

SCOTTISH PUBLIC SERVICES OMBUDSMAN

ANNUAL REPORT 2012-2013

1
Providing a
high quality
user-focused
independent
service



2
Supporting
public service
improvement
in Scotland



3
Improving
complaints
handling



4
Simplifying
complaints
handling
systems



5
Being an
accountable
and best value
organisation



SPSO

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

A handwritten signature in black ink, reading "James B. Muir". The signature is written in a cursive style with a large, looping initial 'J'.

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My ultimate commitment is to ensure justice for the people of Scotland. I want this office to contribute to improving people's lives through better public services.

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OMBUDSMAN'S INTRODUCTION



The Ombudsman service is even more necessary in times of economic hardship when the already vulnerable are disproportionately disadvantaged.



Annual reports are a good opportunity to reflect on what has changed and what has stayed the same, and to look ahead to future challenges. This annual report is the first to chart progress against our 2012/16 Strategic Plan. I am pleased to report that, despite increasing numbers of complaints and significant cuts in our resourcing, we are well on course to deliver the key objectives of that plan.

Maintaining quality in times of change

What stayed the same in 2012/13 was that the number of complaints we received increased, as did our productivity, and there were further expansions of our remit. This has been the pattern since 2009/10 – in that time we have seen a 23% increase in complaints, and a 15% reduction in resource, excluding funding for new areas of responsibility.

In line with our predictions, complaints received rose by 5% in 2012/13. Our productivity also rose, and we dealt with 9% more complaints than in the previous year. This increase in productivity is a remarkable achievement, given our budget constraints, and the fact that there are fewer than 50 of us to look after almost all of the public sector in Scotland. I commend my staff for their continuing hard work and dedication.

Overhauling complaints procedures and building future improvement

It is disappointing that in 2012/13, I upheld 46% of the complaints that were valid for us to look at, compared with 39% in the previous year. These are complaints where the public service provider has already had the opportunity to look into the complaint and provide resolution. The increase in upheld complaints demonstrates the continuing importance of our work to improve public service providers' complaints handling.

The most radical change we brought about in 2012/13 was led by our Complaints Standards Authority (CSA). This small SPSO team is on track to deliver the decision of Parliament that there should be standardised complaints handling procedures across the public sector that are simple, streamlined and accessible, and that deal with complaints as quickly and effectively as possible.

Over the past two years the CSA has worked collaboratively with public bodies to develop common complaints procedures for the local government, registered social landlord, further and higher education and Scottish Government sectors. Hundreds of organisations across Scotland are now committed to a two stage procedure – frontline resolution and investigation – with complainants having the right to an external review by SPSO or a similar body if they remain dissatisfied.

As well as developing complaints procedures that will benefit complainants and organisations, the CSA has provided the groundwork for future continuous improvement. New recording and reporting systems have been set up. Performance measures have been agreed with the sectors and with the regulators that will ensure compliance with those measures. This means that in Scotland we will soon be in the unique position of having rich complaints data within organisations and across the various sectors in the public service. This will help us all to benchmark and identify emerging trends. The CSA has carried out our statutory role to promote good practice in complaints handling in a number of innovative ways, including establishing sectoral networks and a cross-sectoral online community forum. Its informative website carries guidance on good complaints handling and hosts our online training centre.

The architects of the new complaints landscape – Professor Lorne Crerar and Douglas Sinclair – have given positive verdicts on our work to bring about this groundbreaking new approach to complaints handling.

(L – R: Jim Martin, Lorne Crerar, Douglas Sinclair)



It is an enormous personal pleasure to evidence the fulfilment of the vision and ambitions of my Review for the reform of the Complaints Handling System for Public Bodies in Scotland. I strongly believe the SPSO has put in place a leading world class system which helps ensure that public service delivery is to the highest level. The Ombudsman and his team should be congratulated for a job well done. PROFESSOR LORNE CRERAR

The approach by the Fit for Purpose Complaints System Action Group can be summarised in one word: simplification. That objective has now been achieved. We now have standardised, simplified complaints handling processes for each public service sector. The SPSO has built this strong and enduring foundation on which our public services need to continue to embed an ethos which sees genuine complaints as opportunities for learning and which empowers complaints handlers to resolve as many complaints as possible at the first level. DOUGLAS SINCLAIR

Highlighting injustice and improving public services

Our traditional role as an ombudsman service is in handling the complaints brought to us by members of the public who claim suffering or hardship as a result of something going wrong in a public service. Our job continues to be to restore public confidence and add value by putting things right where we can.

We have included a selection of case studies in this report to illustrate the range of our work. Some studies are examples of where we have made recommendations to put things right and ensure failings are not repeated. Others show some of the positive actions that organisations have taken in response to complaints. Still others are included as examples of where organisations have delivered a service and investigated the complaint properly.

Thematic reports

This year, for the first time, we are publishing separate, more in-depth analyses of our findings in each of the main areas under our remit. These will be published over the summer and early autumn and will help us provide more detail about each area, to be used as a tool for sharing and learning.

We received a record number of complaints in 2012/13, and through our new reporting mechanism we put more decisions into the public domain than ever before. These contain a mine of information about what can go wrong, and what organisations and ultimately my office can do to try to put things right.

A range of views

Users and observers of our office express a range of views about our service, both positive and negative. To demonstrate this I have given examples of some user comments.

Firstly, people tell us they are satisfied that through us they have got the answers they were looking for.

Thank you for taking the time to telephone me to inform me of your decision. I just wanted to thank you for looking into this for me – I can see how thorough it has all been. Even if the outcome had not been in 'my favour', I still would want to say 'thank you', because you must have put an awful lot of work into all of this.

It was kind of you to listen to me, and to understand how it all made me feel, because at the heart of all this ... is how awful it all made me feel. I feel like I can put it all behind me now.

Although the SPSO is the end of the complaints line for people who are unhappy with a public service, we do not always have the legislative power to look into a matter or to bring about the outcome or change that people want. Nowhere is this more apparent than in complaints about the planning system (which is the second highest category of complaint about local government services after housing).

Although I am disappointed that you were unable to uphold any of my complaints against the council, I just wanted to say thank you for all your time and work. I still think that there are serious flaws in the planning system but accept your findings in my complaint.

Inevitably, given our role as the final decision-maker, we will never satisfy everyone who brings a complaint to our office. Our job can entail managing the difficult behaviour of people who have become disillusioned with a public service and with SPSO. Some people speak and write to me and my staff in terms that are not always easy to deal with, and we carry out staff training, including courses run by organisations like the Samaritans, in dealing with this.

Despite the fact that I have absolutely no confidence in your organisation and quite frankly consider it to be a useless, toothless quango, I will be pleased to have a response. I have though copied this letter to my MSP with the suggestion that your offices should be closed down immediately.

Making a difference

In resolving complaints, the goal is not only individual redress, important though that is. We are also committed to ensuring that organisations put in place changes that mean that the same things should not happen to someone else. This is why our decisions often carry recommendations for improvement and this is a key way in which our service makes a difference. In 2012/13 we issued over a thousand recommendations. Some of the case studies that appear later in this report contain examples of these.

Governance and complaints

Over the past year, I have visited senior teams in many of Scotland's councils and health boards and I plan similar visits in future with housing associations and further and higher education organisations. I know from these discussions that there is a strong leadership commitment to improvement. These are difficult times of reducing budgets, a rising demand on services and changes in how those services are delivered. In this context, I urge organisations to do two things. The first is to see our decisions as tools for prioritisation and improvement, and the second is to use the expertise and support provided by our CSA team to ensure that complaints procedures are open and accountable and used effectively as sources of feedback and learning.

The Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust has concentrated minds as never before on the importance of complaints as a lever for prevention and learning. In the wake of Francis, it is simply untenable for organisations not to have governance arrangements in place that recognise the value of complaints and use them actively to improve services.

In light of Francis and other reviews of the NHS in England, it is important that the distinct roles of the SPSO and regulators are clearly understood. Our role is to seek redress for people at an individual level. However, if an investigation points to the possibility of a systemic issue, we can and do make broader recommendations as well as publicly alert the appropriate regulator to look into the matter.

Administrative justice

Administrative justice is the sphere of justice that seeks to ensure that the rights of individuals are protected when powerful public bodies make decisions. For this to work effectively, individuals need to know how to participate in, question and challenge decisions that affect them and their communities.

This is an important principle and we increasingly use the language of justice and rights in our policy work. I am encouraging policy makers to ensure that when they are considering new rights, duties or responsibilities they also consider the right to question and challenge. I accept that this is a complicated area because this right is not absolute, and the rights of individuals need to be balanced against the rights of the broader community. There are of course times when finality is needed in decision-making and policy makers may view it as impractical or undesirable for there to be an unrestricted right to challenge. Nevertheless, the right to do so should be embedded in policy changes and it is essential that this is done at the formulation stage rather than, as has sometimes been the case in the past, left to the end of the process. When this has happened, the SPSO can become the target for disaffection by people who feel that this right has been denied to them. Their anger and frustration is often aimed at SPSO and I understand why, but we cannot bear responsibility for systems that we did not set up.

Consideration also needs to be given to how user-friendly the system is. Complex systems with numerous routes for complaints and appeals can be baffling and discouraging. The SPSO was formed in 2002 as a one-stop shop to reduce this complexity and our experience is that simplicity is of great benefit to users. This was emphasised in the Crerar and Sinclair reviews and the more recent Christie Commission report. I repeatedly highlight in consultation responses, meetings and other engagement the need for the administrative justice system to be looked at holistically, for there to be a meaningful right of challenge, and for the perspective of the service user to be paramount.



I urge organisations to see our decisions as tools for prioritisation and improvement, and to use our expertise and support to ensure that complaints procedures are open and accountable and used effectively as sources of feedback and learning.



Looking ahead

I believe we have now maximised the benefits of the process changes I introduced to improve the quality and timeliness of our decisions. SPSO is good value for money and I see recognition of this in Parliament's decision to expand our role to include improving complaints standards and the Government's decisions to widen our remit in new areas. We are, however, a demand-led service. To increase demand without allocating the resources required to maintain our service levels puts the quality of what we do and the service we offer at real risk.

My ultimate commitment is to ensure justice for the people of Scotland. I want this office to contribute to improving people's lives through better public services. To do this I must have the right processes and sufficient resources in place

to run the high quality complaints handling service the public deserves. The Ombudsman service is even more necessary in times of economic hardship when the already vulnerable are disproportionately disadvantaged.

I will, therefore, continue to have discussions that may make some people uncomfortable. I want there to be a mature debate about the powers of the SPSO. For example, why should these be greater in health complaints than in those about local authorities or prisons? In what ways could we strengthen our human rights approach in our work? I also want to explore different funding models. I will continue to seek clarity about enhancing our accountability and will always insist on protecting our independence.

I think that this is no less than the public would expect from Scotland's Ombudsman.

Jim Martin
Ombudsman



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Providing a
high quality
user-focused
independent
service

CASEWORK PERFORMANCE

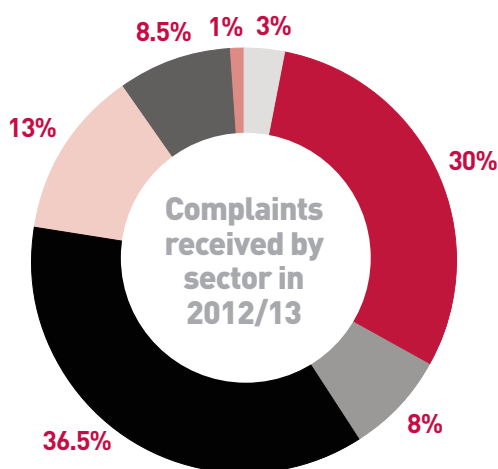
STRATEGIC OBJECTIVE 1

This section reports on our 2012/13 annual business plan key priority for this strategic objective, which is to deliver an efficient and effective complaints handling service, working to stretching but achievable targets, continuously building quality and accessibility.

As a free, accessible alternative to the courts, we provided over 4,000 people in Scotland with access to independent advice and final stage reviews on decisions made by public bodies. In 2012/13 we dealt with 9% more complaints than last year, a total of 4,077. We achieved this with the same level of investigation resource through a continued focus on performance management and further streamlining our complaints process.

Case volumes and efficiency

In 2012/13 we received 531 enquiries and 4,120 complaints compared to 625 and 3,918 in the previous year.



Sector	Complaint
Local government	1,505
Health	1,237
Scottish Government and devolved administration	525
Water	353
Housing associations	328
Further & higher education	127
Other	45
Total	4,120

Given that since 2009/10 case volumes have risen year on year, and based on the increases we saw in some sectors this year, we anticipate a further increase of up to 10% in 2013/14. This will include an expected rise in prison healthcare complaints. These came under our jurisdiction in November 2011 as a result of changes brought about by the Scottish Government, but the resulting complaints only began to reach us in numbers in 2012/13. This coming year, we will also receive complaints about the new Scottish Welfare Fund – a consequence of another Scottish Government policy decision which took effect from 1 April 2013.

Our Complaints Standards Authority's work in simplifying complaints procedures across the public sector is likely to lead to complaints reaching us more quickly than when some of those processes had more stages and no set standards on timescales. This is a positive step for public service users as it means certainty around response times, less delay and speedier resolution, but it could potentially lead to a higher volume of complaints finding their way to SPSO. This is something that we will monitor closely.

Like all casework-driven public services with fixed or reducing resources, the challenge for SPSO is to respond proactively and efficiently to an increasing volume of complaints, while maintaining the quality and impartiality of our decisions and delivering an open, accessible and empathetic service. In 2012/13 we reviewed our business process to consider how we could streamline it further. As part of this initiative, in 2013/14 we are carrying out targeted work with a group of public service providers to help them have greater impact on the volumes of complaints that they resolve and to prevent escalation to the SPSO.

Timescales

Despite the increase in case volumes, we continue to work hard to meet our own timescales for handling enquiries and complaints. The time taken can 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 and we publish them on our website.

In 2012/13, it was clear that increasing complaints numbers had impacted on timescales. We dealt with 97% of advice cases within our target of ten days (our target was 95%). We made a decision on or progressed for further investigation 69% of cases within our target of 50 working days (our target was 95%), and we issued 55% of decisions within our target of six months (our target was 85%). Our final measure was the number of public investigation reports we laid before the Parliament within 12 months of receiving the complaint, and our performance was 96% (our target was 95%).

We achieved this in spite of the level of complexity and gravity of the subjects, the volume of evidence that must be gathered and the need for detailed expert advice on many of the more complicated cases. It was achieved against a background of reducing resources and rising complaints numbers. Much of the increase was in complaints about the NHS which rose most sharply – and such complaints are often among the most complex and time-consuming that we handle. Our most recent research of complainants' views, published in August 2012, tells us that people are less concerned about timescales than they are about thoroughness of investigation. We have been clear and consistent in our message internally and externally that, put bluntly, if we have to decide between timescales for delivering what we do and the quality of what we do, we will not sacrifice the quality of our decision-making.

Each year we review and refresh our performance measures to ensure they are

focusing on and driving performance in a way that is best for service users. The refreshed performance measures for this strategic objective and other areas of the business for 2013/14 are set out in the business plan, which is published on our website. To achieve these measures requires efficiency on our part and on the part of our advisers, the right resourcing levels, and the ongoing cooperation of public bodies in working to the deadlines we set them.

Quality of decisions and service

The SPSO offers the right to an independent, impartial, evidence based final review of decisions made by public bodies. In 2012/13 we continued to show how we delivered this through funding and governance arrangements that comply with the Ombudsman Association independence criteria, and by ensuring that we follow the principles of natural justice in making evidence based decisions.

Our aim is to allow individuals to tell their stories in a user-friendly way, not bound by courtroom formalities and prohibitive costs, in a manner that is meaningful to them. We also want to ensure that we understand what the person is hoping to achieve by complaining to us and that where possible we make recommendations that are in line with the action they are seeking. We, therefore, carefully explore with complainants the outcome they want, and explain early on in our dialogue with them what we can and cannot achieve.

We do this both in writing and, increasingly, over the phone ensuring that we understand and agree what the complaints are, whether the matter is one we can look at and whether the organisation has had a full opportunity to resolve the matter. We then gather and analyse the relevant evidence. During the investigation process, our decisions are guided by the SPSO Act, which sets out what we can and cannot look at; by the policies and legislation relevant to the complaint, and by technical advice provided by independent specialist advisers.



Our aim is to allow individuals to tell their stories in a user-friendly way, not bound by courtroom formalities and prohibitive costs, in a manner that is meaningful to them.





While no two cases are ever identical, the volume of casework intelligence brings consistency in our decision-making. It also gives us the ability to draw on prior knowledge, and to build proportionality into judgements and recommendations.



People who bring us their complaints invariably feel strongly about the issues they are raising. We take our responsibility as the final stage decision-maker in the complaints process very seriously. Where we are not able to uphold a complaint, having assessed the evidence, our job is to ensure that we clearly explain how and why we have reached our decisions. Our aim is always to do so with empathy and understanding for the individual's circumstances. This is not always easy but our staff work hard to achieve this difficult balance and we know from complainants' feedback that we can and do get it right for the majority of people.

We understand that the nature of what we do means that some individuals will never accept the decision we reach on their case. This can occasionally lead to persistent expressions of frustration and criticisms of this office and it can also lead to people exploring other avenues for their complaints issues to be heard, such as through the media or by political lobbying. We know that this is part and parcel of being the final stage in the complaints process. We accept and welcome constructive and balanced criticism and seek to engage and learn from it, wherever it comes from.

The fact that we see multiple cases about similar issues helps to ensure balance in reaching our decisions and making recommendations. While no two cases are ever identical, the volume of casework intelligence brings consistency to our decision-making.

It also gives us the ability to draw on prior knowledge, and to build proportionality into judgements and recommendations. This perhaps in part explains why there were no judicial review challenges to our decisions or recommendations in 2012/13 by either complainants or public organisations, and why these organisations have continued to recognise and respond to the expectation that they will carry out our recommendations, even when they do not agree with them.

We also pay close attention to multiple cases to see if there are patterns that may indicate systemic failure. We set out later in this report the work we do to publicly share our decisions with others so that these are as visible as possible. This allows us to also reflect the quality of service that people are receiving both from us and from other organisations.

We have a process that allows both parties to ask for decisions to be reviewed if they consider there is new evidence or there are factual inaccuracies. This includes decisions not to look at a complaint, as well as the decisions we issue following investigation in a decision letter. In 2012/13, we received requests for review on 5.5% of all such decisions and we revised our decision in ten cases (0.2% of the total cases). We publish statistics about requests for review on our website. We deal with comments on drafts of the detailed investigation reports we publish in full through a separate process.

Driving improvement

Another way that we test the quality of our work, including that of our decisions, is through our quality assurance (QA) process. Under our new QA process, in 2012/13 we randomly selected 10% of the complaints at different stages in our process. No decisions were changed as a result of this and all findings, including examples of best practice, were fed back at an individual, team and organisational level to ensure continuous improvement. In 2013/14 we will continue to look for ways to strengthen our QA process, and seek out examples of good practice in other organisations.

Where individuals are unhappy with our service, rather than with our decision, we respond through our service delivery complaints process. This is a non-statutory scheme that we have put in place because we recognise how important it is for us to demonstrate best practice in our own complaints handling. To help us do this, we appoint an external Independent Service Delivery Reviewer. His findings are in a later section of this report.

To ensure that we are learning and improving from all the information we receive about our service, we have an internal forum. This meets quarterly to consider all the intelligence that we receive about our service – for example from requests for review, quality assurance and service delivery complaints – and recommends and implements improvement initiatives.

As a result of this feedback, and of complainant focus group research that we published in August 2012, we asked the Samaritans to run courses for our complaints reviewers about effective communication with people who are severely distressed or angry. We recognise that the softer skills of understanding and listening

can be just as important as expertise in technical matters, and that we have a duty to support staff and complainants in dealing with the sometimes harrowing experiences that we investigate.

On very rare occasions, however, we may take the view that an individual's engagement with us is inappropriate or disproportionate. It may be damaging for staff or diverting resources from frontline services. If this happens, we apply our unacceptable actions policy. This helps us manage contact with that individual in a way that minimises the impact of their behaviour. The policy has been widely referenced by other public bodies, perhaps indicating a wider challenge and a general need for training and support of staff in public services. In 2013/14, we will further develop our tools and guidance in this difficult area.



We test the quality of our work, including that of our decisions, through our quality assurance process. We will continue to look for ways to strengthen this process, and seek out examples of good practice in other organisations.



Case outcomes and impact

As the Ombudsman explains in his introduction, this year we are publishing separate, more in-depth analyses of our findings in each of the main areas under our remit. In this report, therefore, we provide a brief overview of the volume of complaints in each area, showing the change from previous years. Most notably there has been a 28% increase in the number of health complaints we dealt with, 4% of which relates to the new area of prison healthcare complaints. In our themed health report, we examine this rise in complaints about the NHS in more detail. We received 23.5% more complaints about the NHS this year compared to last. We attribute the increase to greater public concern and awareness of what can go wrong, as well as to changes in the way complaints are recorded and handled as a result of new duties placed on health boards under the Patient Rights (Scotland) Act 2011.

In 2012/13 we handled 531 enquiries and 4,077 complaints. All enquiries are dealt with at our advice stage. We also handled 2,476 complaints at this stage (3% more than the previous year) and of these 40% were premature (i.e. they reached us before they had completed the organisation's own complaints process). We explain what happens at this stage below.

Advice

At the end of this annual report, there is a detailed table with all the outcomes of the complaints we dealt with. Here, we identify some of the key points. All complaints and enquiries come first to our advice team. Their role is to provide information, signposting and support. They can also make a decision on a complaint if they consider that it is premature or if it is clearly a matter we are not legally able to consider. Where they can they will signpost people to other agencies who may be able to help if we have been unable to. In volume terms, complaints handled at the advice stage are a large proportion of the overall complaints received (around 60% of the total) and much of the work of this team is conducted by telephone.

Our advice team spend much of their time dealing with complaints that reach us prematurely. There are two main reasons

Complaints dealt with by sector 2011–12 and 2012–13

Sector	2011–12	2012–13	% difference
Further and higher education	115	138	+20%
Health	937	1,197	+28%
Housing associations	278	316	+14%
Local authority	1,497	1,507	+1%
Scottish Government and devolved admin	852 <i>incl water</i>	874 <i>incl water</i>	+3%
Other	69	45	-35%

In 2011/12, we reported water complaints as part of the Scottish Government sector; this year we are publishing separate themed reports about water and Scottish Government and devolved administration bodies.

for people contacting us too early. The first is that the complainant has not been told enough about the organisation's complaints process and does not understand how to escalate their complaint.

The second is that, despite the complainant having the correct information, their complaint has got stuck in the system. In the first scenario, our advice team explains the organisation's complaints process and where appropriate supports the complainant to progress their complaint. In the second, as well as providing advice and support, the team may contact the organisation concerned to ask them to get in touch with the complainant to explain the reason for the delay. It is good news for complainants that the rate of premature complaints continues to fall – three years ago it was 51%, two years ago 45%, last year 43% and this year 40%.



We upheld or partly upheld 46% of valid complaints, up 7% from 2011/12. These are complaints where the organisation has already had the opportunity to investigate, and yet we are still finding that there has been a failing.



Assessing and investigating complaints

Last year, 1,601 cases were passed on from the advice stage for further, detailed review. At this stage, we try wherever possible to talk to the complainant to make sure we understand their complaint and what outcome they want. We aim to see if there is a resolution that would be agreeable and acceptable to all parties, and last year we resolved 47 complaints at this stage. We also have to assess whether there are reasons we should not take the complaint further. We can only investigate where we have been given the legal power to do so. We know it is frustrating for complainants if we can't resolve a complaint or take it further and so we try to make this decision as quickly as we can. Last year, we made a decision at this stage that we could not take 615 cases further. This was because they 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. We provide a breakdown of the decisions we made at this stage at the end of the annual report.

At the investigation stage, we issued decisions by letter in 895 cases (an increase of 27% on last year). Each month, we publish summary reports of as many of these cases as we can and lay them before Parliament. These reports detail the complaint, our decision and whether recommendations were made. We also published 44 detailed investigation reports in full.

We talk in more detail about the impact of our casework in the next chapter. However, we would like to highlight those 44 reports. These

cases represent a small proportion both of our caseload and of our published reports but are the most resource intensive. We hope all of our published reports help to raise wider public awareness and to support learning. We feel these detailed investigation reports have particular potential to do this and take care to highlight them in our e-newsletter when we publish all the reports each month. There were 21% fewer detailed reports this year. The number of cases that need dealt with in this way is not high and the figure fluctuates each year. It is important to stress that we make a specific decision on every case investigated to see whether it should be dealt with in this way. Like many of our decision letters, these reports contain recommendations, which we make in order to provide individual redress and wider service improvement. We discuss the impact of recommendations further in the next chapter.

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 46%, up 7% from 2011/12. Much of this increase was due to a rise in upheld complaints about local authorities (from 32% last year to 47% this year). We report on this in more detail in the separate thematic report about this sector. These are complaints where the organisation has already had the opportunity to investigate, and yet we are still finding that there has been a failing. While the position for each sector varies, this signals that across public services there is a need for a continued focus on supporting good quality complaints handling practice, both at the frontline and at the second tier stage of the process when senior personnel become involved in the decision-making.

Casework performance information for 2012/13 is available on our website at www.spsso.org.uk/statistics

Key figures 2012/13

- > Since 2009/10, we have seen a **23%** increase in complaints and a **15%** reduction in our resource*

- > The number of complaints received this year rose by **5%** on last year

- > We handled **4,077** complaints, **9%** more than last year

- > The number of premature complaints fell to **40%** of our caseload (3% less than last year)

- > People who received advice, support and signposting: **3,007**

- > Number of cases decided following detailed consideration pre-investigation: **662**

- > Complaints fully investigated: **939** (23% more than last year) with **850**** publicly reported to parliament

- > We made **1,003** recommendations for redress and improvements to public services (62% more than last year)

- > The overall rate of upheld complaints was **46%** (up from 39% last year)

* Excluding funding for new areas of responsibility.

** In a small number of cases we do not put information in the public domain, usually to prevent the possibility of someone being identified.



2

supporting
public service
improvement
in Scotland

MAKING A DIFFERENCE

STRATEGIC OBJECTIVE 2

In this section we report on our 2012/13 annual business plan key priorities for this strategic objective. These are to:

- share strategic lessons from our casework with service providers and appropriate scrutiny bodies;
- ensure service providers implement SPSO recommendations; and
- use communications tools effectively to promote understanding of the SPSO.

Sharing strategic lessons

Our main instruments for change are our investigations and recommendations. When we examine a complaint, we shine a light on the treatment someone has received from a public service provider. If we find that something has gone wrong – and we did in 46% of cases that we could investigate in 2012/13 – we want to put things right for the individual and to ensure, as far as possible, that the same things do not happen to anyone else. We do this through our recommendations, and by sharing lessons with others through our stakeholder engagement plan and communications channels.

Public reports

We published 850 public reports last year. We highlighted earlier the 44 cases that we consider are the most significant. When we assess what cases should be reported in this way, rather than in summary, we use public interest criteria.

These can include:

- **significant personal injustice**
- **systemic failure**
- **significant failures in the local complaints procedure**
- **precedent and test cases**

Informing service providers and appropriate scrutiny bodies

The primary recipients of these reports are the complainant and the organisation concerned. We also send the public interest reports to the chairs of the relevant governing body, such as the council leader or the chair of the health board. Where appropriate, we may raise concerns about the possibility of a systemic issue with a regulator or other relevant organisation. All our reports, detailed public interest and short decision ones, are publicly available to raise wider awareness and to support learning across sectors. We publicise all our reports through the Ombudsman's monthly e-newsletter, which highlights themes and issues from the reports. It is sent to 1,800 recipients including MSPs, scrutiny bodies, service providers, advocacy agencies and the media.

We send a number of organisations annual letters with some analysis of the complaints we have received about them or with information about organisations they regulate. In 2012/13 we expanded the number of organisations to which we send these letters. In addition to every council and health board for which we received complaints, we sent letters and statistics to the Scottish Housing Regulator, Scottish Water, Business Stream, the Scottish Prison Service, Scotland's Colleges and Universities Scotland. All of the letters, along with comprehensive annual statistics, are published on our website.

During his 2012/13 visits to councils and health boards, the Ombudsman reinforced important messages from the complaints we saw about their organisation, discussed general sectoral issues, and listened to feedback to help improve our performance and service. As the majority of our published public interest reports are about the health sector, a 'sounding board' of representatives from different professional groups was set up for sharing developments about health matters. It met for the first time in March 2012.

Policy engagement

The Ombudsman gave oral and written evidence to two Holyrood committees in 2012/13. He appeared before the Local Government and Regeneration Committee, to speak about our annual report, and before the Health and Sport Committee, as part of their inquiry into the regulation of the care of older people in acute settings.

We responded to a further nine inquiries, work plans or consultations where the subject matter had a direct impact on or relevance to our work. We responded in particular where their scope related to changes that would affect users of public services or were about how organisations can learn from mistakes. This included Healthcare Improvement Scotland's consultation on 'Building a national approach to learning from adverse events through reporting and review'. We were later invited to participate in their working group on learning from adverse events, which met for the first time in May 2013.

Drawing on our experience of what people want when things go wrong with public services, particularly in the NHS, we responded to consultations on no-fault compensation for injuries resulting from clinical treatment and on a proposed Apologies Bill. Our experience of water complaints informed our response

to Consumer Focus Scotland's consultation on proposals for a Regulated Industries Unit. We also gave advice when it was proposed that the Children's Commissioner should be able to carry out investigations on behalf of individual children and young people.

Our Complaints Standards Authority (CSA), with its focus on streamlining complaints processes, was responsible for much of our policy engagement in 2012/13. It will continue to play a key role in this area in the coming year. It provided responses or input to:

- the consultation on the integration of adult health and social care in Scotland;
- the Scottish Housing Regulator's consultation on Scottish Social Housing Charter indicators; and
- the consultation on the Charter of Patient Rights and Responsibilities (introduced by the Patient Rights (Scotland) Act 2011).

The CSA was also invited to participate in a short life working group to consider and decide upon the most appropriate options for social work complaints (and appeals guidance), following the Government's consultation on the review of social work complaints. We expand on the CSA's input in the next section of this report.

All our evidence sessions and consultation responses are posted on our website at www.spsso.org.uk/media-centre/inquiries-and-consultations

Scottish Welfare Fund

A key change that we prepared for in 2012/13 and which came into effect from 1 April 2013 was the Government's introduction of the Scottish Welfare Fund. The fund is administered by local authorities so the SPSO, by default, became the final point for complaints. In preparation for this change, we gathered knowledge on the subject, and briefed our staff on the type of complaints that will come to SPSO and our powers in this area. We also produced new leaflets for advisers and complainants, with background information and case studies.

The Ombudsman and other senior SPSO staff discussed these, and other policy areas, with key stakeholders, including MSPs, Scottish Government officials, consumer and advocacy groups, regulators and inspectorates.

Administrative justice framework

We also had strategic input into the administrative justice arena. As the Ombudsman highlights in his introduction, we have in particular used our policy work and consultation responses to emphasise, when policy changes are being formulated, the importance of building in consideration of people's right to challenge decisions. We have also emphasised that the starting point for policy changes should be the perspective of the user rather than that of organisations, and that change should be looked at holistically. With this in mind, we welcomed the Government's invitation for us to discuss their intention to develop a Strategy for Administrative Justice in Scotland. We were pleased to provide a user-focused emphasis, and to be involved in discussions and workshops held by the Scottish Committee of the Administrative Justice and Tribunals Council about the role and remit of the body that will replace it. We also supported the Scottish Human Rights Commission's development of a national action plan for human rights for Scotland, through the Ombudsman's membership of the advisory panel and through other engagement.

Ensuring our recommendations are implemented

The case studies in this report provide examples of the kinds of recommendations we make. There are hundreds more available in the cases published on our website. We may recommend, for example, that a health board should review or change a nursing practice or a consent policy, or carry out training or awareness raising. Very often, we recommend that they make a full or meaningful apology to the person who brought the complaint.

Across all areas of jurisdiction in 2012/13, we made 1,003 recommendations on cases we closed (up from 619 last year). We track every recommendation to ensure that the organisation implements it within a specified timescale and provides suitable evidence to show that it has done so effectively. In 2012/13, of 918 recommendations due for implementation, 78% were carried out within the agreed timescale and 99% within three months of the target date.

It is difficult to quantify the impact of our recommendations, but we know from discussions with public bodies, the Scottish Government and others that organisations refer to our published case summaries to ensure that their own practices and procedures are in line with recommendations. In the health sector, we know that the Scottish Government track our recommendations across all health boards. We see this as an excellent way of ensuring learning across a whole sector and would welcome it being adopted in other areas.



We track every recommendation to ensure that the organisation implements it within a specified timescale and provides suitable evidence to show that it has done so effectively.





The digital revolution is shaping society and culture, and transforming public services. We recognise that, increasingly, individuals are using technology to access private and public services.



Using communications tools effectively

2012/13 was the first full year of publishing summaries of our investigation decisions and recommendations. We published 806 decisions, in addition to the 44 public investigation reports.

These are all searchable on our website by sector, organisation, date and outcome, and provide a wealth of material for complainants and organisations. As mentioned earlier in this section, we promote the learning from these reports through the Ombudsman's monthly e-newsletter. In 2012/13, we redesigned and relaunched the e-newsletter and a healthy average of 35% of subscribers open it.

The media is of course a useful tool for amplifying the reach of our complaints work. Each year we analyse media coverage of SPSO, and 2012 showed a continuing trend of increased reach.

We regularly review and, where appropriate, update our information leaflets for the public. We have around 20 leaflets on complaint subjects as diverse as antisocial behaviour, GP practices and council tax benefit. These are all available online and as hard copies. In 2012/13 we published a number of new leaflets, including about the Scottish Welfare Fund,

prison and prison healthcare complaints, student complaints, and information rights. After the April 2012 local elections we also published a *Guide to the SPSO for councillors*. Like our *Guide for MSPs/MPs and Parliamentary Staff*, this explains our role and remit and provides advice and support on matters such as getting consent from the person affected by the complaint and on making complaints.

The digital revolution is shaping society and culture, and transforming public services. We recognise that, increasingly, individuals are using technology to access private and public services.

To ensure that we meet the changing needs and demands of our service users, we continually measure and monitor the impact and value of our on- and off-line services.

Last year, we carried out an expert evaluation and accessibility audit of our main digital platform, the SPSO website. This work included several tests designed to gauge how well it meets the needs of users, including those of disabled users. The results of the accessibility review resulted in changes to our website and mobile platform, which will be fully implemented by summer 2013. There is more about our work to ensure accessibility in the equalities section of this annual report.

Complaints information www.spsso.org.uk



@SPSO_Ombudsman

“ Looking further ahead, we want to find new ways to meet the public in the communities they live in, hear from them about their concerns and raise awareness and understanding of our service. ”

We also dipped our toe into the world of social media, setting up Twitter accounts for our SPSO and CSA websites in October 2012. These additional communication channels are a minor but significant part of our stakeholder engagement strategy. We see Twitter as an extension of our corporate voice, supporting the strategic objectives of making our service accessible to all users, raising informed awareness of our role and promoting good complaints handling through networks, sharing good practice and training.

At the end of March 2013, we had posted 40 tweets and had around 150 followers. Many of our followers are key stakeholders.

Of course, we recognise that there are many people who do not have internet access and we continually seek ways to provide an inclusive service. During a prison visit in 2012, we set up a discussion forum amongst young offenders to gather real-time, face-to-face feedback on our communications materials and perceptions of our service. As a result, we changed the wording of our prisoner leaflets to clarify our role and independence, and worked with young offenders to produce audio-visual information.

As, however, the telephone remains our main means of contact with our customers, we have undertaken training to ensure that we do this in a meaningful and effective way.

We are continuing to develop ways of raising awareness among hard-to-reach or typically excluded users and potential users of our service, particularly through advocacy and advice centres. As we do each year, we had a stand at the Gathering organised by the Scottish Council for Voluntary Organisations. We find this an excellent opportunity for networking with the third sector, advocacy and consumer groups, and particularly Citizens Advice Bureaux workers. One of our objectives for 2013/14 is to build on our relationships with these groups. We want to ensure that the routes to our service are open to all, especially given our new role with the Scottish Welfare Fund. Looking further ahead, we want to find new ways to meet the public in the communities they live in, hear from them about their concerns and continue to raise awareness and understanding of our service.

We are developing several projects under our 2013/14 business plan to fulfil these aims.

Complaints Standards Authority www.valuingcomplaints.org.uk



@valuecomplaints

CASE STUDIES

Introduction

This is a selection of case studies from investigations we published in 2012/13. 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: delay in sending ambulance; poor complaints handling

Case 201103310

This complaint was about the length of time that an emergency ambulance took to arrive, when a man died after becoming extremely unwell at home. The ambulance service said the delay was because of failures in the system and by the call taker. We found that, although the outcome might have been the same even had the ambulance arrived more quickly, the delay made a very traumatic experience even worse for the man's wife. Although the service had addressed some of the failings, their complaints handling was poor. They had tried to explain the system difficulties in their response, but the information was too technical and the response letter was not sent until about a year after the event. We said that they should have investigated the complaint as a priority to ensure that any failures in the emergency callout service were fixed immediately. They also did not apologise for what went wrong, or for the significant distress caused, which we found unacceptable and insensitive.

Recommendations

The ambulance service review the systems issue; report to us on additional support for less experienced call handling staff; review their complaints handling and apologise in full to the man's wife.

To read our decisions visit www.spsa.org.uk/our-findings

Local government: housing benefit; council tax benefit appeals Case 201003747

After a joint investigation with the Department for Work and Pensions (DWP), it was decided that a claimant was not entitled to all the benefits she was receiving. Although she tried to appeal, the council began recovering overpaid housing and council tax benefit. While appealing against the withdrawal of DWP incapacity benefit, the claimant asked the council for a discretionary payment to write off the council-related benefit overpayments, but they said they could not do this. She asked again, as she was suffering hardship, but the council did not respond. They later said they were awaiting the outcome of a DWP appeal before making a decision. That appeal was determined in the claimant's favour, and the DWP wrote off all her overpayment. Although the council did not accept that decision, they then agreed not to recover the rest of the overpaid benefits. We found that they had not dealt properly with the claimant's request for the council's own decision to be sent to appeal. They should also have considered suspending deductions from her benefits, as their policy was to stop these when an appeal was outstanding. As well as this, they had delayed in dealing with her second application for a discretionary payment, and had not communicated appropriately.

Recommendations

The council credit the claimant's rent and council tax accounts with the amount already taken, and apologise for all the failures we identified; review their practices to reflect housing and council tax benefit guidance; remind staff that they should handle applications promptly and communicate effectively with applicants.

Health: facilities and activities Case 201104822

Positive action taken by organisation

The State Hospital introduced a new clinical model, setting up new hub and cluster units. Each of the four hubs supports a cluster of three wards, with various social activities taking place in the hub. There is also a central unit for more formal therapies and educational activities.

A patient in the hospital complained that when this was introduced he was unreasonably pressurised to attend activities in the hub although he did not like it there. The board acknowledged that there were initial problems with the new regime. This sometimes meant that wards were closed, or patients relocated to other wards, to allow staff to be suitably deployed while ensuring patient and staff safety.

Our investigation found that since the man's original complaint to the board – which they upheld – matters had improved. They had addressed staff recruitment and training and reviewed policies to allow more flexible use of resources. This had allowed them to keep more wards open while still staffing the hub, and in the last few months the man's ward had not been relocated. He said that he thought this only happened because he had complained. However, we explained that the complaints system is meant to be used so that issues can be raised and solutions found.

We took independent advice on this case from a mental health adviser, and did not uphold the complaint as we found no evidence that the man was unreasonably pressurised to attend the hub. Our adviser said that good and positive progress had been made on the new model. He said that staff would be failing in their duty of care if they did not try to encourage patients to engage with treatment programmes.

Prisons: personal property Case 201104125

Positive action taken by organisation

A man, who is a prisoner, complained that he was not allowed to have two electrical items although he had purchased them in a previous prison and was allowed to use them there.

We obtained a copy of his current prison's policy which confirmed that the items were prohibited. Our investigation found that his previous prison did permit him to have them, as prison governors have discretion about which items they allow. However, his current prison had already acknowledged the discrepancy and offered to reimburse him the cost of the items. We considered this reasonable and did not uphold the complaint.

We accepted that lack of consistency across prisons could be a source of frustration for prisoners. However, as the Scottish Prison Service confirmed that they were currently taking steps to source a national supplier for such goods and developing a uniform policy about their use, we made no recommendations about this.

Housing association: dampness in let property

Case 201100230

A tenant complained that the association knew of dampness in his house before letting the property to him, and that they delayed in carrying out repairs. The association had indeed been aware of what they thought was minor dampness, which they had addressed before it was let. It turned out later that the problem was more severe. It affected homes in the whole building and so other owners, as well as the association, were jointly responsible for repairs. We accepted that the association did not know this before letting it, and that when they found out, they tried to get the other owners to agree to resolve this. We were, however, concerned at the length of time the tenant had lived with the problem, although the association had already offered him a payment to make up for this. We were also concerned that there was no written record of the accompanied viewing with the tenant before the let, which would have noted any issues brought to his attention.

Recommendations

The association consider the tenant's request for housing points, if his property shows more signs of internal dampness; and in future retain a note of the accompanied viewing of property.

Health: treatment and care of an elderly person

Case 201102756

An elderly man who had acute kidney failure was transferred to a community hospital for rehabilitation, where he remained for almost two months, although his condition worsened during his time there. He was eventually transferred to another hospital, but died the next day. Our investigation found failings in the care at the community hospital. It provided mainly nursing care, and used external GP services to assess and treat patients who became unwell. We found that two out-of-hours GPs failed to recognise how poor the man's condition was, and did not arrange to transfer him to another hospital soon enough. We also found that decision-making, care and communication about palliative care by nursing staff was inappropriate.

Recommendations

The health board carry out a critical incident review of these events; consider routine discussions about care escalation for patients admitted to such establishments, and how to ensure that severe illness is promptly recognised, by using suitable scoring systems; consider a strategy to determine the appropriate limits of care as soon as a patient becomes acutely unwell, where there has been no advance discussion.

Local government: complaints review committee – failure to review

Case 201101997

This complaint arose after an elderly man was diagnosed with dementia. His family knew that he would eventually need residential care, and that at that point the council would assess his finances to decide what he should pay towards care costs. The family decided to temporarily transfer some money to his wife, so that she could benefit from the interest until then. She, however, unexpectedly moved into residential care herself. Before she was financially assessed, the family moved the money back into the man's account. On the financial assessment forms, they explained what they had done, and why. When the social work department looked at this, they decided that the money in fact belonged to the man's wife, and she should be considered as still having it. This meant that she had to pay the majority of her care costs. A social work complaints review committee (CRC) looked at this, but said they could not comment on the social work department's decision, which was a matter of professional judgement. We took the view, however, that the CRC should have looked at it, and that in not doing so they had denied the family the opportunity to challenge the original decision.

Recommendations

The council apologise to the family and arrange for the financial assessment to be independently reviewed; ensure they tell those having their case reviewed by a CRC of the extent of the CRC's remit and powers; and ensure that CRC members have appropriate training and access to expert advice to deal with all matters presented to them.

Health: siting of facilities Case 201103887 Positive action taken by organisation

A man complained when a health board decided to relocate a hospital pain management clinic. He said that the previous location was more accessible for him and he now faced a journey time of over eight hours for a 15 minute appointment. The board suggested alternative means by which he could attend the clinic but he did not feel they were appropriate. He felt the board had not taken his health needs into account when deciding to relocate the clinic and complained to us.

We explained that health boards have the authority to decide where to site services in their area. The board had provided information about public transport links and the availability of patient transport services. They had also offered to pay a taxi fare for his next appointment and said that the matter would be kept under review. They also suggested that to avoid the need for travelling, he could have a telephone consultation. We concluded that the board had taken appropriate action.

Water: sewer flooding Case 201103863

Positive action taken by organisation

A woman complained that after heavy rainfall flooding prevented her from getting out. She said this had happened several times. It had ruined her garden, and the authority had refused to compensate her for the damage.

Our investigation found that the water authority agreed that there was a problem in the area and had been trying to resolve it. They had been unable to find a solution but now planned to appoint engineers to look at this. They had kept in contact about the complaint, usually by phone, and, after a few months, had written in detail to update residents on what was happening. They also told the woman that as they had not been negligent they would not pay compensation.

We explained to her that flooding could be a very difficult problem to resolve. There may be more than one cause, and other organisations may share responsibility. Flooding is not always the fault of the water authority and they could not always get funding to resolve major flooding problems. We explained that funding was part of a complex process. The authority could not simply decide to spend more or increase water charges to get extra money. We also explained that it was not their responsibility to deal with all rainwater, and that some responsibility lay with the local authority, who had separate sewers of their own.

We considered that the water authority had actively tried, and were continuing to try, to resolve the problem. We found no evidence that their handling of it was unacceptable. In respect of the compensation claim, our role is, broadly speaking, limited to considering whether the authority followed their procedures in reaching their decision about it. The question of if, or how much, compensation is due is a matter for the courts. We found no evidence that the authority did anything wrong when coming to their decision.

Local government: stair lighting Case 201200538

Positive action taken by organisation

A council tenant complained about changes to the lighting in the close that he shares with his neighbour. He said that, historically, lighting was provided from dusk to dawn, but that this service was withdrawn.

Our investigation found that the council were not obliged to provide lighting in the close. The original light was connected to the neighbour's electricity supply and, although there was an understanding that the light would be left on overnight, this was ultimately at her discretion. When a new tenant moved into that property she decided not to use the light. Although the council were not required to light the close, we found that they had provided the man with a second light, over which he had sole control.

We were satisfied that this was an appropriate gesture and that they had suggested other steps that he could take to increase the level of lighting available.



3

improving
complaints
handling

4

simplifying
complaints
handling
systems

COMPLAINTS STANDARDS AUTHORITY

STRATEGIC OBJECTIVES 3 AND 4

In this section we report on our 2012/13 annual business plan key priorities for these strategic objectives. These are:

- to facilitate the improvement of complaints handling by public service providers
- to simplify and standardise the design and operation of complaints handling procedures (CHPs) across the public sector, in line with the vision set out in the Crerar and Sinclair reports.

Strategic objective 3: to improve complaints handling by public service providers

This objective focuses on improvement through monitoring, promoting and facilitating the sharing of best practice in complaints handling and supporting service providers in improving their complaints handling. We aim to achieve this through developing and coordinating networks of complaints handlers, promoting good complaints handling by providers through the sharing of best practice and by developing and delivering high quality training.

Douglas Sinclair set out in the recommendations of his 2008 report from the Fit for Purpose Complaints System Action Group that:

- **A network for complaints handlers should ... be established. Scrutiny bodies and service providers should work together to devise ways to bring complaints handling employees together to share experiences and support each other.**
- **The SPSO should establish a cross-sectoral network of complaints handlers and a website to allow complaints handlers to share best practice in complaints handling.**

Networks of complaints handlers

In 2012/13 we successfully established the local government and registered social landlord (RSL) complaints handlers networks, which met for the first time in September and October 2012.

The networks are led by individuals from each sector. They have begun a programme of discussion focused on supporting complaints handling practitioners, sharing best practice and learning, developing standardised reporting frameworks and providing a forum for benchmarking performance against SPSO indicators. The networks also provide a voice for the sectors on specific issues affecting complaints handling.

The networks were established from the working groups set up to help develop the model CHPs for each sector and have provided a useful support mechanism. We plan to use a similar approach to developing networks in other areas to help create a cross-sector network of complaints handlers.

Valuing Complaints website and online forum

In 2012/13 we facilitated the sharing of knowledge and best practice in complaints handling through the launch of our dedicated CSA website. The website, launched in May 2012, provides:

- information on the CSA and progress on roll-out across the sectors, including access to model CHPs and the requirement to implement these;
- 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;
- an SPSO training centre providing access to our e-learning resources and information about directly provided courses offered by our training unit.

Our aim has been to develop the website and forum and increase its usage as a central information point for complaints handlers. The online forum aims to facilitate the effective professional networking of complaints handlers and support the sharing of experiences and learning.

VALUING FEEDBACK AND COMPLAINTS

3. NHS COMPLAINTS & FEEDBACK PROCESS

- WELCOME
- COMPLAINTS
- FEEDBACK
- OTHER PROCEDURES
- QUIZ
- WHAT'S NEXT?

Welcome

Welcome to the **Valuing Feedback and Complaints Programme**

It is important that we all know how to respond appropriately to all forms of feedback in order to provide the highest standards of compassion and care to patients, carers and family members. This programme looks at ways you can encourage all forms of feedback and use it to improve the services you provide, identify and solve problems quickly and early without the need for more formal procedures which can sometimes be off putting for people who have concerns. We must all recognise the value of feedback and complaints, and more information can be found in the ['Can I Help You?' Guidance](#)

Estimated Time

20 Minutes

Click here to begin

This programme has 5 modules:

- 1. The Value of Feedback
- 2. Encouraging Effective Feedback...and using it
- 3. NHS Complaints & Feedback Process (this module)
- 4. The Value of Apology
- 5. Managing Difficult Behaviour

Each module is written to enable you to work through it on its own and in any order. If you are new to the NHS or to the NHS Feedback and Complaints process you will find it most helpful to work through the modules in order from 1 to 5.

Each module has a short quiz to allow you to test your knowledge and understanding. There are activities and resources to allow you to help you to apply your learning back in the workplace.

The following icons indicate the status of each section in this module:

- Section complete
- Section in progress
- Section not started



MacBook Pro

Training unit

Training courses

Our training unit continued its good work throughout 2012/13, meeting a steep increase in demand for direct delivery courses resulting from the introduction of the model CHPs and CSA engagement with the RSL and local government sectors. We expect this trend to continue into 2013/14 as we roll out the CHPs for the remaining sectors.

In 2012/13 we directly delivered 71 courses, including 43 in the RSL sector and 21 in local government. This represents a 97% increase on the number of courses requested and delivered in 2010/11 (36) and a 73% increase on 2011/12 (41).

The training unit courses continue to get very high ratings from participants and are accessed by a wide range of organisations across sectors. The rollout of e-learning training provides significant scope and value, particularly for frontline public sector staff. However, 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 this to be a significant factor in how we help manage the numbers of complaints coming to the SPSO.

E-learning courses

A significant development in 2012/13 was the development and launch of our e-learning modules on frontline complaints handling. We developed these in response to concerns expressed by some service providers in our consultation on the rollout of the model CHPs. They told us that, given the strong focus on frontline resolution and the empowerment of frontline staff, they would find training and awareness for these staff challenging.

Our e-learning platform provides modules that are free and accessible to all public sector staff. They aim to increase awareness of the importance of good complaints handling and the role of frontline staff in complaints, and help improve the skills required for successful frontline resolution. The first course, specific to the local government sector, was launched in May 2012, with a similar course for RSLs following in August 2012. The courses are proving popular, with around 2,000 users signed up directly through our training centre. In addition, a number of organisations have integrated the courses into their internal e-learning systems and have rolled these out to the majority of their staff.

Over the final quarter of 2012/13 we also developed e-learning modules with NHS Education Scotland (NES) to support the roll-out of training on the Patient Rights (Scotland) Act 2011 and its requirements on feedback and training. In 2013/14 we plan to develop packages for further and higher education and Scottish Government frontline staff, to support the implementation of model CHPs in those sectors.

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

Strategic objective 4: to simplify the design and operation of the complaints handling system in Scottish public services

Simplified complaints handling procedures

2012/13 was a significant year in moving towards our vision of a streamlined complaints handling system across the public sector. Having published model CHPs for local government and RSLs in March and April 2012, we developed model CHPs for further and higher education and the Scottish Government, Scottish Parliament and associated public authorities. These were published in December 2012 and March 2013.

The model CHP for further and higher education was developed in partnership with Scotland's Colleges (now College Development Network) and Universities Scotland and in consultation with working groups of college and university representatives. This engagement was valuable in providing sector-specific input and identifying areas where there was a need for a sector-specific approach. In particular it took account of challenges currently faced by the sectors in terms of funding, restructuring and an increasingly competitive environment. For the Scottish Government, Scottish Parliament and associated public authorities we engaged with the Scottish Government Public Bodies Unit, Scottish Parliament and Audit Scotland on appropriate arrangements.

In line with our targets, the model CHP is now operating in over 160 registered social landlords and across all council services in Scotland's 32 local authorities. The NHS are also operating a standardised process under the revised *Can I Help You?* guidance, published by the Scottish Government in March 2012.

Scotland's 37 colleges and 19 universities are on course to implement by September 2013. With over 70 Scottish Government and associated public authorities required to implement by April 2014, we are well on course to achieve a fully standardised complaints system across the public sector in 2013/14.



We are well on course to achieve a fully standardised complaints system across the public sector in 2013/14.



CSA engagement and support

Working in partnership with service providers, regulators and other stakeholders has been key to our success in facilitating the development and implementation of the model CHPs. Throughout the year we have supported organisations and other stakeholders in a range of ways to help with the adoption of the model CHP, improving complaints handling standards or by providing advice, guidance and support in relation to complaints handling procedures.

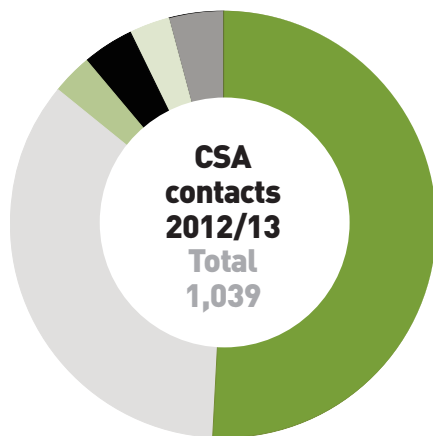
Enquiries and requests for support

In terms of direct support and engagement for service providers, between April 2012 and March 2013 we responded to over 1,000 stakeholder enquiries.

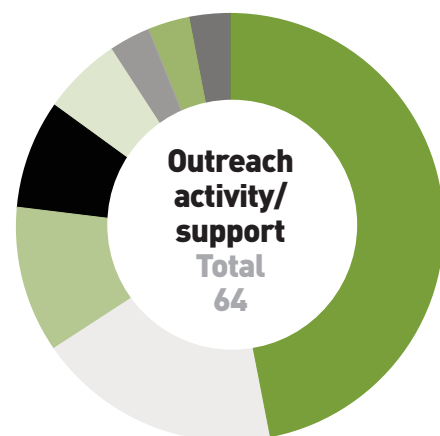
The majority of our activities related to RSLs and local government, reflecting the early publication of the CHPs in these sectors, with RSLs accounting for 51% and local government 35% of contacts. This involved support on a range of issues related mainly to implementation, including specific guidance on CHP requirements and good practice, compliance checks, support for staff training/systems changes and general complaints handling guidance. Many were straightforward requests, but others required detailed advice, guidance and follow-up contact.

The publication of model CHPs for the further and higher education sectors in December 2012 and our plans for publishing a model CHP for the Scottish Government, Scottish Parliament and other public authorities in Scotland in March 2013, saw a rise in our activities with these sectors towards the end of the year. This accounted for a further 10% of our support activities. The chart below illustrates the range and extent of these contacts across the public sector in Scotland.

arrangements that organisations were putting in place. We used them to explain the requirements of the model CHPs, provide feedback on developing CHPs and organisational plans for implementation, and provide tailored advice on improving complaints handling processes and culture. We also provided support through the RSL and local government complaints handlers networks and through the NHS Complaints Personnel Scotland (NCPAS) organisation which has provided a similar network for NHS complaints professionals for many years.



Category	Percentage
RSL	51%
Local government	35%
Higher education	3%
Further education	4%
Scottish Government & associated bodies	3%
Other	4%



Category	Percentage
RSL	47%
Local government	19%
Scottish Government & associated bodies	11%
Higher education	8%
Health	6%
Water	3%
Further education	3%
Other	3%

Meetings, events and conferences

We provided speakers at a total of 64 conferences, meetings and events across sectors, delivering presentations to staff, management teams, regulators and representative bodies.

There is a sectoral breakdown in the chart below. Our outreach activities were crucial in ensuring senior level commitment to improving complaints handling and the quality of the

“ **For the first time members of the public will have access to clear, transparent and consistent information on the volume of complaints received by service providers and how they have handled these.** ”

CHP Compliance

We want to be as light-touch as possible in monitoring implementation of the model CHPs, whilst ensuring that organisations have adopted the CHP and its requirements in full. The SPSO Act 2002 now contains powers for the Ombudsman to monitor and report on non-compliance. Our aim, however, was to work with regulatory and sponsor bodies to develop a consistent method for monitoring compliance with the model CHPs within existing regulatory structures including, wherever possible, through self-assessment. In 2012/13 we achieved this by:

- developing arrangements with Audit Scotland to assess compliance through the Shared Risk Assessment (SRA) and annual audit processes, providing Audit Scotland with an assessment of compliance for all local authorities.
- embedding the model CHP and its requirements in the Scottish Social Housing Charter. This will be monitored in 2013/14 by the Scottish Housing Regulator (SHR) as part of their wider monitoring of the Charter. All RSLs are required to confirm their compliance with the CHP to the SHR.
- incorporating compliance arrangements for further and higher education into the Scottish Funding Council's financial memorandum for further and higher education institutions.
- agreeing with the Scottish Government and Audit Scotland to pursue the possibility of stipulating compliance with the CHP as an expectation on all central government bodies as part of future changes to the existing sponsorship framework.

Complaints handling performance

One of the aims of the CHPs is to improve the information available about complaints to help develop a performance culture in complaints handling across the public sector in Scotland. As well as requiring service providers to analyse and report complaints information internally on a regular basis, CHPs require them to publish annual information on complaints performance statistics.

With each of the model CHPs we published indicative performance indicators, designed to be broadly consistent across the sectors. We worked with the Chartered Institute of Housing, HouseMark and the Scottish Housing Best Value Network to develop detailed guidance on performance indicators. This was published in December 2012, to assist RSLs in assessing their complaints handling in line with the SHR's requirement to report on the Charter. Using those indicators as a basis we have developed more detailed indicators for local government, with that sector's complaints handlers network. These will also form the basis of development with other sectors.

The indicators will help us move towards a greater consistency of reporting on complaints across the sectors and provide an excellent basis for developing benchmarking arrangements for comparing performance. For the first time members of the public will have access to clear, transparent and consistent information on the volume of complaints received by service providers and how they have handled these.

Social work and social care

We have raised concerns about the lack of clarity in how complaints are handled in this area of multiple overlapping procedures/legislative routes for complainants. This is particularly important because social work and social care decisions impact hugely on individuals and families. The social work complaints procedure, in particular, is an area where most stakeholders agree that reform is needed. This was subject to review by the Scottish Government throughout 2012/13 in line with the recommendations of the 2008 Sinclair report.

The Scottish Government's report of their consultation on the review of social work complaints was published in August 2012. This 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. This was felt to be the most likely to create a fit-for-purpose complaints system for the future. It is one that we support, given that it aligns with the aims of simplifying the complaints landscape.

The strength of these options is that there would be a streamlined internal model for handling complaints, and the individual could have an objective, external view of decisions that have a potentially profound impact on them. It is also a model that would be adaptable enough to cope with the changes being brought about by the move towards integrating health and social care. We highlighted the implications of this for service user complaints through various engagements with key stakeholders during 2012/13.

In February 2013 a social work complaints working group set up by the Scottish Government 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 (COSLA), the Association of Directors of Social Work and a number of third sector organisations, including Capability Scotland and Children First. We have since held further discussions with the Association of Directors of Social Work and Capability Scotland on the details of the potential options ahead of a final proposal being agreed in 2013/14.



Clarity in how complaints are handled in this area ...is particularly important because social work and social care decisions impact hugely on individuals and families.





5 being an
accountable
and best value
organisation

CORPORATE PERFORMANCE

STRATEGIC OBJECTIVE 5

In this section we report on our 2012/13 annual business plan key priority for this strategic objective. This is to deliver operational efficiency, effectiveness and accountability through clearly defined priorities, performance measures and resources that meet business needs, while supporting development of new areas of business.

Managing resources effectively

The SPSO makes an annual budget application to the Scottish Parliamentary Corporate Body (SPCB). This is considered by the Parliament's Finance Committee and the Scottish Government. Over the three year period between 2010/11 and 2013/14 the SPSO committed to achieving as a minimum a 15% real terms decrease in its 2010/11 baseline budget. The 2011/12 budget represented a saving of 6.5%, which was largely achieved through restructuring the organisation. The approved budget for 2012/13, in cash terms, was £3.29 million, a 6% decrease on the refreshed 2011/12 baseline budget.

We also achieved this reduction and ensured value for money through, for example, regularly reviewing all contracts and procurement arrangements as well as through shared services initiatives. In 2012/13, we continued to share office space with, and provide corporate services to, other SPCB sponsored office holders and to liaise with the SPCB on other potential areas for saving.

The actual expenditure for 2012/13 was £3.23 million, below the approved budget. This additional saving was achieved largely through

the higher than anticipated revenue generated by our training unit. The approved budget for 2013/14 is £3.207 million, a further 2.7% decrease on 2012/13. The summary of our 2012/13 expenditure can be seen in the table later in this section. The Public Services Reform (Scotland) Act also requires us to provide information on specific expenditure areas. We publish this regularly on our website, and will publish our full audited accounts there, once these have been signed off in October 2013.

The challenge for SPSO as a demand-led organisation is to continue to seek efficiencies in an environment of increasing demand and rising caseloads, in a way that minimises the impact on the service user and maintains the independence and credibility of our office.

In 2012/13 we successfully achieved a productivity increase of 9%, with an end year caseload of 546 against a target of 500, in spite of a 5% increase in complaints.

We undertook a review of our core complaints process to ensure it was as efficient and streamlined as possible. As a result, we have introduced a number of initiatives to help us continue to build on our strong record of improving productivity as well as service quality as we progress in 2013/14.

To ensure that SPSO is managing its resources to best effect, there are a number of checks and balances in place. These are set out in more detail by John Vine, chair of the SPSO Audit and Advisory Committee, in the governance and accountability section.

“ The challenge for SPSO as a demand-led organisation is to continue to seek efficiencies in an environment of increasing demand and rising caseloads, in a way that minimises the impact on the service user and maintains the independence and credibility of the office. ”

Improving operational efficiency

The corporate planning process plays a key role in ensuring operational efficiency and effectiveness. The 2012/16 Strategic Plan is available in full on our website. It sets out our five strategic objectives and equalities commitments, and provides the framework for developing our annual business plans and accompanying annual performance measures.

In 2012/13, progress against these plans and measures was reviewed regularly by operational management, the senior management team and the Audit and Advisory Committee. Details of this progress are documented against each strategic objective in the relevant sections of this annual report. Our business plans for 2012/13 and 2013/14 and performance measures for each year were shared with SPCB officials. These plans and measures, along with minutes of meetings to record and monitor progress, are on our website.

Information from external and internal auditing processes is also used to drive efficiency and effectively manage risk. There were no significant findings arising from the 2011/12 external audit completed in November 2012. This found that we have effective corporate governance structures and a risk assessment approach that is fully embedded into the corporate and performance management, business planning and financial reporting processes of the organisation. This year, as part of the three year internal audit programme for 2012/15, the internal auditors looked at the areas of accounting and budgeting, business continuity, payroll and facilities management. In each area we achieved either a satisfactory or good rating.

We had a strong record of ICT systems reliability in 2012/13. We also continued to explore ways to seek efficiency gains through technology. We are working towards upgrading the existing case management system to allow for smoother processing of online applications. This work is due to be completed in 2013/14.

Our people

As an Investors In People employer, we work hard to ensure we provide managers and staff with the knowledge, skills, tools and support to manage and deliver strong performance, sometimes in very challenging circumstances, to engage effectively with our goals and meet our service commitments.

We monitor staff absence closely to maintain a position well within public sector norms. In 2012/13 we worked with our teams to develop and deliver a learning and development programme that met individual, team, and organisational objectives. We provided update training to staff on the legal and investigative aspects of our work. In partnership with organisations like the Samaritans, we continued to build skills in dealing with people when they are at their most vulnerable. We take the safety of staff and service users seriously, enhancing it through audit and training activities.

Meeting our obligations and statutory duties

We have a number of other specific statutory duties that we report on in full on our website. One of these is sustainability, on which we are required to report under the Public Services Reform (Scotland) Act 2010. In 2012 we published our first sustainability report on our website, monitoring carbon emissions and waste management activities, and met the targets set.

A second area is access to information. We have a responsibility to protect the sensitive personal data gathered through our casework and to provide as much access to information about us as possible. We also have to meet the obligations

of the SPSO Act to conduct all investigations in private. We take this very seriously.

We receive a number of requests for case-related and organisation-related data each year. In 2012/13, we received 123 requests under Freedom of Information and Data Protection legislation, compared to 142 in the previous year. Our policy is to process these requests in the way that gives the member of the public the greatest access to information wherever possible. There were only two appeals against our decision about the information to provide.

Reports on the above areas and other material about our corporate performance are available on our website.

Summary analysis of expenditure	2013 £000s	2012 £000s	2011 £000s
Staffing costs	2,559	2,660	2,385
Other operating costs			
Property*	293	292	301
Professional**	138	166	94
Office running costs***†	358	324	310
Total operating expenditure	3,348	3,442	3,090
Capital	62	128	48
Other income	(180)	(93)	(90)
Net expenditure	3,230	3,477	3,048
Staff FTE	47	45	46

* Including rent, rates, utilities, cleaning and maintenance

** Including professional adviser fees

*** Including ICT, annual report and publications

† Office costs for earlier years adjusted to exclude notional cost of capital which is no longer charged.

Full audited accounts are available on the SPSO website www.sps0.org.uk

Forward Business Planning

Our key point of reference for the four year period beginning 2012 is our Corporate Strategic Plan. We published our 2012/2016 plan at the end of March 2012, after inviting stakeholders – the public, the Parliament, public service providers, regulators and others – to comment on a draft plan. Their responses were highly supportive of the five strategic objectives and equalities commitments that we set out. We commissioned independent analysis of the responses and, where appropriate, we changed the draft plan. The consultation, responses, independent analysis and our reasoning for the changes were all published on our website, along with the final plan.

The five strategic objectives constitute our high-level strategic plan and under it will sit business plans for each year. Our equalities commitments remain the same for the duration of the plan. Inevitably, business plans sit within an environment that is continually changing and which can directly impact on our work. This annual report charts progress against the first year of our Strategic Plan, which is available in full, along with our 2013/14 business plan, on our website. Both these plans contain targets and goals against which our progress can be measured, and which are shared with officials of the Scottish Parliamentary Corporate Body.

Our five corporate strategic objectives are:

1

To provide a high quality, user-focused independent complaints handling service

By developing our capacity as complaints handlers to be able to deliver individual benefit to our customers; by being accessible and dealing with all enquiries and complaints impartially, consistently, effectively, proportionately and in a timely manner; and by producing clear, accurate and influential decisions about complaints.

2

To support public service improvement in Scotland

By continuing to raise informed awareness of the role of the SPSO and to feed back and capitalise on the learning from our consideration of individual enquiries and complaints, for example, through thematic reports, and by working in partnership with public service deliverers, policy makers, scrutiny bodies and regulators to promote good administrative practice.

3

To improve complaints handling by public service providers

By using our expertise and resources to monitor, promote and facilitate the sharing of best practice and support service providers in improving their complaints handling.

4

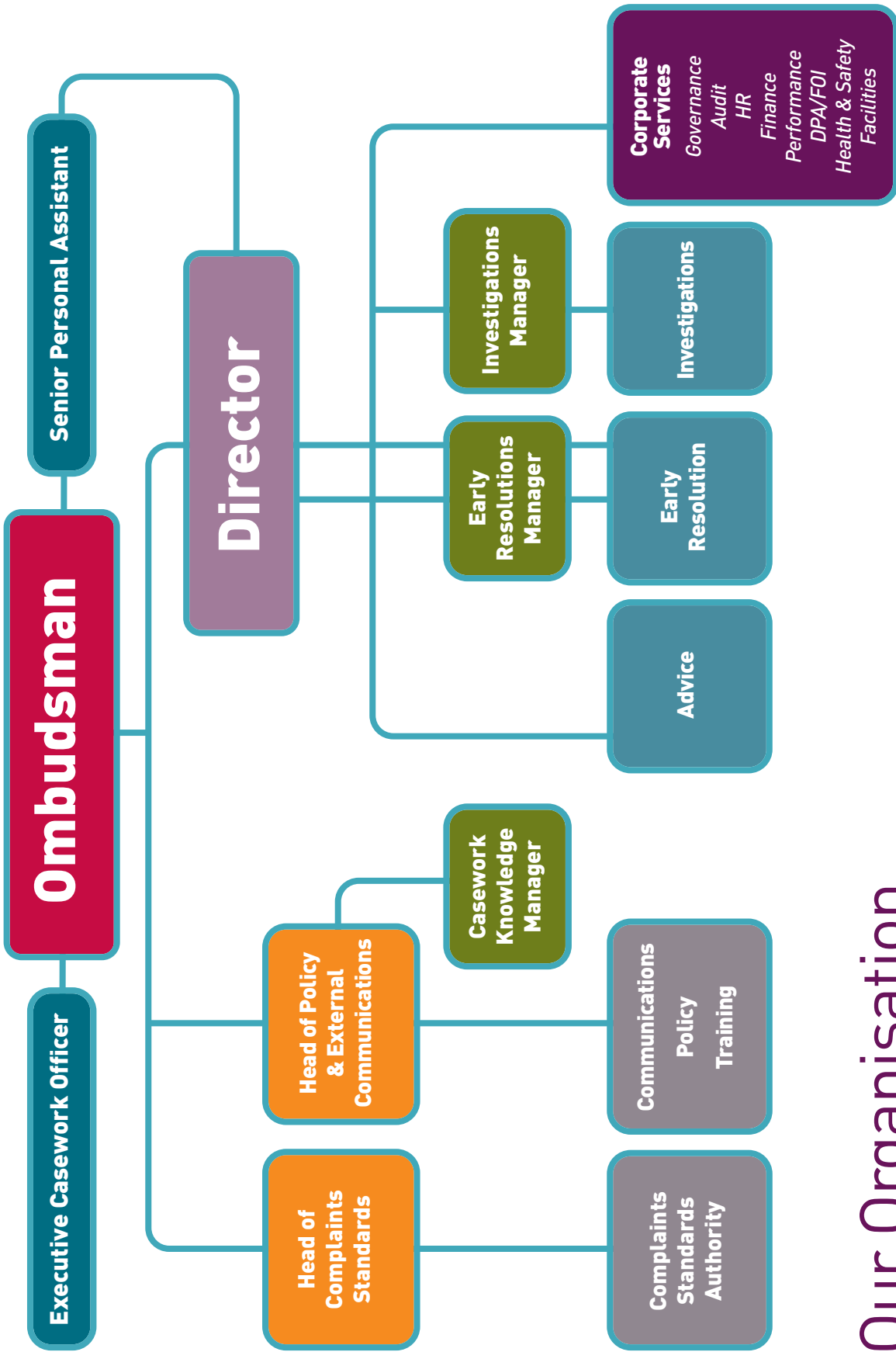
To simplify the design and operation of the complaints handling system in Scottish public services

By working in partnership with service providers, regulators and other key stakeholders to facilitate the development of and compliance with simplified, standardised and user-focused complaints handling procedures across the public sector as an integral part of the wider administrative justice system in Scotland.

5

To be an accountable, best value organisation

By making best use of our resources and demonstrating continuous improvement in our operational efficiency and supporting the professional development of our staff.



Our Organisation



**Equality
and
diversity**

EQUALITY AND DIVERSITY

Our strategic plan has five equalities commitments. This section explains how we have acted to fulfil them. With input from our equality and diversity specialist, we have worked to highlight equality elements in complaints and to ensure that our policies and practices comply with equality legislation. Our specialist also helped our Complaints Standards Authority (CSA) team in their work on producing model complaints handling procedures and guidance to help organisations understand how to meet their equality obligations when handling complaints.

Monitoring

We want to know who uses our service, and when people bring us a complaint, we ask them to complete a monitoring form. We handle the information they give us separately from their complaint, and make sure that data about our service users remains anonymous.

Last year, only 577 people completed the forms, compared to 808 in the previous year. As a percentage of those who brought us complaints, this represented 14%, compared with 21% the previous year. This drop is likely to be because we moved from a combined complaints and monitoring form to one where the two documents were separate. Completing the form is voluntary, but we do want to gather as much information as we can about who uses our service, helping us in the equally important task of knowing who does not. So, in light of the reduction in responses, we moved back to a combined form in June 2013, and anticipate that return rates will rise.

Many of the statistics we received were very similar to last year. Of those who responded, we found that:

- > 42.5% were female, and 54% male, with 3.5% not telling us their gender
- > 64% fell into the age groups 35 – 49 (27%) and 50 – 64 (37%)

- > 5% of respondents said that they were under 24
- > 95% considered themselves to be from a white ethnic group
- > Around 27% considered themselves to have a disability, of which the majority (66%) related to physical mobility problems.

In the news

From time to time, our decisions attract media attention. Below are some newspaper headlines from last year, highlighting decisions about equality and human rights-related issues.

The mothers fighting back against birth intervention

The Observer, 16 December 2012

University told to do more for disabled students

The Herald, 7 June 2013

Lack of BSL interpreters putting deaf people at risk

The Guardian, 8 May 2013

Deaf patient given silent treatment

Daily Record, 29 March 2013

Deaf patient's plea for help is ignored

Scottish Daily Mail, 29 March 2013

Deaf patient denied interpreter by Dundee Hospital

Scotsman.com, 8 March 2013

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.

Our office is physically accessible and we have induction loop facilities for those with hearing difficulties. We also want to make sure that we provide a range of contact methods for people who get in touch with us, so we ask on our complaint form if the person has any particular needs in terms of how we keep in touch with them. As far as we can, we then make reasonable adjustments to ensure that our communication is as helpful as possible for them. Last year, most of the adjustments we made were for people with learning difficulties – mainly dyslexia – and sight or hearing impairments. For example, when a person found written communication difficult because of dyslexia, we made sure that we always phoned to tell them what was happening. In another case we used the Tynetalk text service provided by Action on Hearing Loss to discuss the complaint with a person whose hearing was impaired. We corresponded in large font or easy read format with several people and took extra time to communicate with a complainant who needed longer than usual to correspond with us because of a disability. We provided translation facilities so that we could write to and discuss complaints with people who do not have English as their first language. And we translated copies of our leaflets and posters into other languages, such as Polish and Vietnamese.

Our website is an essential channel for communicating with the public and our stakeholders. Last year our IT support service provider carried out an accessibility audit. This identified potential issues for users of assistive technologies and users with disabilities. In the coming year, on the basis of the findings, we will improve the overall online user experience.

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 do this by sharing the learning from the complaints we receive. We include case studies in our annual report and share the learning from our work every month through our website and the Ombudsman's e-newsletter. For example, in March 2013 we drew attention to one of the case studies that follow, where interpretation was not provided for a hospital patient. We highlighted that organisations to whom the Equality Act 2010 applies should examine their policies to ensure that in similar circumstances they would be ready to provide suitable support, in line with their legal duty to do so.

We do not, of course, determine equalities and human rights issues (which is the job of the courts) but we have a role in ensuring that organisations reflect in their policies and practices the obligations placed upon them by the Equality Act.

Another example that follows is of an issue that we have highlighted in previous annual reports – a failure to understand or to meet the requirements of the Adults with Incapacity (Scotland) Act 2000. We are concerned that we still receive complaints about this, having brought the legislation and its requirements to public attention over the past two years.

It was clear from the records that that Ms A felt isolated due to being deaf and not being able to communicate. Ms A's notes stated that that an interpreter was to be contacted at the family's request... I consider that it was unacceptable for the board not to obtain British Sign Language interpretation for Ms A during her 12-day in-patient admission to the hospital, and upheld the complaint.

JIM MARTIN, OMBUDSMAN'S COMMENTARY, MARCH 2013

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.

We cannot deal with all the issues that members of the public bring us, and we know how important it is that we signpost them to places that can. This is why our leaflets provide information about other avenues through which they may be able to pursue their concerns, or where they may be able to find out more about their rights. Through our CSA work we have encouraged organisations to share good practice, policies and procedures in complaints handling in the light of any work they have undertaken as a result of the Equality Act.

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

Our CSA website gives organisations information and support about good complaints handling. In December 2012, we published an article and guidance from our equalities adviser there. The guidance aims to mainstream equality in complaints handling. It explains some of the many implications of the Equality Act for all of us in the public sector, particularly in terms of complaints processes, and in ensuring that

these have fair and equal treatment built in from the start. It also includes examples of best practice. In addition, our model complaints handling procedures require organisations to be mindful of their equalities obligations, in particular the need to make reasonable adjustments where necessary.

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

We are a small employer with a low staff turnover. However, we are committed to ensuring diversity of our staff. We regularly monitor the diversity of our workforce and through rigorous recruitment, selection and development processes, we ensure that individuals are selected, developed and promoted on the basis of their abilities alone. We positively value the different perspectives and skills of all staff and make full use of these in our work. 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 SPSO in their approach to diversity.

CASE STUDIES

The information in these case studies focuses on the equality-related issue rather than all the issues raised in the complaint.

Higher education: a student with additional support needs Case 201201566

We received a complaint on behalf of a student with Asperger's (a form of autism, in which people may find difficulty in social relationships and in communicating). His father complained to us that university staff were not made sufficiently aware of his son's needs as a disabled student. He said that this was because his son's disability was 'hidden' – i.e. his condition was not obvious to those who met him. We agreed that there were some shortcomings in relation to the individual learning plan (ILP) which was not regularly updated or reviewed in the way it should have been. Although we did not uphold all the complaints raised with us, we found that the student was invited to a meeting, the purpose of which was not made clear in advance, and without inviting him to bring along a supporter or advocate. We agreed that he should have been invited to bring somebody with him, particularly as his ILP identified that in difficult situations he was prone to anxiety which could overwhelm him. We also found that the outcomes of meetings between him and the university were not adequately recorded. This was particularly important as he had an identified need to record and confirm verbal discussions.

Recommendations

The university arrange for a programme of staff training to raise awareness of hidden disabilities and their impacts; review the procedures related to the review and updating of ILPs; make greater use of notes to record discussions, issues, changes, decisions and update ILPs, and copy these for any student with any additional support needs; ensure that staff pay greater attention to the detail of the ILP when dealing with students with additional support needs; and use email to confirm arrangements for students with additional support needs arising from hidden disabilities.

Health: interpretation services Case 201104213

A woman, who is hearing-impaired and communicates using British Sign Language (BSL), was admitted to hospital for surgery. During her 12-day stay in hospital, although hospital staff tried to communicate with her, they did not provide a BSL interpreter. This was despite the woman repeatedly pointing to a poster for interpreter services and twice handing staff a BSL interpreter's card. It was clear from the hospital records that she felt isolated because of the lack of communication. During our investigation, we took independent advice from our equality and diversity adviser. She said that staff had not taken appropriate steps to obtain a BSL interpreter for the woman, which they had a legal duty to do under the Equality Act. As soon as they knew that she needed an interpreter, they should have drawn up a clear plan to coordinate the availability of medical staff with that of a BSL interpreter who was sufficiently trained to be able to communicate complex medical issues.

We found that, in failing to obtain a BSL interpreter, the board did not follow their informed consent policy. Although we recognise that there is a shortage of such professionals, we took the view that hospital staff did not try hard enough to find an interpreter, which was unacceptable.

Health: interpretation services *continued*

Recommendations

The board consider amending their interpretation and translation policy to highlight their legal obligations, and to make clear that BSL is a registered language; produce further guidance for staff on what to do when a patient says they need a BSL interpreter; consider providing training to staff on deaf culture, language and legal rights; consider seeking input from deaf people to review the effectiveness of the implementation of the interpretation and translation policy; offer to meet with the woman and a BSL interpreter to answer any questions she has about her treatment and to apologise, explain and feed back how her complaint has helped them to develop their service.

Health: assessment for capacity Case 201101255

An 85-year old man lived alone and had a number of health difficulties. When he fell at home and broke his hip, he was admitted to hospital for a hip replacement. He was discharged from hospital after two weeks, but two days later he fell again. He was readmitted to hospital, where his condition gradually deteriorated and he died. His son complained about a number of issues relating to the care and treatment that his father received in hospital. One of his concerns was that staff had failed to consider and assess his father's cognitive function. The son also complained that they had not communicated directly with him about the plans for discharge, resulting in his father being inappropriately discharged from hospital.

This case raised some particularly difficult issues. Our medical adviser said that it was not possible to decide from the records whether the elderly man's care and treatment was reasonable. This was mainly because there was no evidence that staff had formally assessed his cognitive function, despite some evidence that he might have been suffering short-term memory loss. It was not clear whether this would have resulted in different care, but an assessment was needed to establish whether he had the capacity to make decisions about his own welfare (as required by the Adults with Incapacity legislation). We noted that, if staff believed that he had the capacity to make his own decisions, they had acted appropriately. However, our main concern was that no assessment of that capacity took place, even though there were a number of factors that could have alerted staff to the need for this. Our medical adviser said that on balance it would have been preferable if the son had been involved directly in communication, given the doubts about his father's capacity. All the problems that occurred stemmed from the lack of assessment.

Recommendations

The board provide us with evidence that they have implemented a policy to assess the cognitive function of elderly patients, including whether a patient has capacity to participate in decision-making, taking new government policy on this issue into account.



**Governance
and
accountability**

GOVERNANCE AND ACCOUNTABILITY

Report from John Vine, Chair of the SPSO Audit and Advisory Committee

The Ombudsman, as accountable officer for the SPSO, is responsible for ensuring that his resources are used economically, efficiently and effectively. The SPSO is subject to external audit (currently provided by Audit Scotland), and internal audit (under a shared services arrangement with the Scottish Legal Aid Board). The Ombudsman gives evidence annually to the Parliament's Local Government and Regeneration Committee following the publication of his annual report. He also holds regular discussions with the Scottish Parliamentary Corporate Body about the SPSO annual budget submission and other governance issues that may arise.

Our remit is to work with the Ombudsman at his invitation as a non-executive group, advising on the discharge of the functions of the accountable officer and ensuring high standards of governance and accountability, in accordance with Best Value principles. I am the Independent Chief Inspector of Borders and Immigration and was chair of the committee in 2012/13. I was very pleased to be joined on the committee by Tom Frawley, the Northern Ireland Ombudsman and Anne Seex, one of the Local Government Ombudsmen for England. I am grateful to them for their energy, commitment and wisdom.

The committee's purpose and duties are set out in the SPSO scheme of control. We support the Ombudsman and the senior management team by monitoring the adequacy of the SPSO's governance and control systems and offering objective advice on issues concerning the risk, control and governance of the SPSO. The committee also provide a source of advice and feedback on SPSO strategic objectives and annual business plans and comment on the recommendations of internal and external audit.

The committee met three times in 2012/13. Representatives from the SPSO's external and internal auditors attend our meetings. They can advise us in private when required, before we discuss with the Ombudsman the key operational priorities and risks. In the past year, the committee carefully examined the operational and financial management of the SPSO with a focus on service delivery and value for money to the public. In 2012/13 we specifically looked at the SPSO's proposals for and findings of their new quality assurance mechanism, the external review of their business process, the auditors' findings and issues raised by the Ombudsman in the Parliament, including that of special reports.

We also discussed matters relating to the Ombudsman's work in standardising and streamlining complaints procedures. In all these areas, we were impressed by the clarity and breadth of the evidence provided and the partnership and problem-solving approach shown by the Ombudsman and his senior management team. There is a genuine and impressive commitment from all these individuals to delivering the highest quality service possible within the legislative and financial constraints within which the organisation operates.



In all these areas, we were impressed by the clarity and breadth of the evidence provided and the partnership and problem-solving approach shown by the Ombudsman and his senior management team.



GOVERNANCE AND ACCOUNTABILITY

We have benefited from the constructive engagement of the external auditors and the input and contribution from the internal audit service. In his role as Ombudsman, Jim Martin has been open and constructive with all our requests and has provided considerable energy to and sound leadership of the SPSO.

The significant programme of change being pursued by the Scottish Parliament and Government will bring increased demands on the SPSO in the coming year. I am confident that the organisation is well placed to meet those challenges. While my three-year tenure as chair has now ended, I am reassured from all that I have seen that my colleagues and their successors on the committee will continue to build on the solid foundation we have created to provide the independent scrutiny necessary to ensure continuing public confidence in the SPSO.

Service Delivery Complaints

In 2012/13, we received 45 formal service delivery complaints out of the total 4,651 cases received. Of these, 24 were not upheld, 18 were fully or partly upheld, two had no decision reached and one was withdrawn. Eleven of these complaints were decided by the Independent Service Delivery Reviewer. Complaints are considered by the Independent Reviewer solely at the request of the complainant. We publish statistics about service delivery complaints on our website.

Report from David Thomas, Independent Service Delivery Reviewer

It is uncommon for public sector ombudsman schemes to have arrangements for service delivery complaints to be reviewed externally. It is to SPSO's credit that they voluntarily created such arrangements in April 2007.

During the year ended 31 March 2013, 11 people referred service delivery complaints to me. Two of them complained about two cases. So I looked at 13 case files in total – less than 0.3% of the cases handled by SPSO. Though I focused on the concerns that had been raised with me, I also carefully reviewed the whole of each case file, to see whether there were any wider lessons to be drawn.

All of the people who brought service complaints to me were disappointed in some way with the outcome of their case against the public authority. Some of them found it difficult to distinguish between their view of the merits of their complaint (which is not a matter for me) and their view of the way in which the case was handled (which can be for me).

In seven of the cases that I looked at, I considered that the service delivery complaints were entirely unfounded. SPSO had dealt with the cases impartially, efficiently and with considerable patience.

Some people had unrealistic expectations. Some wrongly expected to be able to direct SPSO's independent investigation of the case. And one person complained that, when he phoned and asked to speak to a senior manager, one was not available immediately – even though, as he was promised at the time, a senior manager called him back promptly.

At the beginning of a case, SPSO summarise the scope of what they will be investigating – which is legally a matter for SPSO. A few complainants thought that they should have the last word on scope. I am glad to note that, during the year, SPSO amended their explanatory leaflet to make it clear that SPSO have the last word on this.

In five of the cases that I looked at, I considered that there had been a handling error in either the case itself or the service delivery complaint: a lack of clarity, a minor delay or a minor procedural error. These handling errors did not have any significant impact on the five cases, but indicated areas in which SPSO might consider improvements to their process.

In one case, there was confusion about whether SPSO could or would award financial compensation. It would have been helpful if SPSO had explained this more clearly. In another case, where the complainant had not cooperated with the investigation, it would have been helpful if SPSO had sent a final warning before closing the case.

In a further case, I considered that there had been a lack of clarity which did have a materially adverse effect on the complainant. SPSO had not made sufficiently clear at the outset that they would not be investigating a financial issue referred to in the complaint form sent to SPSO. The law says a complaint must first be made to the public body concerned, which has to issue a final response before SPSO can look at it. This raises problems where, as in this case, the complainant adds an issue between receiving the public body's response and referring the complaint to SPSO. It was obvious to SPSO that they could not look at the extra issue, but it was not obvious to the complainant. SPSO did not make it sufficiently clear at the outset, or as they went along, that they could not look at the extra financial issue – and it was not unreasonable for the complainant to believe that SPSO were dealing with it. As the original case took a significant time to resolve, it was months before the complainant received SPSO's decision and discovered that it would be necessary to start over again from scratch on the extra financial issue. The financial worry resulting from the delay caused her distress.

In all the cases that I looked at, the Ombudsman and his staff provided me with all of the information that I required. Where I upheld a service complaint, SPSO reacted positively to my report, accepting my conclusions and apologising to the complainant concerned.



It is uncommon for public sector ombudsman schemes to have arrangements for service delivery complaints to be reviewed externally. It is to SPSO's credit that they voluntarily created such arrangements in April 2007.



All cases determined 2012/2013

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	3	21	6	21	7	4	15	77
	Total enquiries	Out of jurisdiction	0	0	0	0	0	0	454	454
Complaints	Advice	Premature	3	21	6	21	7	4	15	77
		Out of jurisdiction (non-discretionary)*	41	293	172	704	131	124	10	1,475
	Out of jurisdiction (discretionary)	8	12	11	40	21	4	25	1	121
	Outcome not achievable	1	18	2	19	3	5	0	0	48
	Not duly made or withdrawn**	2	4	1	13	3	2	1	1	26
	Resolved**	26	298	58	237	104	73	7	7	803
	Total		0	0	0	2	0	1	0	3
	Early Resolution 1	Premature	78	625	244	1,015	262	209	43	2,476
	Out of jurisdiction (non-discretionary)*	3	63	3	46	25	9	1	1	150
	Out of jurisdiction (discretionary)	8	20	20	99	47	7	1	1	202
Outcome not achievable	5	34	3	40	10	6	0	0	98	
Not duly made or withdrawn**	2	34	4	26	9	6	0	0	81	
Resolved**	7	29	1	23	20	4	0	0	84	
Total		0	7	3	15	14	8	0	47	
Early Resolution 2	Fully upheld	25	187	34	249	125	40	2	662	
Partly upheld	2	15	3	10	15	4	0	0	49	
Not upheld	4	10	3	19	14	11	0	0	61	
Outcome not achievable	7	57	17	48	77	25	0	0	231	
Not duly made or withdrawn**	0	1	0	0	0	0	0	0	1	
Resolved**	0	0	0	3	1	1	1	0	5	
Total		0	1	1	1	4	0	0	8	
Investigation 1	Fully upheld	13	84	24	81	108	45	0	355	
Partly upheld	5	60	2	16	6	15	0	0	104	
Not upheld	5	81	7	63	8	14	0	0	178	
Outcome not achievable	10	118	4	75	12	22	0	0	241	
Not duly made or withdrawn**	1	8	1	2	3	2	0	0	17	
Total		21	267	14	156	29	53	0	540	
Investigation 2	Fully upheld	0	25	0	3	3	0	0	31	
Partly upheld	1	9	0	3	0	0	0	0	13	
Not upheld	1	34	0	6	3	0	0	0	44	
Outcome not achievable	138	1,197	316	1,507	527	347	45	45	4,077	
Not duly made or withdrawn**	141	1,218	322	1,528	534	351	514	514	4,608	
Total complaints										
Total contacts										

* includes organisations out of jurisdiction

** previously included in 'no decision reached' category

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