

Report to: The Executive Board
Month: October 2007
From: Carolyn Hirst
For: Noting and Discussion
Subject: Service Quality Complaints
Status: Open

1. Purpose

To provide the Executive Board with a summary of the nature and outcome of Service Quality complaints received by the SPSO in the second quarter of 2007-08 and the learning that has resulted from these complaints.

2. Contribution to the Business Plan

Continuous improvement - on-going

3. Key points

14 Service Quality complaints were received in the second quarter of 2007-08 (the same number as received in the first quarter). 10 of these complaints had been determined by the quarter end, together with 3 complaints from the previous quarter. 1 complaint was put on hold. The main reasons for complaint were issues relating to the complaint handling process (how decision made, bias, conduct of investigation etc), and delay. 46% of the determined complaints were either fully or partly upheld (54% in the previous quarter). This Report sets out the learning for the SPSO from the determined Service Quality complaints.

4. Resource Implications

None.

5. Recommendations

Note the Report contents and discuss as required.

6. Actions required

See above.

Service Quality Complaints 2007-08 Second Quarter

Statistical Summary

14 Service Quality complaints were received during the second quarter of 2007-08 (July to September). There is 1 complaint 'on hold' from 2006-07. It was apparent that a number of the Service Quality complaints received during this quarter had been stimulated by complainants receiving the SPSO User Experience Survey.

All 14 Service Quality complaints received the second quarter were from complainants or their representatives. The main reasons for complaint were issues relating to the complaint handling process (how decision made, perceived bias, conduct of investigation etc) and delay. It is noted that 4 of the 14 complaints were from the same complainant. In all 4 complaints, the complainant did not accept the decision of the Service Quality Manager and took the complaint to the Ombudsman, who agreed with the decision made by the Service Quality Manager.

10 of the 14 complaints received during the second quarter were determined by the end of September 2007, together with 3 complaints received in the previous quarter. 1 complaint was put on hold until the completion of the review of the decision. 46% of the complaints determined in the second quarter were either fully or partly upheld (compared with 54% in the first quarter). The 13 determined complaints are summarised in the Table below:

Main Reason for Complaint	Upheld	Partly upheld	Not upheld	No Finding/ Withdrawn	Total Cases	%
Delay	2	-	2	-	4	31%
Communication	-	1	-	-	1	8%
Process	-	2	4	1	7	53%
Error	1	-	-	-	1	8%
Total	3	3	6	1	13	100%
%	23%	23%	46%	8%	100%	

Learning from Service Quality Complaints

Again, many of the Service Quality complaints related closely to the decision reached by the SPSO in the original complaint, as most complainants were either dissatisfied that their original complaint was not going to investigation or had not been upheld. This illustrates the importance of developing clear criteria and processes on the relationship between service quality complaints and requests for the review of a decision – a piece of work that will take place in the October to December quarter of 2007-08..

As noted above, 4 of the Service Quality complaints received in this quarter came from the same complainant and were all about the same general issue. Another complainant made repeated contacts related to the same issue. The right of complainants to complain about SPSO service delivery is not in question, in fact, 1 of the 4 complaints mentioned above was valid and upheld. However, the learning here relates to the management of complainant expectations and behaviour.

It is recommended that early and pro-active consideration be given to the use of the SPSO Unacceptable Actions Policy should similar interactions take place in the future.

Another point of learning, particular in situations where a complainant has made multiple complaints or contacts the SPSO on a frequent basis, is the need to take care that assumptions are not made about which body or issue is being complained about.

8 of the determined complaints were at Step 2 of the SPSO complaints process (7 were closed). It is recommended that the 'Bringing a Complaint to the Ombudsman' leaflet be revised to make it clear that the SPSO may decide not to investigate a complaint for reasons other than not being allowed to do so by law.

It is also suggested that there needs to be greater clarity at the outset of the complaint, both in leaflet form and on the website, as to what the SPSO can and cannot do if a complaint is upheld - i.e. cannot 'force' a body to do anything.

5 of the determined complaints were at Step 4. However, unlike the last quarter, 4 out of the 5 complaints related to draft Reports. These mainly related to discontent that the SPSO had apparently not taken account of comments made by the complainant in response to the draft Investigation Report. It was noted that a number of these complaints had the support of elected representatives. It is known that the letter accompanying the draft Report is to be/has been revised and it is recommended that this issue be kept under review. It is also recommended that the SPSO develops criteria/a consistent explanation as to when an Investigation Report may be discontinued – again a reason for complaint has been that the SPSO has issued a Report against the expressed wishes of the complainant.

This quarter again had most complaints about process and it is noted that 2 of these complaints related to perceived bias on the part of the SPSO – either appearing to take the word of an expert adviser without question or not appearing to interrogate the evidence provided by a body i.e. seemingly taking it on face value. In both cases the complaint was not upheld, as advice or evidence had been questioned, but it is considered that this was not demonstrated clearly enough to the complainant.

Delay complaints, in the main, related to historic reasons. One particular complaint (which was partly upheld) highlighted the Importance of letting the complainant know what is happening and why - in this case the Complaints Investigator had not wanted to contact the complainant until the way forward was clear, and this gave impression that nothing was happening (when it was).

The use of professional clinical advisers was an issue raised in 3 of the determined Service Quality complaints. One complaint demonstrated the importance of the clarity and neutrality of language when requesting independent medical advice (so as not to be perceived as biased or 'leading' the expert opinion). Also, it is not apparent whether independent advisers are aware that their reports may be made available to complainants and in some cases it would be helpful if the adviser restricted their opinion to answering the questions asked. A particular learning outcome is a suggestion that if a meeting is arranged between a complainant and a medical adviser, that the reason for and parameters of this meeting be set out clearly beforehand and the role and influence of the adviser be explained clearly to the complainant.