SPSO response to Local Government and Regeneration Committee questions

1. Ultimately, the SPSOs role is to indirectly support improvement in public service provision, through effective and fair public service complaints processes and procedures. What degree of success are the SPSO having in ensuring that complaints systems embed service users rights to challenge decisions?

As I highlight on page 8 of the annual report, simplicity is key in helping people access administrative justice. Complex systems with numerous routes for complaints and appeals can be a barrier to people challenging administrative decisions. Through our Complaints Standards Authority (CSA) we have created, we believe for the first time in Europe, a standardised, streamlined complaints system which gives people simpler access to the administrative justice system. The model complaints handling procedures include consistent definitions of what is covered by the complaints procedures and encourage bodies to signpost to any existing alternative appeals routes to challenge decisions.

This background information is helpful, could you advise what degree of success the SPSO are having in ensuring that complaints systems embed service users rights to challenge decisions

SPSO follow-up: As outlined above, the model CHP for local government includes a sector-wide standardised definition of what is covered by the complaints procedure. This includes disagreement with a decision where the customer cannot use another procedure to do so, for example where a separate statutory right of appeal exists in relation to council tax or planning. It is entirely within a local authority or other service provider's power to change a decision as a result of issues highlighted from the handling of a complaint if they identify a failing which affects that decision.

The model CHPs also clearly signpost to SPSO which provides an external route for people to challenge the way a decision that affects them has been made. We exist to allow for challenge on the basis of maladministration or service failure. We can recommend changes to decisions if we think that is appropriate, although we are rarely able to look at discretionary judgement.

2. To what extent do Local Authorities continue to view complaints as a nuisance rather than learning from them?

It would be unfair to say that local authorities view complaints as a nuisance. We have made much progress in complaints handling with the introduction of the model CHP and I have been greatly encouraged by the positive attitude of the local government sector through their work in partnership with the CSA. I think it is fair to say, however, that a positive 'valuing complaints' culture is more prevalent within some organisations than others. The fact that we upheld 46% of all complaints investigated last year and 47% about local authorities tells us that organisations could do better in learning from complaints. That is not something which is unique to the local government sector.

The CSA has helped provide the building blocks for a successful complaints system: clear, simple procedures; a positive focus on resolving complaints early; clear definition of roles and responsibilities; and a focus on robust, transparent information on complaints performance and learning. The model CHP now requires local authorities and other public sector bodies to publish regular commentary on the outcomes, trends and actions taken in relation to complaints which will provide, for the first time, information for the public on how they have learned from complaints. However, the CSA can only go so far in helping complete that cultural change. Getting to a point where staff don't see complaints as a threat, are empowered and trained to resolve issues close to the frontline and learning from all service failures informs service improvement takes time. It also require strong leadership and training with a clear, visible signal from the most senior level that complaints matter and should be welcomed. The model CHPs and the e-learning training we have delivered are acting as a cultural catalyst but the onus is on individual local authorities (and the sector as a whole) completing the transition and delivering ongoing improvement in their complaints handling.

3. We acknowledged that your remit does not extend to complaint outcomes; and indeed that effective complaint procedures will not necessarily lead to a positive outcome as deemed by the complainant. That said do you believe there would be as much, if not greater, value from benchmarking/monitoring how the learning from the outcome of complaints is shared, rather than concentrating on benchmarking complaint handling processes?

You are correct that there is significant value in monitoring, sharing and benchmarking the outcome of complaints. The performance indicators the CSA have developed for the local authority sector, in partnership with the Local Authority Complaints Handlers Network (the network), include an indicator on learning from complaints (see http://www.valuingcomplaints.org.uk/wp-content/media/SPSO-performance-indicators-for-the-Local-Authority-Model-Complaints-Handling-Procedure.pdf). This will require all local authorities to publish a statement outlining changes or improvements to services or procedures as a result of the consideration of complaints. In addition the model complaints handling procedures for all sectors require organisations to publish, on a quarterly basis, the outcomes, trends and actions taken in relation to complaints which will provide comparative information on this for the first time. Our aim is that a large part of the role of the networks will be in sharing and benchmarking this learning.

In terms of monitoring outcomes of complaints the indicators also require local authorities to monitor, report and publish the number of complaints upheld/partially upheld/not upheld at each stage of the CHP. The aim of this is to encourage local authorities and others in the sector to assess and compare the proportion of 'positive' outcomes achieved, particularly at the early stage of complaints handling, allowing them to compare and track the proportion of complaints resolved at the frontline. The requirement to comply with the CHP requirements is built into existing regulatory structures, including Audit Scotland's approach to Shared Risk Assessment and annual audit processes, with an onus on self-assessment wherever possible. The indicators are, for example, built into the Public Service Improvement Framework used in local government to self-assess performance.

In terms of the final paragraph would the committee be correct in thinking that rather than monitoring the outcomes from complaints the indicators merely record the result of the complaint i.e. whether it is upheld or not? The Committee's interest is not in the result per se but in the learning that takes place as a result of the determination of the complaint. Do you believe there would be as much, if not greater, value from benchmarking/monitoring how the learning from the outcome of complaints is shared, rather than concentrating on benchmarking complaint handling processes?

SPSO follow-up: As outlined in the first paragraph above, the performance indicators include an indicator on learning from complaints (see Indicator 8). This will require all local authorities to publish a statement outlining changes or improvements to services or procedures as a result of complaints and is, therefore, focused on the outcomes of complaints. This includes a requirement to outline information on:

- how outcomes are reported and published;
- the number of services changed, improved or withdrawn as a result of complaints together with a description of the actions taken
- Action to reduce the risk of recurrence
- Action taken to ensure that staff members all learn from complaints

This will, for the first time in Scotland and, we believe, the UK, provide consistent comparable information on the outcomes of complaints responded to by local authorities. The network (and others, including Parliament and the public) will be able to use this to compare and benchmark information on the learning from complaints.

4. 50% of complaints received are "premature complaints", can you provide more detail about these, and is there any pattern in types of complaints and authorities with the highest incidence? Would it be helpful to highlight this information?

There are some subjects of complaint that generate high complaint numbers and the pattern of premature complaints follows the overall subjects of complaints, with housing, social work and planning the top three overall (page 23 has a table showing premature complaints by subject). The subject of many premature complaints is unknown or out of jurisdiction since at this early stage categorisation can be difficult because of the lack of detailed information provided by the complainant.

While we do not think league tables are helpful, we do highlight each authority's premature complaints rate in the annual letters we send them (for 2012/13 see http://www.spso.org.uk/statistics-2012-13#letters). The tables in each letter show the rate of prematurity for the authority against the general sectoral rate, as well as a comparison with the previous year's figures.

In addition to the annual letter, we provide each authority with a spread sheet showing more detail of all the complaints we have received and handled, including premature complaints. We do not publish the spread sheet because it contains personal data. This degree of detail is provided in order to encourage authorities to examine whether there are

patterns and to ask themselves why there may be a high incidence in a particular area. Some organisations request information about premature complaints on a more frequent basis than annually, and we are happy to provide that to them.

Our aim is to provide information that supports organisations in understanding complaints about their services, including premature complaints. Once they have this information they can spot micro trends within their own services. Ultimately local authorities are free standing democratically elected bodies that are responsible for acting on the intelligence they receive.

5. What is the difference between an inquiry and a complaint, and can you explain the difference in the figures on page 7 which state 50% of complaints are premature yet around 70% to the advice team are premature?

The difference is explained in full on our website at http://www.spso.org.uk/explanation-terms; here is a shortened version.

An enquiry is an approach by a member of the public seeking information or advice, for example about whether we can deal with a complaint about a particular issue or how to pursue a complaint about a particular organisation. Enquiries include queries made about organisations and subjects outwith our jurisdiction. Not all contacts are classified as enquiries, but all significant contacts are recorded.

A complaint is an approach to us by or on behalf of a member of the public making a complaint about something which, subject to more detailed consideration, might be investigated under the terms of the SPSO Act. A complaint may cover a number of issues and be about more than one public body. An additional approach by an existing complainant may or may not be counted as a separate complaint depending, for example, on how closely it is related to the previous complaint and whether it has been raised with the organisation concerned.

Page 7 highlights the work of the advice team. Within that team itself, 70% of the complaints which they determined were premature. The rest of the complaints, which they did not determine, moved to the next stage of our process. Taking all of the cases determined by this office, 50% were premature. The table on page 23 shows all the outcomes at each stage in detail.

6. How are local authorities spreading the learning from complaints beyond their own boundaries?

We are keen to help the sector build on this and improve its mechanisms for sharing information on complaints across the sector. However, we can only go so far with the remit and resources we have and clearly SOLACE, COSLA and the Improvement Service, have a key role to play in this.

As outlined above in relation to question 2, much of our focus so far has been on helping organisations improve their capacity for learning within their organisations. That is an important starting point in ensuring that organisations are responsive to failures in their own service delivery.

In terms of a cross-sector approach, we have developed the complaints handlers network which will provide the key forum for sharing information from complaints across the sector. We have also provided a platform for complaint handlers to share information through our online Valuing Complaints Forum. As outlined above in relation to question 3 the network will soon have access to comparable, consistent information on complaints which will help them to focus on areas of improvement for the sector as a whole. This will provide valuable information on service failures for all in the sector.

7. Environmental Health and Cleansing complaints rose by 50%, what is encompassed by such complaints? Is this rise a symptom of the squeeze on local authority budgets?

This category covers complaints about matters such as bin collection and street cleaning, drainage problems, smells and noise eg from cooling units or restaurants. A number of cases were about discretionary decisions on policy issues (eg how often the bins are emptied).

While the percentage is high, the table on page 10 where it is mentioned and the text below the table show that the numbers were relatively low (60 in 2012/13, therefore 40 in 2011/12). So the number of complaints about this area has risen by 20 (out of a total of 1,505). If the Committee is particularly interested in the reasons for this rise, it may be helpful to analyse the stage these complaints reached in our process (eg were they premature) and whether there were high numbers of complaints about this area about particular authorities. Should the Committee wish me to carry out this work, please let me know.

The squeeze on local authorities budgets could be expected to result in an overall increase in complaints to us, for example about the closure of facilities. However, complaints to us about local authorities were slightly down last year on the previous year. There may be a number of reasons for this as people's motivation for making complaints can be complex. Reasons include improved complaints handling by the organisations themselves, or people not complaining because they do not think it will make any difference. We have seen a big rise (23.5%) in complaints to us about the NHS, and we think that this may be a consequence of people seeing more publicity about complaints being taken seriously and leading to action, which has in turn made them feel more comfortable about complaining. It is not possible to say that increases or decreases on their own are results of changes in the underlying quality of services.

8. Given the role of the SPSO there is a risk that organisations will give more focus to complaint handling than on the outcomes that follow? i.e. 'following the process'. How can this be avoided?

We have a dual role, casework and complaints standards.

In our casework role we look at how an organisation has carried out its investigation of a complaint and we also look at whether the outcome was reasonable. If we found flaws in how the complaint was handled we would criticise the organisation for that that uphold the complaint. We would also look at whether the outcome for the complainant was reasonable and if it was not we would where possible recommend a remedy for that injustice and where appropriate make a wider recommendation to ensure that the problem did occur again.

In our complaints standards role, the key is training to ensure that staff are focused on achieving a positive outcome and not solely focused on following the process. The emphasis of the model CHP is on empowering staff to achieve a positive resolution for customers, wherever possible, as early as possible and as close to the frontline as possible. Our online e-learning modules, developed to support the CHPs and available for all local authorities to access, put more focus on the skills that can help frontline staff achieve a positive outcome than they do on the process they are required to follow. This includes the importance of understanding what the customer wants to happen when they complain, how to get it right from the start, active listening and finding the appropriate solution for the customer. We believe that this empowerment of frontline staff has helped shift the approach to handling complaints towards one focused on the outcome. Elma Murray, Chief Executive of North Ayrshire Council and current Chair of SOLACE, stated recently to this committee:

'North Ayrshire Council encourages its local staff to deal with everything at the point of service delivery. We try to allow our staff the authority and the room to take their own local decisions to best fit people.

The Scottish Public Sector Ombudsman's work with local authorities over the past year or two is also quite interesting. We have now all adopted a single common complaints-handling procedure, which means that before a complaint goes anywhere else, the first point of complaint resolution is with the local staff member. That has been a change in our focus, which supports staff's authority to do things at the coalface.'

The model CHP itself also provides flexibility to allow staff to focus on achieving a positive outcome rather than be bound by the requirement to meet the process. For example, the frontline resolution stage (stage 1 of the complaints process) allows the timescales for the complaint to be resolved to be extended from 5 to 10 working days in situations where a resolution is seen as possible within that extended timescale. For stage 2 complaints the timescale for extensions is open ended, subject to clear and regular communication with the customer. There is also the ability to instigate mediation outwith the process if that is something which staff feel will help resolve the situation.

We must keep in mind, however, that robust process and procedure are important to underpin this outcomes-focused approach. Clear published standards on which the customer can base their expectations of the response to their complaint are important. The reason that the model CHPs were introduced was as a direct result of the conclusions

of the Crerar and Sinclair reports in 2007 and 2008 which identified the lack of a clear, consistent, simple and timely process as the greatest barrier to a fit for purpose complaints system. Complex processes were a barrier to customers complaining - or managing to escalate their complaints where they remained dissatisfied – and the lack of robust and available information on complaints across the public sector made it difficult to assess where the problem areas lay. The system was, in essence, broken. We must not lose sight of where we were as a public sector or of the progress that has been made in this regard.

The Committee is greatful for the information but more interested in the current position and how it can be improved further going forward. Similar to the follow up question on number 3 in what ways do you understand that local authorities are seeking to use the outcome of complaints to make service Improvements?

SPSO follow-up: Our response above addressed the question posed of how we can avoid the risk of organisations following the process and not focusing on outcomes. This highlighted our approach to doing so through empowering staff, focusing on achieving resolution at the frontline and providing flexibility in the process to allow room outwith procedural restrictions to focus on achieving a positive outcome. The revised question (in what ways do you understand that local authorities are seeking to use the outcome of complaints to make service Improvements?) requires a separate answer.

With regard to the current position, this is a question which would be best posed to local authorities themselves including SOLACE, COSLA and the improvement Service. We have suggested, however, that learning could be improved and could involve, for example, a greater role for some organisation monitoring and ensuring improvement on a cross-sector basis, similar to the approach the Scottish Government Health Directorate takes in relation to NHS complaints.

Going forward, as we outline in response to question 2, the CSA has helped provide the building blocks for a successful valuing complaints culture, including in terms of how local authorities report, monitor and publish information on the outcomes and learning from complaints. We have set out requirements which all local authorities are committed to complying with and helped the sector establish a network which will provide a forum to share learning. From engagement through the process of implementing the local authority CHPs, we are confident that, going forward, local authorities are now more focused on seeking to use the outcome of complaints to make service improvements. As we outline in response to question 6, however, our resources and remit can only take us so far. We are keen to help the sector improve its mechanisms for learning from complaints but the sector themselves have the key role to play in this.

9. Which Local Authorities are not members of the network?

The local authority complaints handlers network has met on six occasions since November 2012. In total twenty five local authorities have provided attendees over the lifetime of the working group and one other, Angus Council, has recently applied to join. Local authorities that have not provided a delegate are: Comhairle nan Eilean Siar; Dumfries and

Galloway Council; Falkirk Council; Moray Council; Orkney Council; and Shetland Islands Council. Whilst these local authorities have not been involved in the network meetings, they have been actively involved in other ways. Comhairle nan Eilean Siar and Dumfries and Galloway Council were, for example, members of the SPSO/SOLACE working group which developed the model CHP. Others have been involved through our online Valuing Complaints Forum or have been in contact in relation to the implementation of their procedures or training of staff.

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10. Under "building future improvement" you refer to performance measures being established. Could you explain what type of performance measures you envisage being established and what they will tell you and allow you to continue to improve? To what extent are the performance measures directed at outcomes and the extent to which the same or similar outcome related issues are repeated in complaints?

This section of the report refers to the performance indicators the CSA have developed, referred to above under question 3. As outlined in response to question 3, these indicators do contain some focus on outcomes and learning from complaints and will allow benchmarking of issues within and between sectors. As per our response to question 6, we would emphasise that it is for the service providers, not the SPSO, to identify failings and repeat failings and take action to prevent recurrence.

The Committee do not wholly agree with this position and would expect that if the SPSO identified repeated failings, either within or across authorities these would be highlighted to the appropriate regulator or to this Committee. We would welcome your thoughts on how this could be achieved.

SPSO follow-up: It is important that I highlight the distinction between identifying repeat or systemic failings through SPSO's handling of complaints brought to us and repeat or systemic failings only identifiable through the body of complaints raised with the service providers themselves (the vast majority of which SPSO does not see).

The indicators referred to in the question above relate to the latter, the complaints received by providers themselves which SPSO does not see. Analysis, reporting and monitoring of outcomes from these complaints is something we are seeking to help the providers themselves improve going forward but responsibility for this lies with the service providers and, ultimately, their regulators. Our statutory role in monitoring and promoting trends and best practice in complaints handling is clearly set out. Under these powers what we are able to require these bodies to do and have done through the CHPs is to aggregate and publish against the performance indicators.

With regard to those complaints SPSO does see, as we have highlighted to the Committee we do monitor, identify and highlight trends and systemic issues to various forums and bodies, including Parliamentary Committees. The latest example of this is the sectoral reports published this year which provide detailed summary of complaints received for each sector under our jurisdiction. Where we see repeat failings we raise these with the

appropriate body, be that Health Improvement Scotland (HIS), the Scottish Housing Regulator (SHR), the Water Industry Commission for Scotland, the Health or Justice Committees etc. This is partly the reason for us drawing attention to the need to clarify the process for special reports which we raised again in our briefing to the Committee and discussed at the oral session. The matter of addressing with repeat failings from complaints is one we have raised repeatedly with the Committee.

Our briefing to the Committee states clearly where we see the responsibility for learning and improvement lying and also suggests a central role for an organisation in the local government sector. We welcomed the Committee's decision to write to SOLACE following the discussion at the oral session to invite them to consider a mechanism for identifying systemic issues etc.

11. In the event that you identify legislative gaps what action do you take to alert relevant policy officials and the Parliament?

Our engagement varies depending on what the legislative gaps or potential gaps are about. To give you an example, in the case of plans for health and social care integration our policy team contacted the relevant policy team in the Government to discuss complaints pathways with them in person and we provided our views in our consultation response. Following this, the Ombudsman gave evidence to the Health and Sport Committee and he has also raised the matter in numerous meetings, including with the then head of NHSScotland and other senior officials. On self-directed social care, we raised concerns in our consultation response about the lack of clarity around the complaints process.

On the Children's Bill and the social work complaints review, we were contacted by government policy officials, requesting assistance from us. When the discussions moved to the area of resourcing, as they have for social work, we updated SPCB officials about the implications.

When we found problems with prisoner access to the NHS complaints process, we highlighted the matter through our e-newsletter and sectoral reports, and the Ombudsman gave oral evidence on the matter to the Health and Sport Committee. An MSP has raised it as a Parliamentary question.

We provided input to an MSP on their proposed Apology Bill in the form of discussions and written contributions including sharing the research we have gathered about Apology legislation in other countries.

In terms of the SPSO Act itself, we highlighted to this Committee the lack of a mechanism for the Ombudsman to lay a special report before the Parliament and this matter is now being considered by the Standards Committee.

We are pleased there is an increasing recognition of the importance of considering complaints processes early on in policy discussions and that we are being invited to take

part in discussions about potential changes at an earlier point than we have been in the past.

12. Could you explain how certainty around response times etc. (page 11) could lead to an increase in complaints?

We have designed and helped implement a more accessible complaints system, as Parliament asked us to do. This will help many more customers achieve a positive outcome. A possible unintended consequence of this, however, is that more people access the system and then pursue their complaints through to review by the Ombudsman where they do not believe they have achieved the correct outcome.

Historically, people could be caught in complaints processes for long periods with no set timescales and many stages. It is generally accepted that under such arrangements only the most determined individuals would have pursued their complaints. The new standardised approach arising from the work of the CSA means that people can now move through the two stage process to receive a final response much more quickly. Combined with well-trained, well executed complaints processes this should mean better, quicker outcomes for public service users. However, with larger numbers of people moving through the full complaints process, there is also a likelihood that larger numbers of people will then choose to exert their statutory right to pursue matters further by taking their complaint to the SPSO. The key is for public bodies to focus on improving their decision making and working to get it right first time more often, reducing the number of complaints coming to SPSO which are upheld. In this regard you may wish to engage with the sectors themselves on how they are working to address this.

The evidence so far is that the level of premature cases coming to this office is continuing to fall away so that people are being correctly signposted at the right point in the process to SPSO. This is a positive outcome for public service users, although it does create resourcing challenges for SPSO. We will continue to monitor overall volumes received, although, as we note elsewhere in this response, the reason for increasing numbers of complaints is complex.

13. Given that justice delayed is justice denied, what action is the SPSO taking to improve its performance against its targets of progress within 50 days and decisions within 6 months?

The amount of time spent on each individual case can vary significantly and there are a number of external factors that influence this such as the length of time taken to gather information from both complainants and bodies under jurisdiction and, in the majority of cases taken to full investigation, to seek expert advice from one or more sources. The SPSO has a number of mechanisms in place to ensure that the time spent on each case is justified activity and kept to a minimum given the particular complexity of that case including close tracking of responses from bodies under jurisdiction, regular monitoring of case ages, quality assuring timescales to assess for unjustified delays, and investigating service complaints about delay.

The profile of the SPSO's caseload is changing. The level of premature cases is falling and the number of complex cases is rising, largely as a result of the increasing number of health complaints being considered at investigation stage. These cases require more resource to manage and are therefore more likely to take longer.

To ensure we improve on the targets we set ourselves, whilst managing an ongoing rising caseload (around 13% at this point in the 2013-14 year) we continue to seek ways to process work most efficiently with a fixed resource. The focus this year is to work with bodies bringing high volumes of complaint to support them in reducing case numbers coming to SPSO. In turn this will impact on SPSO's ability to continue to improve our own performance.

The Committee notes that the profile of your case load is changing but remains unclear what it is that you are being asked to do differently and what the added complexity is within health complaints. Could you elaborate please.

SPSO follow-up: Resolving premature complaints takes less resource than mature complaints. With premature complaints we are in the main signposting and providing support and advice to help people through local complaints procedures. Mature complaints that reach our early resolution and investigation stages take more resource – we need more documentation, we analyse, may interview, seek specialist advice, make recommendations etc. The profile change is that more complaints coming to us are mature, hence, they take up more resource.

The added complexity within health complaints is that, uniquely, we have powers of clinical judgement in this area of public services. This means that we are able to consider what the health professional did and whether it was reasonable in the circumstances. So we often will be examining medical records and other clinical evidence and seeking independent specialist advice. This is more complex than dealing with say, whether a council tax charge was correctly made. More of our mature cases are health cases, and since these are resource intensive cases, this impacts on our resources**.**

14. What does the SPSO consider to be the reasons why no cases were taken to judicial review and how do you avoid the danger of adopting a risk adverse approach by, for example, favouring local authorities to ensure that reviews are not taken?

To put our low rate in some context, I asked other public service ombudsman in the UK and Ireland what their experience of judicial review was. The Irish Ombudsman has never been subject to a judicial review. The Welsh Ombudsman has gone two years without a challenge and told us that there have only been a handful throughout the life of that office. The Parliamentary and Health Services Ombudsman with an English Health as well as UK jurisdiction says they receive on average 4/5 applications for leave to judicial review each year. The Northern Ireland Ombudsman has one ongoing at present. It is also the experience of other Ombudsman that, when they occur, such challenges are much more likely to come from complainants than organisations under jurisdiction.

Our experience of low or no judicial reviews in light of this picture is not exceptional. In terms of managing the risk of review, the fact that other Ombudsman have found these are significantly more likely to come from complainants mean that if we were risk adverse we would not be favouring local authorities. There is also no evidence that we favour organisations over complainants. We upheld 46% of all complaints investigated last year. The strongest way of evidencing unbiased decision-making is transparency and we publish all the decisions that we can online.

This does not mean that we do not choose to manage this risk. While judicial review is rare, we are mindful that we are subject to the jurisdiction of the courts and the way we choose to manage this risk is by ensuring that our decisions can stand up to the level of scrutiny a court would place on them. Any decision which favoured a local authority would not be able to stand up to that level of scrutiny and would actually increase the risk of an adverse judicial review.

15. You are asked to internally review 5.5% of all decisions, how many complaints does that relate to and what actions do you take to bring the existence of review to the attention of complainers?

The request for review process allows complainants or bodies to request a review of a decision on the basis of new information or factual inaccuracy. Last year we received 216 such requests from complainants and 7 from bodies. Ten of these requests led to a revision of the original decision. As soon as complainants bring their complaint to the office, they are notified of the request for review process in our 'what we do when we get your complaint' leaflet. They are also advised of our service delivery complaint process. Once we have reached a decision, the complaints reviewer issues the decision letter in which the complainant will again be advised of the process should they wish to access it.

In the majority of cases, through explanation and discussion, the complaints reviewer is able to clearly demonstrate how they have reached their decision and answer any further queries that the complainant may have. We continuously seek ways to develop our staffs skills to have these often difficult conversations where a complaint is not being upheld. We make every effort to help the complainant understand how the decision has been reached and to be reassured that we have heard and paid attention to all of the information they have provided us with and have weighted it fairly.

16. We note that no decisions were changed following your QA process, although we infer that a number of findings were made. Could you provide some examples of these findings? What action have you taken on these findings?

The QA process is used for a number of purposes. It helps us assess whether our casework is being delivered to the standards we set ourselves as well as to pick up on areas for improvement and best practice that can then be fed back into our service improvement system to drive quality and culture change. The QA process looks at a number of areas including whether the process that has been followed was in line with our

requirements, if the decision reached was sound and how well the service was delivered in terms of both timeliness and communication.

The types of findings and recommendations that arise from the QA work relate to these areas. For example, in relation to the decision reached the type of finding might be that, whilst the decision was sound, the explanation of the decision could have been clearer or, alternatively from a best practice point of view, the explanation provided to the complainant was clear, concise and empathetic and to be used as an example for others to learn from. All of the findings from each of the quarterly QA reviews are fed back to individuals and teams as well as the service improvement group, who have operational responsibility for identifying systemic or organisation wide issues and implementing changes.

This also arose in questioning by the Committee. Could you confirm our understanding that there is no option for a complainer to request their case be taken through the QA process.

SPSO follow-up: Yes. Our QA process is a standard internal management tool used by SPSO management, designed to drive up quality. There are other processes - the service delivery complaints process and the request for review process - that are specifically designed for external use where a complainer has concerns about the handling of their case and they can raise issues either about the service provided or the decision reached.

17. Are we correct in understanding that the "small number" of cases not identified (see page 17) is 89, or almost 10% of investigations?

That is correct. As we indicate in the notes below the table, we exclude some cases from publication, usually because to do so might risk someone being identified. We have a statutory duty not to identify complainants and take this very seriously.

In 2012/13, 17 (of the 89 cases) were complaints about water. The reason that these cases were excluded was that they were cases that had transferred to us from Waterwatch Scotland, the previous complaints body that was abolished. It was agreed by the Government's water transition team that oversaw the transfer that we would not publish transition cases because they would be dealt with under atypically, having started under one process and been finished under another.

18. The information provided under strategic objective 2 relating to informing providers and bodies is entirely process driven. How does the SPSO assess if you are meeting your objective to make a difference?

The heading of the chapter is making a difference and this section is about our second strategic objective which is about i) how we share strategic lessons ii) ensure service providers implement SPSO recommendations and iii) use communications to promote understanding of SPSO.

On a case-by-case basis, the main way we know we are making a difference is because of the evidence we require to satisfy ourselves that our recommendations are being implemented effectively. In some of our recommendations we ask organisations to act in conjunction with the appropriate body, for example we recently asked a health board to arrange an external review of their radiology practice and procedures, in consultation with The Royal College of Radiologists, and provide evidence of this review to the SPSO. In our briefing to the Committee, we provide further detail in the outcomes section on how our recommendations make a real difference to the public.

In relation to sharing strategic lessons and promoting understanding of SPSO, we know we are making a difference because of the positive response we have had to our new sectoral reports from providers and bodies. One of the ways we are getting feedback on the impact of the reports, as well as our other communications tools is through our sounding boards. We have set up two sounding boards, for the NHS and for customers, and are in the process of setting one up for local authorities.

We readily acknowledge in the annual report the difficulty of quantifying the impact of our work and alongside that we emphasise a key point, which is that it is for other organisations to pick up on and use our work to inform theirs.

19. Similarly on policy engagement and administrative justice you report a considerable amount of effort. It would be as interesting to understand what they results of this effort are, to what extent have you been successful in influencing policy etc.?

Given that we have a very small policy team, we need to be selective in the effort put into this work. We focus on the areas in which we have a strong locus and where our complaints handling expertise can be used. As we outline in our response to question 11, the main efforts we have made in this area are in highlighting the importance of building in complaints procedures early on when policy changes are being formulated and trying to ensure that complaints procedures are aligned and are simple for the public to access and use. This approach informed our work on health and social care proposals; the Children's Bill, SPSO special reports. More recently we have advised the Petitions Committee about jurisdictional limitations in education complaints and highlighted to the Justice Committee our views on proposals for lay monitors to take complaints from prisoners.

In terms of success in influencing policy, an example is the action taken by the Scottish Government in response to our raising the problems of prisoner access to the NHS complaints process. On health and social care, as we mention in question 11, we were pleased with the Cabinet Secretary for Health's agreement with the Ombudsman on the need for simple complaints systems.

On administrative justice, we were pleased that the Scottish Government have moved ahead with their decision to put in place an Interim Committee. Our Head of Complaints Standards has been asked to sit on this. We also were asked for advice on how to take this forward and concentrated on the need to make the needs of the user central. Again, we have had positive responses from the Scottish Government to this.

It is worth emphasising again that while we provide input, on our own initiative and when asked, decisions are ultimately in the hands of the Parliament and Government and other stakeholders.

20. It is interesting to note the approach of public bodies in tracking recommendations, are you aware if local authorities adopt a similar approach? If not should this be encouraged?

Everyone has access to our decisions and recommendations for their sector and can view these on a monthly basis from our compendium reports. We know anecdotally that some bodies in the Local Authority sector systematically track the recommendations made within their own sector so as to ensure that their own practice is in line with these. The onus here is on each individual body but there may be a role for the sector taking a lead role in co-ordinating these, whether through COSLA, SOLACE or the Improvement Service.

As the annual and sectoral reports refer, in addition to this, the Scottish Government Health Department tracks recommendations within the health sector and the Scottish Prison Service in prisons and we see this as a progressive model for other sectors to follow.

21. And following on from the above are there any formal mechanisms in place to encourage learning across sectors?

As outlined above in relation to question 6, the complaints handlers network will have a key role in sharing information from complaints across the local government sector. As we develop networks across the different sectors one of our aims is to encourage an exchange of learning between sectors to focus on common areas of improvement or sharing of best practice where these are identified but this is not something we have within our current business priorities.

22. It is disappointing to read that 22% of recommendations are not implemented within the agreed timescale, can you give any reasons for this delay, does it relate to particular types of cases, recommendations or specific areas?

As we highlighted in our evidence to the Committee last year, whilst we work hard to engage with boards and bodies to meet the timescales wherever possible, ultimately it is down to each individual organisation to implement the recommendations on a timely basis. There is some variation between sectors in the percentage of recommendations not being implemented on time, ranging from 32% in the small number of housing recommendations we make to 18% for local authority recommendations. There may be structural or operational reasons for this, for example in the way that different authorities take decisions, which can slow down the implementation of recommendations, or in cases where recommendations are more complex, implementation may sometimes take longer than first anticipated.

23. We note the extent of the monitoring etc. undertaken by SPSO (page 22) could you indicate what benefits flowed from this work, what were the outcomes/improvements/learning that followed?

We take monitoring to refer to our monitoring of the impact and value of our on and off-line services. The outcomes/improvements/learning from this were strengthening our links to advocacy services and the redesign of our monthly e-newsletter and website.

The key changes to the e-newsletter was introducing longer summaries of our public interest reports and more links and to website that we segmented the information for our various user groups to improve the online user experience. This reflected our new approach to providing sectoral complaints information in the form of specific reports. Feedback on this has been very positive, in particular from our NHS sounding board. The open rate of the monthly e-newsletter has risen 5% at the end of Q2 of 2013/14 (around 200 people open the enewsletter within an hour) and the visitor traffic to our website has increased by 8.3%.

The monitoring also provided evidence for developing further links with advocacy and advice agencies, who are often the organisations that can tell vulnerable people about our service and support them in making complaints. Specific outputs are e-learning modules for Citizens Advice advisers, attending conferences and workshops with organisations like the SIAA and Alliance Scotland, and a project to set up a microsite to share resources such as SPSO facts sheets and leaflets and to act as a centre for information about sources of advice and support and about effective complaints handling.

We are looking forward to learning from the expertise of our customer sounding board to test how we can best use our resources to reach hard-to-reach or typically excluded users and potential users of our service.

24. Could you confirm that the anticipated outcome from utilising social media etc. more widely is likely to be an increase in complaints? What plans does the SPSO have to use such media to drive other changes, for example reductions in premature complaints?

We hope that social media will increase the likelihood of an increase in complaints among certain demographics, specifically children and young people. However, we are also aware that social media is often used to express opinion rather than as a vehicle for making complaints.

We are already using social media to try to bring about reductions in premature complaints, for example by using twitter to signpost people to where they may be able to get help if we are not the appropriate organisation, and to help people understand the extent of our remit. For example, we will use tweets to redirect people to the right place for their complaint or concern (such as the Financial Ombudsman Service, Shelter, Ombudsman Services). Where people have concerns that might be ones we could look

at, we invite them to contact our freephone advice line or to email us so that we can hear about their complaint in detail.

We are aware that technology is changing is all the time and that how people use it is also changing, and are developing a digital strategy to help us ensure that we are responding to the new ways people will use to contact us and to make complaints. We also hope to gain input from our customer sounding board about how we might use social media to reach communities that we do not hear from very often.

We have used communications technology to set up an online community forum on our CSA website for discussion and sharing best practice in the professional complaints handling community, both within and between sectors.

25. The case studies contained in the report are helpful in understanding the work of the SPSO, and we note the range of recommendations that are shown. Many of these recommendations suggest actions by bodies; it would be interesting if, perhaps in future reports you were also able to provide some detail of how such recommendations improved the work and service of such bodies. We would find it useful if benefits and outcomes flowing to other bodies as a direct result of SPSO recommendations could be captured.

Many of the recommendations made relate to complaints handling – the performance and improvement of individual bodies in relation to complaint handling is becoming increasingly transparent through the publication of performance data and so the benefits of SPSO's work should become more transparent in that regard.

Some recommendations are only relevant to the individual case and the learning which is applicable to other bodies is limited. However, some cases do address wider or systemic issues and the learning from these cases can and is shared in a number of ways, including through our own monthly commentaries and publication of decisions and reports. However, we can only go so far with the limited resources we have to allocate to such activity. To test how recommendations improved the work and service of bodies or to measure benefits and outcomes flowing to other bodies would require the resources and skills of improvement agencies and regulators to track and analyse this impact.

The Committee is not asking the SPSO to routinely track or analyse complaints. However in your annual report you include case studies which have clearly been tracked. The committee would find it useful if in future reports you were also able to provide some detail of how such recommendations improved the work and service of such bodies etc. Can you confirm this can be achieved without expending significant resources for those few cases you highlight.

SPSO follow-up: We track all of our recommendations. As highlighted in our briefing to the Committee, each recommendation is issued with a deadline for completion and we monitor completion rates. We are rigorous in asking organisations for evidence of implementation, such as copies of the new policy/procedure or review/audit we have asked for with the action plan for implementation; documentation showing that the staff

training we asked for has been carried out; proof that credits/payments we have asked for have been made; copies of apology letters demonstrating that they satisfy our guidance on a meaningful apology and so on.

It is not our role to follow up to check continuous and systematic improvements in all cases where a recommendation might apply. To give an example, in a healthcare setting we might make a recommendation that staff on a ward be re-trained in carrying out a slips, trips and falls assessment. We would check that this training had been carried out by the deadline we requested, but continuing to check whether this is happening consistently on an ongoing basis throughout the board (ie establishing what is custom and practice on an ongoing basis) is clearly the role of the regulator rather than the SPSO.

26. What measures are used to evaluate the effectiveness of the e-learning courses, and what is the result of any such measurement?

We have not, as yet, undertaken an evaluation of the e-learning modules as our priority has been on completing the development and roll-out of training modules across the sector. We rolled out the latest modules for further and higher education in July of this year and are currently developing courses on Investigation skills for NHS complaints handlers. We plan to undertake an evaluation in quarter 4 of this financial year following completion of this launch activity. This will involve obtaining feedback from local authorities and others on the impact of the modules, focusing in part on the numbers of staff who have accessed the training. Although we track numbers who access the e-learning directly from our website (currently over 2,500), many local authorities have adapted the e-learning package for use on their own internal systems. We know from some local authorities that they have rolled the e-learning out to a majority of their staff. It is important to highlight, however, that there is an onus on individual organisations in evaluating the effectiveness of training within their organisations and identifying any remaining gaps.

As with all training evaluation it is difficult to measure impact in numbers alone given the qualitative nature of the activity. Our evaluation will also ask local authorities and others to assess whether, in their view, staff are applying what they have learned, what improvements they have identified or measured (for example, through increases rates of resolution at the frontline), areas that may require further training and the value frontline staff placed on the training. It is worth noting that our e-learning modules have been developed on the basis of the direct delivery courses we have been delivering for a number of years and which have received consistently positive feedback from participants.

Anecdotally, feedback on the e-learning modules has been very positive and there is demand to expand the range of these to other areas of complaints handling. We have also received enquiries about access to our training materials (and the CHPs more generally) from other jurisdictions, including some local authorities in New Zealand. Most recently, and closer to home, NHS Education Scotland (NES) have received enquiries from the NHS in England and Wales for access to the NHS e-learning modules - developed by NES and the SPSO and based on the SPSO local authority modules – for them to adopt and adapt for NHS staff England and Wales.

In evaluating the impact of e-learning – and assessing whether we can provide further packages here - we need to bear in mind that the resource our training unit is limited (this amounts to less than 1 FTE plus some ad hoc resource from our CSA and Complaints Investigation teams). We have provided these initial packages to providers but we will be limited in how far we can go in re-designing these or rolling out further programmes.

27. We would be interested in understanding how the complaint handling indicators for local government will assist in a "move towards a greater consistency of reporting on complaints across the sectors".

All of the model CHPs for the different sectors contain the same or similar indicative list of indicators for those sectors. These are outlined in our response to question 3 and there is more detail in the local government sectoral complaints report. We have developed those for the local authority and housing sectors to adapt them to the specific needs of the individual sectors but they remain broadly similar. Given that these remain broadly similar we will be in a position where we have greater consistency of reporting on complaints across the sectors.

28. What effect is envisaged on SPSO workload from the output of the social work complaints working group and in particular the SPSO taking on the role of complaint review committees?

It is important to point out that a decision on social work complaints has not been made. We are awaiting the decision of Scottish Ministers and it not at this stage entirely certain what the SPSO's role might be or when this might take place. Both of these factors would have an influence on any impact on SPSO.

On the basis of preliminary discussions, the most obvious impact on SPSO will be in terms of dealing with the increased volume of complaints and the need to recruit specialist skills and advice, similar to those we have in health and some other specialist areas. We have submitted estimates to the Scottish Government (copied to the SPCB) on the potential impact on SPSO of the role proposed by the working group (although yet to be agreed by ministers). The costs have not yet been approved by Scottish Government and are indicative only at this stage. Further dialogue would be required with the SPCB.

Our estimate of the total number of complaints is between 300-400. The complaints that we handled are also likely to be more complex and require further investigation than those we currently investigate, given that our role in relation to these complaints will be significantly wider, focusing on professional judgement rather than reviewing the handling by the CRCs. Total staff headcount to deal with these complaints is estimated at 4.5 FTE following transfer with some required in the lead up. These estimates are based on analysis of current levels of social work complaints to SPSO and to CRCs and estimates for future levels based on previous transfers of complaints responsibilities to the SPSO. It also factors in resource levels used for previous transfers of complaints functions to SPSO. We have also submitted cost estimates for recruiting specialist advice on social

work based on existing costs associated with advice on health complaints, where we have a similar role as proposed with social work.

These are estimates and are dependent on a number of variables and uncertainties which we have highlighted to the Scottish Government and the SPCB. The most significant variable relates to volume of complaints - our ability to accurately predict the cost of social work complaints is significantly affected by the lack of robust available data on the current volumes at local authority level. In addition to this uncertainty, experience in changes to our remit in health complaints in 2005 demonstrates that we are likely to see a significant ongoing increase in complaints in future years. We received 1,237 complaints in 2012/13 compared to 239 in 2003/4 before changes to the NHS system. Significant changes to local authority provision of social work services (including self-directed support) are also likely to have an ongoing impact on numbers of complaints brought to local authority levels.