle of fertility treatment. They thought they'd be offered a second cycle, but the health board decided not to do so. There had been some delay in starting the initial treatment, and by the time we saw the complaint, the opportunity for more treatment by the board had gone. Although we decided that the decision not to provide the second treatment was within NHS guidelines, we criticised the way in which the couple were given information about the criteria for treatment. We also criticised the delays in the process. We decided that the only meaningful way to provide redress was to recommend that the board make a financial payment for the amount that another cycle of treatment might cost, should the couple seek treatment elsewhere.

This was an unusual recommendation and we made it knowing that the NHS is not required to fund every available treatment. We recommended this because of a combination of very particular factors – the delays, the time-limited nature of the medical procedures, and the specific personal circumstances of the people concerned.

Case **201200390**

Complaints Standards Authority

Key steps 2013/14

Transforming the complaints culture

A simple, standardised complaints system for the public sector

This section outlines how we have made a difference in simplifying and improving how complaints are handled by public service providers. This includes the key achievements of our Complaints Standards Authority in 2013/14. The CSA undertakes the statutory duties given to SPSO following the Crerar and Sinclair reports, which recommended improvements to the way complaints are handled in Scotland. In line with these, we have led the development and implementation of standardised complaints procedures. We have also continued to fulfil our duty to monitor, promote and facilitate the sharing of best practice in complaints handling through:

- supporting public bodies
- coordinating networks of complaints handlers
- developing and sharing best practice
- high quality training.

We want to make sure that complaints procedures are simple and clear. When there are proposals to change how services are delivered or how people can ask for a decision to be looked at again, we draw on our experience of the complaints people bring us. We provided input into several areas in 2013/14. The key ones are listed below and expanded on at the end of this section:

- health and social care integration
- review of social work complaints procedures
- Scottish Welfare Fund
- Scottish Tribunals and Administrative Justice Advisory Committee.

Complaints handling procedures (CHPs)

In 2013/14, more of the public sector implemented the standardised model CHP. Like our previous work with local authorities and registered social landlords (RSLs), we adopted a partnership approach and consulted with working groups of sector representatives to develop these. The successful implementation of these CHPs means that Scotland's colleges and universities and over 70 organisations in the Scottish Government, Scottish Parliament and associated bodies sector are following the same complaints system.

The NHS already have a standardised process in place under the revised *Can I Help You?* guidance, published by the Scottish Government in March 2012. In April 2014 the Scottish Health Council published a report[1] on feedback, comments, concerns and complaints about the NHS. It recommended that the CSA should lead on the development of a more succinctly modelled, standardised and person-centred complaints process for NHS Scotland. We are considering the report and the way in which this and other SPSO-related recommendations can best be taken forward.

While there are minor sector-specific differences, the model CHPs in place in each sector contain the same key elements. This means that for the public there are, generally, consistent, simple, accessible and timely procedures in place. We are confident that we have helped achieve, as far as we can, the Sinclair report's vision of a simplified, standardised complaints procedure operating across the public sector. Full alignment, however, will be subject to further legislative changes in a number of areas including social care and social work, which we discuss further below.

1 http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx

Transforming the complaints culture

Ensuring that the complaints procedures work

In carrying out our duty to lead on standardising CHPs we decided at the outset to involve regulators and scrutiny bodies. We were keen that reporting and monitoring of complaints should form part of the other information that public service organisations are obliged to provide. We therefore developed arrangements with Audit Scotland, the Scottish Housing Regulator and the Scottish Funding Council to ensure that compliance with CHPs is monitored as part of regular scrutiny activity.

Organisations are required to self assess and we provide tools to support them in doing this. We have, however, also carried out additional monitoring work on compliance and have been pleased with the overall results. In 2013/14, we looked at the first two sectors to implement model CHPs – local government and RSLs. We informally sampled the accessibility of local authority CHPs and we tested CHP compliance across a random sample of RSLs. The outcomes were positive and we found the vast majority to be compliant, subject to minor amendments which have now been made. We discussed any concerns with the organisations themselves and with Audit Scotland and the Scottish Housing Regulator who were content with our approach to monitor ongoing improvement before initiating any compliance action.

We provided particular support to the Scottish Prison Service, through participating as observers in an SPS internal audit of complaints handling arrangements. We welcomed the opportunity to observe complaints handling in prisons and offer our advice and expertise on various aspects of how complaints are handled including compliance with the complaints handling provisions of the Prison Rules, which were developed in line with key CSA principles.

The health sector is slightly different, as the Patient Rights Act requires NHS boards to produce an annual report on their use of feedback, comments, concerns and complaints. Boards published their first reports for 2012/13 and the Scottish Health Council reviewed[2] these, comparing how boards responded to the new requirements and identifying potential areas for improvement in future reporting.

Reporting and publicising complaints handling performance

Under the model CHP, organisations have to publish annual complaints statistics and learning against performance indicators. 2013/14 will be the first year for which relevant organisations publish clear, transparent and consistent complaints information.

We carried out some sample monitoring of this during the year in the sectors already fulfilling this requirement (local authorities and RSLs). Again, we were pleased that the vast majority of organisations had measures in place for internal management reporting. However, in some cases this did not follow through to externally publishing the outcomes of complaints. Where we identified problems, we provided support and guidance. We appreciate that this level of reporting is new for most organisations and that there may be some issues early on.

> "We were keen that reporting and monitoring of complaints should form part of the other information that public service organisations are obliged to provide."

2 http://www.scottishhealthcouncil.org/publications/research/review_of_nhs_feedback.aspx

Transforming the complaints culture

The respective complaints handlers networks for each sector discussed our findings, including what worked well and areas for improvement. The results were also discussed with Audit Scotland and the Scottish Housing Regulator who were content with our approach to ongoing monitoring of this requirement.

The performance indicators were developed in partnership with the networks and are designed to be broadly consistent across the sectors. We are continuing to support the networks in their discussions about how performance indicator information should be presented and benchmarked. The aim is to move towards a greater consistency of reporting on complaints and provide a basis for comparing performance and supporting ongoing improvement.

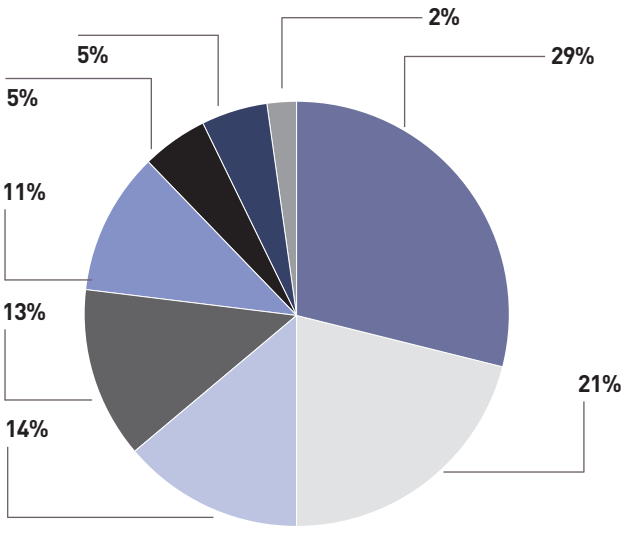
Advice, support and guidance

A key aspect of our role is to work closely with service providers, regulators and other stakeholders to offer advice, support and guidance about the model CHPs and effective complaints handling. Throughout 2013/14 we continued to provide this support across a range of issues. Many were straightforward requests, but others required detailed advice, guidance and follow-up contact.

Stakeholder enquiries

In 2013/14, the CSA responded to over 900 stakeholder enquiries. As we anticipated, there was a shift in the source of the requests, reflecting the stage of each sector in implementing its model CHP. Many requests were about implementation, although the fact that the local government sector continues to provide the majority demonstrates that there is an ongoing need for advice on wider aspects of good complaints handling.

CSA contacts 2013/14



CSA ENGAGEMENT AND SUPPORT	TOTAL	PERCENTAGE
Local government	265	29%
Scottish government agencies	190	21%
RSLs	124	14%
Higher education	121	13%
Further education	102	11%
NHS	43	5%
Other	41	5%
Members of the public	22	2%
Total	908	100%

Transforming the complaints culture

Meetings, events and conferences

We provided speakers at a total of 70 conferences, meetings and events throughout the year. In doing so we provided direct support and advice to individual bodies across all sectors. We also engaged stakeholders at a number of cross-sector events and conferences, including by speaking at various national complaints conferences.

Our presence at these events allowed us to add value in several ways. This included:

- providing expert advice and guidance on implementing the requirements of the model CHPs
- explaining the need and value of reporting of complaints performance and learning outcomes
- illustrating ways in which the consistent reporting of data will allow for benchmarking of performance across sectors
- re-emphasising the governance requirements within the roles and responsibilities of senior staff in complaints management.

Overall our outreach activity has helped to continue the focus on improving the complaints culture amongst public service providers.

Reflecting the interest in the progress of our complaints improvement work, we were invited to speak at events in England to share our expertise in simplifying and improving complaints handling, including an Academic Registrars Council event for higher education complaints handlers and a conference of national health and social care managers.

Valuing Complaints website and online forum

In 2013/14 we continued to facilitate the sharing of knowledge and best practice in complaints handling through our dedicated CSA website, which provides:

- information on the CSA and the statutory basis for its work
- the model CHPs and implementation guidance
- good practice guidance on complaints handling and links to relevant sources of information and best practice in complaints handling
- an online community forum for discussion and sharing best practice in the professional complaints handling community, both within and between sectors
- the SPSO training centre with access to our e-learning resources and information about courses.

Resourcing constraints meant that we could not develop the website and forum as much as we intended to in 2013/14. We want complaints handlers to use the website as a central information point, and in the coming year we will be asking them how they would like this work to be taken forward.

The CSA website is at www.valuingcomplaints.org.uk

Sharing best practice

Networks of complaints handlers

The aim of the networks is to share good practice, develop tools and guidance, support complaints handling practitioners and provide a forum for benchmarking complaints performance information. The key to their effectiveness is that each network is led by the sector for the sector with SPSO as members. Our role is to help facilitate their development, contribute our expertise and ideas and provide support and advice on aspects of good complaints handling and the model CHPs.

Networks were set up in 2012/13 for local authorities and RSLs. In 2013/14 more were set up in the further and higher education sectors and the Scottish Government established a forum for all complaints handlers within its departments.

Local authority complaints handlers network

This is chaired by North Lanarkshire Council and has over 60 members, including SPSO. This year, all local authorities have been involved in the work of the network, which met four times in 2013/14. It considered a range of issues including feedback on the operation of the model CHP and performance reporting and indicators. There were sessions about the needs of children in the complaints process and the handling of education service complaints. The network considered and shared best practice on learning from complaints. The key theme in 2013/14 was benchmarking, with the Improvement Service leading discussions on how best to align the benchmarking of complaints information with their own benchmarking approach.

RSL complaints handlers network

The RSL network, chaired and coordinated by Queens Cross Housing Association and Castle Rock Edinvar Housing Association, met once during 2013/14 with over 50 housing associations having been involved in meetings to date. As well as sharing good practice, the network looked at how complaints categories could be standardised to help benchmark performance and at reporting complaints performance.

New networks

The further education complaints handling advisory group was formed in the development phase of the model CHPs and is chaired by College Development Network. The group met regularly throughout 2013/14 to discuss the implementation of the new CHP and reporting of information. The group operates as a smaller sub-group of the Quality Development Network Steering Group, inputting to this wider group of all colleges as and when required.

The higher education sector have developed a group of complaints handling practitioners which meets regularly to share best practice in complaints handling. The Scottish Government also set up a network for its complaints handlers, led at Director level. The SPSO will contribute to these groups as and when required.

Outputs

Some of the networks have published specific products, such as standardised reporting templates, lessons learned reports and good practice guides. We commended the further education group for the work carried out by Cumbernauld College, supported and guided by College Development Network, in developing an online complaints handling tool for use by all colleges. This is an excellent example of sharing services, allowing colleges to develop a consistency of recording and reporting across the sector. We welcomed these outputs, which are useful across individual sectors and also support the creation of a cross-sectoral network of complaints handlers.

To join a network, contact csa@spso.org.uk

Training

Classroom courses

In 2013/14 we directly delivered 56 frontline and investigation skills courses, with particular demand from the sectors where new model CHPs were introduced during the year. In new areas we delivered:

- five courses in further education
- nine in higher education and
- nine across a range of Scottish Government and associated public authorities.

We also delivered:

- eighteen courses to local authorities
- seven to housing associations
- four to health bodies and
- four to a mix of organisations.

It was a busy year, but with model CHPs now operating in most sectors, we expect demand in these sectors will slow in 2014/15. We do, however, anticipate demand from the NHS following the recommendations on training made in the Scottish Health Council report *Listening and Learning.*

Our courses continued to get very high ratings from participants and the materials were much sought after, including by other ombudsmen in the UK and overseas.

In addition to the direct delivery courses, we developed tailored materials for GPs and dentists. With the support of NHS Education for Scotland (NES), we created audio case studies as a training tool for practice managers. SPSO trainers delivered workshops on how to use the material to over 200 GP and dental practice managers, who could then use the materials to train their own staff.

We also wanted to reinforce the message about corporate responsibility and complaints. In light of the lessons of the Francis Inquiry, the Ombudsman delivered a series of master class sessions for chief executives and non-executive directors of NHS boards on the role of complaints in good governance. These focused on the importance of complaints and their value as indicators of performance, service quality and risk. NES has a video recording of this session available on its website alongside all the other tools that we have developed for NHSScotland staff.

Classroom-based training for complaints investigators and others involved in complaints handling remains crucial to improving the way that organisations deal with complaints, particularly in reaching the right decisions first time. Along with the new streamlined approach to complaints handling, we expect training to continue to be a significant factor in how we help drive improvements in complaints handling culture and manage the numbers of complaints coming to the SPSO.

E-learning courses

In 2012/13, we developed and launched our first e-learning modules on frontline complaints handling. The aim of these is to help the people dealing directly with the public to feel more confident responding to complaints. The modules in each sector were designed to support staff awareness of the model CHP and good practice in frontline complaints handling. In 2013/14 over 2,500 registered users accessed the modules directly from our website. In addition to this we are aware that many public authorities have adapted the e-learning package for use on their own internal systems. This was ground-breaking work, and, in light of the good uptake rates and positive feedback, we expanded the range of modules into new sectors, adapting them for college and university frontline staff in August 2013.

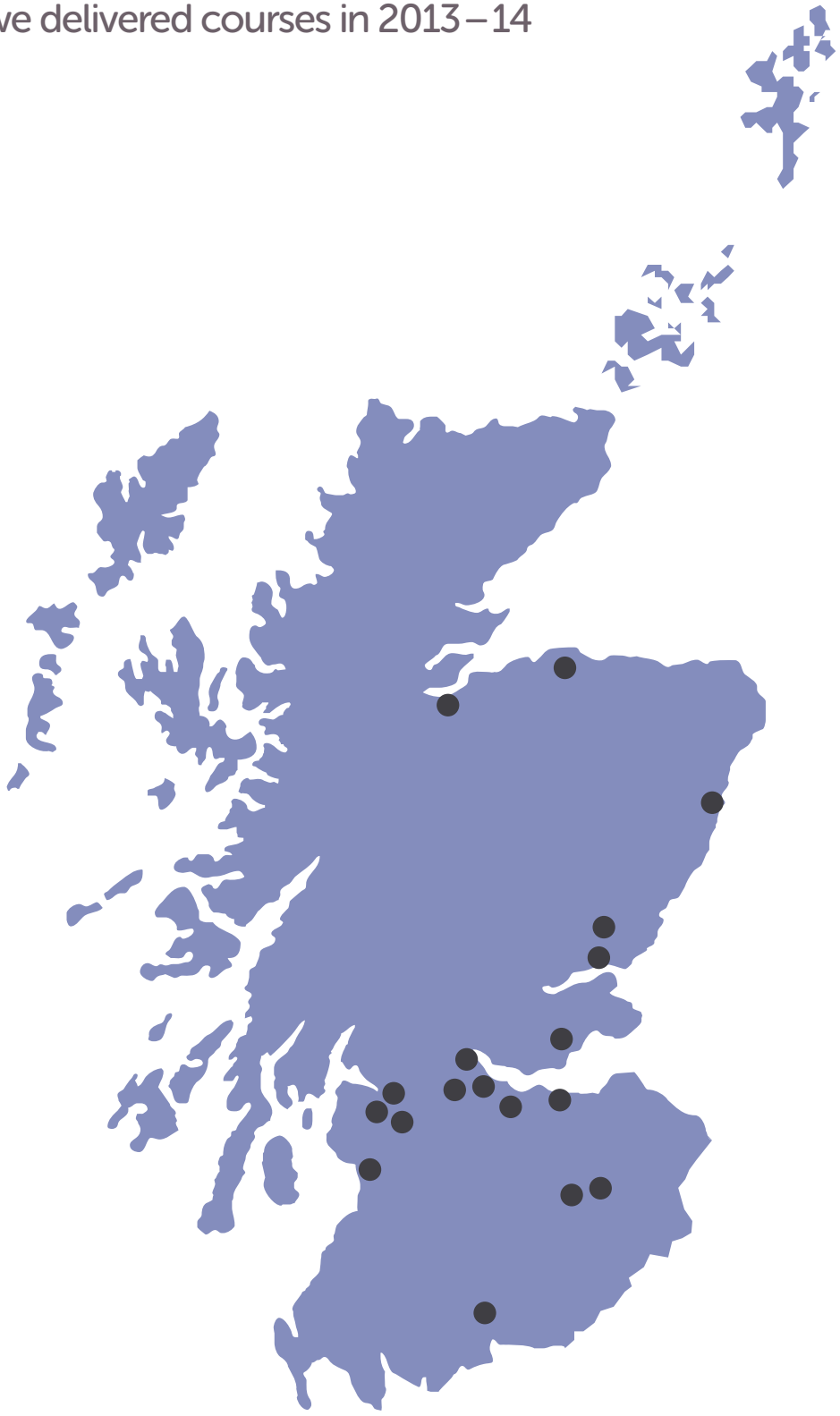
In the health sector, we built on the previous year's work in developing e-learning modules for frontline NHS staff by developing a new e-learning module on investigation skills. It helps participants explore the complaints investigation journey from first receipt through to the final decision. It also covers learning lessons from complaints and includes examples of good practice. We developed this as part of our second year of a programme of activity with NES, and aim to adapt this module for use in other sectors.

Our approach to e-learning has received positive feedback and the e-learning modules for frontline NHS staff have been requested for use by the NHS in England and local authorities in New Zealand.

All our e-learning training materials are free and are available to all public sector organisations.

Transforming the complaints culture

Where we delivered courses in 2013–14



For more about our training activities, visit **www.spsotraining.org.uk**

Transforming the complaints culture

Simplifying the landscape: key areas of policy contribution

Health and social care integration

The integration of health and social care was a key focus for us this year. In our responses to Scottish Government consultations on two areas – self-directed support and delegation of certain local authority functions under mental health and adults with incapacity legislation – we raised the important issue of the need for clarity around complaints. We also highlighted this in our response to the Health Committee's call for evidence about the Public Bodies (Joint Working) (Scotland) Bill.

We were invited to give evidence to the Health Committee at an October 2013 roundtable event about the role of regulators and complaints bodies in relation to integration. We highlighted the need for the complaints route to be clear and accessible to service users, and for there to be no legislative barriers restricting public bodies in their ability to investigate and respond to complaints in a joined-up way.

Social work

Following their review of and consultation on social work complaints procedures, the Scottish Government indicated that their recommended options were those that would see local authorities adopt the model CHP for social work complaints (but with some flexibility around timescales) and the SPSO taking on the role of Complaint Review Committees, with a remit over professional judgement. This was felt to be the most likely to create a fit-for-purpose complaints system for the future. We supported this option, as it fits with the aim of simplifying the complaints landscape in Scotland and will align social work complaints with wider local authority complaints handling, making things simpler for complainants and organisations alike.

In February 2013, the Government's social work complaints working group reached broad agreement on these future options, subject to further discussion on detail. The working group included SPSO, the Care Inspectorate, the Convention of Scottish Local Authorities, the Association of Directors of Social Work, the Scottish Social Services Council and a number of third sector organisations, including Capability Scotland and Children First.

Following the recommendations of the working group in July 2013, in advance of making a decision on this, the Government elected to commission further research on the needs of service users. As we have underlined throughout the lengthy review, consultation and working group process, people using social work complaints procedures are likely to be vulnerable and in need of support and effective, timely decisions. We have also highlighted, on the basis of cases that we have seen, that the current system is failing these vulnerable service users.

Scottish Welfare Fund

The Scottish Welfare Fund (SWF) provides day-to-day living expenses to those on low incomes who are in crisis, as well as providing essential household items to those in need. SWF complaints came under our jurisdiction as part of a two-year interim arrangement in April 2013. The fund is administered by local authorities so the SPSO became the final point for complaints.

The Government consulted on the permanent arrangements for the fund, including the options for review arrangements. Following the consultation, they confirmed their intended policy that the SPSO take on a new role in reviewing decisions. This would mean an unusual extension to our jurisdiction, to include the ability to review and change SWF decisions, and would have a number of consequences, including adaptations to our current remit, processes and procedures.

See our consultation responses at www.spso.org.uk/consultations–and–inquiries

Transforming the complaints culture

The Government's proposal is included in the Welfare Funds (Scotland) Bill. Throughout the consultation on this policy proposal, we have not expressed a view on whether this role should come to us. We have emphasised that the SPSO is a Parliamentary body, and this is a decision for the Parliament to consider in its deliberations on the Bill.

Our consultation response highlights that if we are to take on the role, a number of important issues need to be factored in:

- ***Accessibility, simplicity and timeliness:*** we appreciate that there will be a need to make decisions quickly and to be fully accessible to people who are more likely to be vulnerable and to have complex and multiple needs than the majority of our current service users. Given this vulnerability, any option must be genuinely accessible by them and it will be particularly important that we have the ability to respond quickly.
- ***Reporting and learning:*** it is vital that the system of review can demonstrate that it is impartial and transparent. In line with our current systems for public reporting, we will ensure that we make public the information about our performance, and will publish anonymised summaries of decisions to advise people and agencies who are interested and enable them to learn from the cases we see.
- ***Complaint vs review:*** the proposal would give the SPSO two new powers. These are that we should be able to consider whether the decision is one that should have been made, and to direct the local authority to put in place an alternative decision if we consider a different one should have been made. There are both legal and practical implications of these additional powers.

To prepare for this possible role, we are considering all this with the Government and Scottish Parliamentary Corporate Body, as well as the logistical issues that we would need to resolve to ensure that we meet customers' needs.

Prisons

We responded to two calls for evidence on changes to the role of prison visiting committees (PVCs). In general, we welcomed the proposal to provide lay monitors with a role in complaints handling, building on the existing role of PVCs. However, we said that further clarity is needed to ensure that complaints handling roles are defined well and work together, and that the existing process for handling complaints, particularly that of the prison service, remains the principal avenue through which prisoners can raise complaints. We also said there should be greater clarity on the status of reports and recommendations, and highlighted the importance of transparency of decisions and consistency in what is reported.

Scottish Tribunals and Administrative Justice Advisory Committee (STAJAC)

The STAJAC was established by the Scottish Government in November 2013 to champion the needs of users across the administrative justice and tribunals system in Scotland, to provide external scrutiny of the system in devolved areas and to highlight any issues to Scottish Ministers.

Our head of complaints standards was invited to join the committee to add our experience in improving complaints handling to the committee's advice on developments in the wider administrative justice landscape, including tribunals and other routes of appeal. The committee's workplan focuses on various areas relevant to complaints handling, including the costs of administrative justice and how users can express dissatisfaction within the new integrated system of health and social care. We have continued to emphasise the importance of complaints systems as one of the key routes for service users to access administrative justice and the importance of all administrative justice routes being user focused.

Corporate performance

This section highlights:

- strategic planning and delivery
- improving operational efficiency
- how we support our staff
- statutory reporting
- financial performance

Strategic planning and delivery

In 2013/14, we delivered year two of our 2012–16 strategic plan, which we consulted on and published in March 2012, in line with our legal obligations. The plan sets out our five strategic objectives, which reflect the statutory functions of the Ombudsman. It also contains our equalities commitments, and provides the framework for developing annual business plans and accompanying annual performance measures.

Each year, progress against our strategic plan and annual business plans and measures are reviewed regularly by operational management, the senior management team and the Audit and Advisory Committee. Our business plans for 2013/14 and 2014/15 and performance measures for each year were shared with SPCB officials. All of our plans and measures, along with minutes of meetings to record and monitor progress, are on our website.

Improving operational efficiency

The corporate planning process plays a key role in ensuring operational efficiency and effectiveness. We also use information from external and internal audit to drive efficiency and effectively manage risk. The outcome of the external audit engagement for the year 2013/14 was an unqualified certificate from the external auditors, Audit Scotland.

In 2013/14, as part of the three year internal audit programme for 2012–15, our internal auditors, the Scottish Legal Aid Board, looked at the areas of information systems installation, HR, payroll and absence management, and document management. The auditors raised no issues of significance.

Full external and internal audit reports are available on our website.

We had a strong record of ICT systems reliability in 2013/14. We also continued to improve our case-handling application by automating the transfer of information from our online complaint form into our complaints database. This allows us to process these complaints more efficiently. To further our goal of becoming a paperless office, we carried out a scanning pilot on part of our business and will review the findings in summer 2014. We also installed a SharePoint database, in preparation for introducing an electronic records management system. We developed a Business Classification Scheme for documents and expect the move to the database to be completed by December 2014. These initiatives are designed to improve our efficiency by making it easier to access and share documents.

Corporate performance

Our people

We review our learning and development requirements and deliver training programmes and development opportunities on a rolling basis, to ensure that our staff have the knowledge, skills, tools and support they need to manage and deliver our service. Group training sessions are delivered by a mix of internal and external experts and in 2013/14, this included areas such as capacity and consent; analysing evidence; handling freedom of information requests; and awareness and understanding of mental ill-health.

We obtain external validation of how we support our staff to engage effectively with our goals and meet our service commitments, sometimes in challenging circumstances. We do this through Investors in People (IIP), which recognised us as an Investor in People in March 2011. The IIP carried out their three year review in March 2014 through an independent assessment visit and confirmed that we continue to be recognised as an Investor in People.

We also carried out a staff survey at the end of 2013/14. The results of both the survey and the IIP findings were generally very positive, indicating high levels of job satisfaction, engagement and commitment from SPSO staff. In the staff survey in particular, staff indicated a strong sense of achievement and personal accomplishment and felt supported by the learning and development programmes and robust performance management systems. The IIP assessment highlighted areas for us to focus on in our continuing improvement and we are finalising actions from the staff survey.

The IIP report is on our website and we will publish the staff survey there in summer 2014.

Statutory reporting

Freedom of Information / Data Protection Subject Access

We received 209 requests, review requests and appeal notifications in 2013/14. There were six appeal decisions from the Scottish Information Commissioner against our decision about the information to provide, and three decisions from the UK Information Commissioner's Office.

Environmental and sustainable development

We publish an annual sustainability report, monitoring carbon emissions and waste management activities and in 2013/14 we exceeded the targets set.

"SPSO staff indicated a strong sense of achievement and personal accomplishment and felt supported by the learning and development programmes and robust performance management systems."

For more information, see our website at **www.spso.org.uk/corporate-information**

Corporate performance

Financial performance

We continued our efficiency drive this year, making a 3% decrease against the 2012/13 budget. This was the final year of a three year planned real term reduction of 15% against the baseline budget of 2011/12, which the Scottish Parliamentary Corporate Body asked us to make. Our budget for 2013/14 was £3,207 million.

Costs were reduced as a result of the revenue generated by our training unit and the shared services agreements we have developed (we share our Edinburgh office with the Scottish Human Rights Commission and provide HR expertise to Scotland's Commissioner for Children and Young People).

There is a summary of our 2013/14 expenditure in the table below. We publish information on our website on specific expenditure areas as required under the Public Services Reform Act. We will publish our full audited accounts there, when they have been signed off in October 2014.

Summary analysis of expenditure

	2014 £000s	2013 £000s	2012 £000s
Staffing costs	**2,651**	2,559	2,660
Property*	**309**	293	292
Professional**	**149**	138	166
Office***	**267**	358	324
Total operating expenditure	**3,376**	3,348	3,442
Capital ****	**3**	62	128
Other income	**-154**	-180	-93
Net expenditure	**3,225**	3,230	3,477
Staff FTE	**46**	47	45

* Including rent, rates, utilities, cleaning and maintenance
** Including professional adviser fees
*** Including ICT, annual report and publications
**** Including IT projects

Full audited accounts are available on the SPSO website www.spso.org.uk

"Your incredibly kind, understanding assistance today, does prove that the SPSO's statements regarding access for disabled people are factual, not just lip-service as is so often the case with various companies."

A complainant

"I felt compelled to write to you separately to convey my admiration and respect for the extremely thoughtful, patient and professional way that your staff have supported Mr C throughout his complaints. At each and every opportunity they took time to work out how best to support his needs and where they could make reasonable adjustments for his disability. Their skill and professionalism shone through."

SPSO equalities adviser

"The SPSO decision does not only support my complaint – it also helps any other student with a disability and I am sure I can thank you from them."

A complainant

Equality and diversity

This section explains what we did to fulfil the **five equalities commitments** in our strategic plan in 2013/14. To support this work, we continued to take advice from our equalities adviser, both when looking at the equality elements in complaints we considered and to ensure that our policies and practices comply with equality legislation and best practice in this area.

Living up to our equalities commitments

1 to take proactive steps to identify and reduce potential barriers to ensure that our service is accessible to all.

In 2013/14, we looked specifically at the customer's journey through our process, including how they may want to approach us. We verified that our office is equipped with the right tools for this, for example that it is physically accessible and has induction loop facilities for people with hearing difficulties.

We always ask how people would like to communicate with us. In 2013/14, we made adjustments for 23 people who asked us to adapt our communications with them. We made most of these adaptations for people with learning difficulties – mainly dyslexia – and sight or hearing impairment. For example, we communicated with a man with visual impairment by phone and when we wrote giving him our final decision, we made sure the letter was in the large print he had asked for. We also helped a man who had physical difficulty in writing to make his complaint to us orally. When a woman told us that she had a disability that affects the speed at which she absorbs and responds to information, we made sure that she had extra time to allow her to adequately communicate with us. We provided translation facilities – both on the phone and in writing – for people who do not have English as their first language, and we continued to translate copies of our leaflets into other languages and to provide information in large print.

We took part in an event organised by Independent Living in Scotland, aimed at bringing together disability organisations and scrutiny bodies. As a result, we added a specific performance indicator to our 2014/15 business plan, recognising the importance of involving disabilities and equality groups in our communications work.

We are aware that few children and young people complain to us. As we said in our July 2013 evidence to a Parliamentary Committee looking at a possible expansion of the Children's Commissioner's role in relation to complaints *'It can take both confidence and experience to make a complaint about someone who has power over some aspect of our lives and, while this is difficult for adults, it is likely to be more difficult for the young.'* We welcomed the likelihood that more children and young people may complain to the Commissioner as a result of his expanded role.

We are aware that if we are given a role in carrying out reviews of Scottish Welfare Fund decisions, many of those who might contact us about this will be particularly vulnerable. In June 2014, the Scottish Government carried out an equality impact assessment in advance of the introduction of the Welfare Funds (Scotland) Bill. In it, they noted our approach to equalities planning and monitoring as well as the information and statistics from last year's annual report. They said that they would work with us to highlight the needs of potential applicants as they set up their service, to ensure that equalities considerations are taken into account in service design and monitoring arrangements. This fits with the Ombudsman's stated concern that systems fit the needs of the people using them and allow for us to make decisions quickly.

Given the increasing reliance on online services, we continually improve our website information. In 2013/14, Crystal Mark carried out an independent evaluation of our public website including auditing our accessibility. They gave us some helpful comments, on which we acted, and we continue to display the Crystal Mark on our website.

Equality and diversity

2 to identify common equality issues (explicit and implicit) within complaints brought to our office and feed back learning from such complaints to all stakeholders.

We fed back key learning to stakeholders through a range of tools, most prominently the Ombudsman's monthly e-newsletter. In 2013/14, we published sectoral reports for the first time, highlighting trends and issues.

We also play a part in ensuring that, in their policies and practices, organisations reflect the obligations they have under the Equality Act 2010. Equality issues and human rights issues are, of course, often interlinked and during 2013/14, we identified 24 cases in which human rights were potentially an issue.

Matters to which we drew attention to in 2013/14 included:

- a lack of awareness, understanding or meeting of the requirements of the Adults with Incapacity (Scotland) Act, particularly in health boards. For several years this has been, and remains, an all too frequent concern that we regularly highlight. In one example, a family only learned that a Certificate of Incapacity (which says that a person is not capable of deciding about their own medical treatment) was in place when they asked for a copy of their mother's medical records after she died in hospital. Staff had not discussed this with her family, or asked if any of them could legally decide matters for their mother.
- prisoners with less equality of access to the NHS complaints system than other NHS users. The Ombudsman had already raised this issue with the Health Committee, after which the Scottish Government wrote to health boards reminding them of the process.
- the use of restraints on a prisoner, escorting a disabled prisoner and prisoner diet
- failing to protect children and young people from bullying, or to provide them with additional support for learning
- failings in the way a prison treated children visiting their father in prison.

There are further examples of some of these issues in the case studies below.

3 to ensure that we inform people who are taking forward a complaint of their rights and of any available support, and that we encourage public authorities to do the same.

It is important that we not only tell individuals what their rights are and where they can take issues, but also those who may represent them. When we became responsible for handling complaints about the Scottish Welfare Fund in April 2013, we developed new communications for advisers and independent advocates about our role and process. These explained what people could expect of the new process and of us, and where else they might find help if the problem was one we couldn't help with.

During the year we worked to explain our role and provide support to various organisations and groups that represent or help people, including the Children's Commissioner, Citizens Advice Scotland, Patient Opinion (an independent feedback platform for health service users) and RespectMe (which provides guidance to public authorities on anti-bullying policies, and advice to those affected by bullying). Our customer sounding board includes members representing advocacy and advice organisations.

In our communications in 2013/14, we again used our decisions on complaints to point out to organisations examples where people had not been given their rights. Examples include the failure of a health board to apply the Adults with Incapacity legislation in the case of a man with dementia, and of a college to properly advise and support a young man with learning support needs.

4 to ensure that we play our part in ensuring that service providers understand their duties to promote equality within their complaints handling procedures.

When developing standardised complaints handling procedures, we helped organisations understand how to meet their equality obligations by building in fair and equal treatment from the start. The model CHPs require organisations to take their equalities obligations into account, especially in pointing out the need to make reasonable adjustments where necessary.

Now that the model CHPs have been rolled out across the public sector, the main way in which we meet this obligation is through ongoing discussions with and support for public organisations through the complaints handlers networks. Guidance[3] on our Valuing Complaints website explains some of the implications of the Equality Act for the public sector, particularly in terms of fair and equal treatment in complaints processes.

5 to monitor the diversity of our workforce and supply chain and take positive steps where under-representation exists.

We are committed to supporting the diversity of our workforce. Although we are a small employer with a low staff turnover, we ensure that in all recruitment, selection and development processes, individuals are selected, developed and promoted on the basis of their abilities alone. We regularly monitor the diversity of our workforce and positively value the different perspectives and skills of all staff and make full use of these in our work. The staff survey carried out in 2014 indicates that individual differences are positively supported and respected and that opportunities for development are fairly managed. We ensure that our procurement processes are open and transparent and we require any potential suppliers or providers to demonstrate the same level of rigour as we do in their approach to diversity.

Case Studies

Here we have focused on the equality/human rights-related issue, and so may not refer to all the issues that were in the original complaint.

Restraint of prisoner

A prisoner said that he was placed under restraint with a body belt. He said that he was held this way for more than 12 hours without approval from Scottish Ministers, and that during that time staff did not monitor him properly and he was denied access to toilet and water breaks. The records showed that he was held for longer than he should have been without approval, and there was no evidence that he was continuously monitored during some of that time. This is against prison rules. The records also showed that he was given a drink and toilet access only once, which we found unacceptable.

The prison service had already reviewed their process for restraining prisoners, and had reminded staff they must get permission to restrain someone for that length of time. We said that they should also apologise to the prisoner, and tell staff that full written records must be kept of the time in restraints; and that during that time they should regularly offer access to water and a toilet.

Case **201300592**

3 "Fair and Equal: How does the Equality Act 2010 affect complaints handling in Scotland?"

Equality and diversity

Additional support needs in school

A child was exhibiting behaviours that suggested they might have Asperger's syndrome. After an incident in school, the child was referred to an additional needs tribunal. The tribunal said that the council had not made reasonable adjustments under the Equality Act. The child's father then asked for a coordinated support plan, but this took more than eight months to produce. He complained to us that the council did not apply policy and procedures to meet his child's additional support needs.

The guidelines say that a support plan should be provided in four weeks, so the council had clearly taken far too long to provide this at what was a particularly important time in the child's education. We said that they should apologise to the family and show us that staff have been reminded about what they should do when a plan is requested.

Case **201205207**

Prisoner escort

A man who uses a mobility aid and has a heart condition was escorted from prison to court. He said that, despite his disability, he was handcuffed in an inappropriate way. The escort service agreed that they should have risk-assessed this, but could not be certain whether he had been handcuffed in the way he described. They said they would develop guidance for staff on how to deal with this in future. We could not find out exactly what happened, but we upheld the complaint, as staff did not record whether they had made a risk assessment to show that he had been safely and securely escorted. We recommended that they consider recording the handcuffing style used in future and let us see a copy of their new guidance.

Case **201201756**

Gender referencing

A woman complained that an organisation referred to her as male in their records, after they had agreed to refer to her as female. She said this was a hate incident. We looked at the documents, and found that she was referred to as male in a note on the file. The organisation had agreed to refer to her as female before the note was made, and, therefore, should have done so. We said that they should make sure that staff know that they must refer to transgender customers appropriately, and tell us what learning they've taken from this complaint and how they have passed this on to staff.

Case **201302903**

Equality and diversity

Welfare power of attorney

A woman had power of attorney to make decisions for her late brother, who had profound learning and communication difficulties. He was admitted to hospital, where he died three days later from a blood infection. The woman told us that hospital staff did not discuss his care and treatment with her. She said that when her brother deteriorated, she could have provided important information about his normal condition, which could have informed how he was treated. The board apologised that staff did not act on changes in her brother's medical condition but said this was not due to his learning disabilities.

The board have a good best practice guide in line with the principles of the Adults with Incapacity Act (Scotland) Act 2000, but it was not followed in this case. It says that as well as the views of the individual, staff should as far as possible take account of the views of family and carers. The woman was not involved in the decision-making process and, more importantly, her information about her brother's deterioration was not taken seriously. We said that the board should apologise to her, remind staff of the best practice guidance and make sure it is used for relevant patients.

Case **201304515**

Learning needs in college

A student has a developmental disorder and behavioural symptoms, and was unhappy with the way his college treated him. He had withdrawn from his first course, after which he was assessed and told that he would benefit from learning support. He was encouraged to access this support for his next course, but did not, and again withdrew before completing it. He enrolled for a third course but had to withdraw for medical reasons, and applied for it again the next year. At this point he was told he had to complete an extra module first, to show he could commit to a full course.

Our equalities adviser said that the college didn't do enough to support him. There was nothing to show that they provided guidance, or talked to him about why he was withdrawing from courses, his personal circumstances or what withdrawal might mean for any new applications. We thought they had not taken all his circumstances into account. We also found that saying he had to complete an extra module before he could access the course was inappropriate. We said that the college should reconsider the student's application, and review their policies to make it clear to staff when they should consider making reasonable adjustments for students with disabilities. We also said that they should make a record of discussions between students and staff about withdrawal from courses.

Case **201300085**

Governance and accountability

Report from Dr Tom Frawley, Chair of the SPSO Audit and Advisory Committee

Introduction

1 The Audit and Advisory Committee (the committee) has, for the past number of years, produced an annual report. The report's purpose is to update the Ombudsman, and other key stakeholders, on the work programme of the committee during the year, specifically articulating how it: discharged its responsibilities; the actions it took; and the ways in which it has sought to add value to the governance processes within the office of the Scottish Public Services Ombudsman.

2 The committee meets in accordance with its terms of reference which, in turn, are informed by the work schedule laid out in the Scottish Government Audit Committee Handbook (2008).

3 The principal role of the committee is to provide the Ombudsman with advice and assurance on the adequacy of internal control and risk management within the SPSO, including: the framework of internal control; risk management processes; and the quality and reliability of financial reporting and related matters.

4 These issues are considered through the regular review of the risk management processes undertaken by management, in conjunction with consideration of the work undertaken by internal and external audit throughout the course of the financial year.

5 The committee met on four occasions during 2013/14.

Committee structure and membership

6 The committee membership during 2013/14 comprised three non-executive directors, these being: Tom Frawley; Douglas Sinclair; and Heather Logan. In line with Scottish Government best practice guidance on the operation of audit committees, the committee is chaired by Tom Frawley, a non-executive member. Each meeting was quorate.

7 The committee's terms of reference are kept under regular review as guidance in the field of corporate governance and audit committees is developed. A particularly useful guide for evaluating the effectiveness of the committee is the *'The Audit Committee Self-Assessment Checklist'*, contained within the Scottish Government Audit Committee Handbook referred to above.

Attendees

8 The following people also attended meetings during the year: Patricia Fraser, External Auditor, Audit Scotland; Nick McDonald, Internal Auditor, Scottish Legal Aid Board (SLAB); Jim Martin, Ombudsman; Niki Maclean, SPSO Director (Secretary); Emma Gray, SPSO Head of Policy and External Communications; Paul McFadden, SPSO Head of Complaints Standards; Fiona Paterson, PA to Ombudsman (Minutes); Rachel Hall, SPSO Executive Casework Officer; and David Thomas, Independent Service Delivery Reviewer.

9 The committee routinely receives oral reports from representatives of the external and internal auditors on their work programmes, supplemented by formal audit reports at appropriate junctures during the year.

Governance and accountability

The work of the committee

10 The committee considered the following range of issues, summarising some of the key aspects of its duties deriving from its terms of reference: internal audit; external audit; risk management; and internal control.

11 Specific reviews involved evaluating, and advising on, the following issues, through a series of recurring and specific items dealt with at meetings:

- the accounts for the year just finished prior to their finalisation and submission for audit
- the content of the Governance Statement for the year, presented alongside the finalised accounts
- internal audit's finalised periodic work plan for the financial year
- internal audit opinion for the financial year just finished
- the internal audit strategy and the periodic work plan for the financial year
- emerging findings from internal audit engagements
- the emerging external audit opinion for the financial year just finished and advising the Accountable Officer on signing the accounts and the Governance Statement
- the external auditor's report for the previous year, any emerging findings from the current interim/in-year work of external audit, and external audit's approach to their work
- any residual actions arising from the previous year's work of both internal and external audit
- re-visiting emerging findings from auditors and review actions.

12 The committee also reviewed arrangements made by management in relation to risk management, including how ongoing risks are identified, assessed, monitored, managed and reviewed.

13 The committee regularly reviews Risk Registers prepared by the SPSO. In relation to strategic processes for risk, control and governance, the committee, in the course of its work, aimed to secure assurances:

- that the risk management culture was appropriate
- that there was a comprehensive process for identifying and evaluating risk, and for reviewing what levels of risk were tolerable
- that the Risk Register was an appropriate reflection of the risks facing the SPSO
- that management had an appropriate view of how effective internal control was
- that risk management was carried out in a way that really benefited the organisation and added value
- that the organisation as a whole was aware of the importance of risk management and risk priorities
- that the system of internal control was effective
- that the Accountable Officer's annual Governance Statement was meaningful, and underpinned by credible evidence.

Audit engagements

External audit

14 The committee found the proactive approach adopted by Audit Scotland in planning for the external audit to be most helpful. This process was beneficial in that it succinctly scoped the ambit of the audit, having regard for: the organisationally specific risks and priorities facing SPSO; the national risks pertinent to the SPSO's local operating environment; the impact of changing international auditing and accounting standards; the responsibilities of external audit under the terms of Audit Scotland's Code of Audit Practice; and issues brought forward from previous audit reports.

15 The outcome of the external audit engagement for the year 2013–14 was an unqualified certificate from Audit Scotland.

16 In the opinion of the external auditor, in all material respects, expenditure and income had been applied for the purposes intended by the Parliament and the financial transactions conform to the authorities which govern them. The external auditor further noted that they had no observations to make on the financial statements.

Internal audit

17 Complementing the important role of external audit, internal audit provides the committee with objective assurance that the SPSO's control frameworks are operating effectively. Effective control systems are the foundation of effective risk management arrangements and, in receiving and deliberating on the reports of internal audit, a critical aspect of the committee's accountability role is discharged. During 2013–14, the internal auditors, SLAB, undertook reviews of information systems installation; HR, payroll and absence management; and document management. The overall opinion reached by internal audit in all audits was that of satisfactory assurance. The committee looks forward to receiving the work being conducted into procurement arrangements in SPSO, in due course.

18 The internal audit's Annual Assurance Report provided the Ombudsman with a 'satisfactory' level of assurance, based on the conclusions of their various engagements during the course of 2013-14.

Commentary

19 During the course of the year, the committee took assurance from the fact that no significant areas of concern arose in the course of these various audit engagements that remained unaddressed or unresolved. Moreover, neither auditor at any time has indicated any area of particular concern that should be brought to the committee's attention.

20 The committee was also informed that the necessary co-operation had been received from the SPSO's management and staff. The committee further acknowledges the steps being taken by management and staff to implement recommendations resulting from the various audit engagements.

21 The committee at all times sought to provide a forum for focused debate, involving key internal and external stakeholders, with the ultimate aim of providing assurances to the Accountable Officer on the adequacy of internal control and risk management within the SPSO, including: the framework of internal control; risk management processes; and the quality and reliability of financial reporting and related matters.

22 The committee believes it has effectively discharged its functions in this regard, using the following sources of evidence: terms of reference informed by best practice guidance in the field of public sector corporate governance; a series of regular meetings considering all of the matters noted above; and meeting, on a continuous basis, with senior management to discuss matters of mutual interest, whilst taking assurance from the opinions expressed by the auditors, both internal and external. Consequently, the committee provided assurance to the Accountable Officer, at the appropriate juncture in the reporting cycle, that the assertions made in the Governance Statement were meaningful and underpinned by a robust evidence base.

The Future

23 The committee will continue to monitor progress on all areas under its remit during the forthcoming year, particularly at a time of continuing change for the SPSO, particularly against the context of extensions to jurisdiction. The committee believes the SPSO is well positioned to respond to whatever opportunities or challenges it meets, given the high standards of performance that have been evidenced in the course of the last year, across a number of areas, as highlighted in the engagements of both internal and external audit.

24 The committee will continue to monitor the progress of the SPSO and ensure that the levels of attainment evidenced in the course of the year are maintained, enhanced and refined.

25 The committee would like to thank the external and internal auditors and the management and staff of the SPSO who facilitated its work during the year, in particular the excellent administrative support provided.

Complaints about SPSO

People can complain, through our customer service complaints scheme, about the service we have delivered. Although the law doesn't say that we have to do this, we decided to put a process in place. It has two internal stages, and complainants can ask for a final external review by our independent service delivery reviewer (ISDR). The ISDR's 2013/14 report is below, as well as statistics about these complaints, what we did with them and what we learned from them.

Report from David Thomas, Independent Service Delivery Reviewer

SPSO set a precedent for public sector ombudsman schemes in 2007 by creating external arrangements for the review of service delivery complaints, so the process is now well-established.

During the year to 31 March 2014, I dealt with service delivery complaints in eight cases. This is a reduction of about one third on the previous year, and represents less than 0.2% of the cases handled by SPSO. In all of the cases, the Ombudsman and his staff provided me with all of the information that I required. Besides looking at the specific service delivery concerns raised with me, I also carefully reviewed the whole of the case files in question.

Most of those who referred service delivery complaints to me found it difficult to distinguish their view of the merits of their complaint against the public body (which is not a matter for me) from their view of the way in which SPSO handled the case. Some who complained had unrealistic expectations. There are legal limits to SPSO's powers, which it cannot exceed. And it is for SPSO, and not the complainant, to direct the course of the investigation – not least to ensure impartiality.

In four of the cases that I considered, I did not uphold any part of the service delivery complaint. I was satisfied that SPSO had dealt with these cases effectively, efficiently and fairly.

In the other four cases that I considered, I upheld part of the service delivery complaint – because there had been a handling error in the case itself or the service delivery complaint, a lack of clarity, a minor delay or a minor procedural error. In two of the four, the shortcomings were very minor. In the other two, the shortcomings did not have any material effect on the outcome of the case, but indicated areas where SPSO might consider process improvements.

All the cases turned on their own facts, but areas where SPSO may wish to keep its processes under review include:

- ensuring time limits for complainants always have regard to the actual circumstances of the case and the particular complainant
- giving a final warning before closing a case because of lack of cooperation by the complainant; and
- being clear about whether or not SPSO could or would require the public body to pay compensation.

SPSO reacted positively to my conclusions in all four of these cases and apologised to the complainants concerned.

Governance and accountability

Using complaints to improve quality

We take complaints about our service very seriously and use them as a tool for ensuring the quality and consistency of our work. These complaints link to our service standards, and our findings from them feed into our quality assurance process and the discussions of our senior management team and internal service improvement forum.

In 2013/14, we changed how we record complaints about our service, to bring ourselves into line with what we ask other organisations to do under the model complaints handling procedure. We publish reports on our website about these complaints and the actions we have taken in response to any failings they identify. The reports provide statistics showing the volumes and types of complaints, their outcomes and key performance details, including the time taken and the stage at which complaints were resolved. They also contain a full list of recommendations and actions we have taken.

In addition to putting things right for our customers where possible, we always seek to learn lessons from any service failures and address any systemic issues that may be identified.

In the course of reviewing service complaints, individual instances of service failure are highlighted to our senior management team, where necessary, and to the relevant staff and managers involved, where appropriate. A summary report of complaints is provided to our senior management team, our service improvement group and our Audit and Advisory Committee each quarter. These are analysed for trend information to ensure we identify areas where our service could improve and take appropriate action.

In all cases where our service was not up to the standards expected, we apologised to the complainant and, where possible, took action to help ensure this did not happen again.

Key points

- We received 57 service complaints in 2013/14, representing 1.2% of our caseload
- This was an increase of 27% on the previous year when we received 45 complaints, and was largely due to the greater focus on recording complaints at the first stage of our process
- We dealt with 59 complaints (this includes some carried forward from the previous year) and upheld 29%. Nine were fully upheld, eight were some upheld, four were withdrawn and 38 were not upheld.
- We dealt with more cases (28%) at the first stage of our process, so there was a drop in the number we dealt with at the second stage (down 15%) and the number reviewed by the ISDR (down 36%). This suggests that more service complaints are being resolved quicker and closer to the point of service delivery compared with previous years, reflecting our focus on seeking to resolve complaints as early as possible. The reduction in cases to the ISDR also suggests that, overall, customers are more satisfied with our response to their complaints than they were in previous years.
- Average timescales for stage 1 and stage 2 complaints were 7 and 19 working days respectively. We responded to 51% of complaints at stage 1 and 69% at stage 2 within our target timescales of 5 and 20 working days respectively. The time taken reflects the fact that in some cases we had difficulty obtaining information from or clarifying the issue with the person. Our revised process also focused on resolving complaints at as early a stage in the process as possible. We continue to work to increase the proportion of cases where we meet our targets.

The table below shows a breakdown of closed complaints by stage and outcome. Each complaint contains a number of individual aspects of complaint so the decision outlined represents an aggregate of the outcome of these.

Complaints determined about SPSO 2013–14

SDC TYPE	FULLY UPHELD	SOME UPHELD	NOT UPHELD	COMPLAINT WITHDRAWN	TOTAL
Stage 1 Officer / Manager	6	1	27	3	**37**
Stage 2 Senior Management	3	7	11	1	**22**
Total	9	12	42	4	**59**
Stage 3 Cases to ISDR	0	4	4	0	**8**

All cases determined 2013/2014

Case type	Stage	Outcome Group	Further & Higher Education	Health	Housing Associations	Local Government	Scottish Government and Devolved Administration	Water	Other	Total
Enquiry	Advice & signposting	Enquiry	0	11	4	22	1	2	3	43
		Out of jurisdiction	0	0	0	0	0	0	320	320
	Total enquiries		**0**	**11**	**4**	**22**	**1**	**2**	**323**	**363**
Complaint	Advice	Not duly made or withdrawn	31	331	76	328	93	47	7	913
		Out of jurisdiction (discretionary)	0	25	5	56	19	3	0	108
		Out of jurisdiction (non-discretionary)	12	19	12	42	28	0	10	123
		Outcome not achievable	5	66	24	129	37	25	0	286
		Premature	23	297	161	659	130	108	6	1,384
		Resolved	0	2	3	6	4	0	0	15
		Total	**71**	**740**	**281**	**1,220**	**311**	**183**	**23**	**2,829**
	Early Resolution 1	Not duly made or withdrawn	3	49	6	36	16	3	0	113
		Out of jurisdiction (discretionary)	2	26	4	57	9	7	0	105
		Out of jurisdiction (non-discretionary)	5	15	17	110	41	5	0	193
		Outcome not achievable	1	37	7	40	10	5	0	100
		Premature	4	53	2	33	10	9	0	111
		Resolved	3	18	3	18	9	12	0	63
		Total	**18**	**198**	**39**	**294**	**95**	**41**	**0**	**685**
	Early Resolution 2	Fully upheld	3	17	4	31	25	7	0	87
		Some upheld	1	4	6	25	6	6	0	48
		Not upheld	9	42	12	50	64	11	0	188
		Not duly made or withdrawn	0	7	0	1	2	1	0	11
		Resolved	0	0	0	4	0	8	0	12
		Total	**13**	**70**	**22**	**111**	**97**	**33**	**0**	**346**
	Investigation 1	Fully upheld	4	73	3	20	5	19	0	124
		Some upheld	1	82	9	39	4	13	0	148
		Not upheld	4	115	5	60	10	21	0	215
		Not duly made or withdrawn	0	7	1	2	1	1	1	13
		Resolved	0	1	0	1	1	1	0	4
		Total	**9**	**278**	**18**	**122**	**21**	**55**	**1**	**504**
	Investigation 2	Fully upheld	0	27	0	0	1	2	0	30
		Some upheld	0	11	0	0	2	0	0	13
		Not upheld	0	0	0	0	1	0	0	1
		Total	**0**	**38**	**0**	**0**	**4**	**2**	**0**	**44**
	Total complaints		**111**	**1,324**	**360**	**1,747**	**528**	**314**	**24**	**4,408**
	Total contacts		**111**	**1,335**	**364**	**1,769**	**529**	**316**	**347**	**4,771**

Enquiries signposted by SPSO advice team 2012/13 and 2013/14

	2012/13	2013/14
Association of British Travel Agents	2	0
Age Concern Helpline	2	1
Audit Scotland	2	3
Bus Passengers Platform	0	1
Care Inspectorate	6	3
Citizens Advice Bureau	47	59
Civil Aviation Authority	1	0
Commission for Ethical Standards in Public Life in Scotland	0	3
Consumer Direct	9	1
Dental Complaints Service	2	0
Drinking Water Quality Regulator	0	1
Financial Ombudsman Service	115	47
Information Commissioner Office Scotland	13	15
Law Society of Scotland	0	2
Office of the Scottish Charity Regulator	1	6
Ombudsman Services: Communications	20	15
Ombudsman Services: Energy	18	22
Ombudsman Services: Pensions	5	3
Ombudsman Services: Property	8	6
Other	59	35
Parliamentary and Health Service Ombudsman	33	24
Passenger Focus	0	1
Planning Aid for Scotland	2	2
Police Investigations & Review Commissioner	13	12
Post Office / Royal Mail	1	0
Private Rented Housing Panel	11	8
Public Concern at Work	3	5
Public Services Ombudsman for Wales	1	0
Public Standards Commissioner for Scotland	7	1
Referred to Employer / Human Resources	18	11
Referred to Legal Advice	26	10
Samaritans	1	1
Scotland's Commissioner for Children and Young People	0	1
Scottish Information Commissioner	3	0
Scottish Legal Aid Board	0	1
Scottish Legal Complaints Commission	10	6
Scottish Parliamentary Standards Commissioner	0	1
Scottish Traffic Commissioner	1	0
Shelter Housing Advice Line	3	12
Standards Commission for Scotland	1	0
Telecommunications Ombudsman	3	0
The Office of the First Minister	1	0
Water Industry Commission for Scotland	6	1
Total	**454**	**320**

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