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[Signature]

James B Muir
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Welcome to our 2015–16 annual report.

Complaints and enquiries

A key theme in 2015–16 was the increasing number of health complaints we investigated – 9% more than the previous year. Health complaints have increasingly become the main subject of our investigative work – in 2015–16 they accounted for a little over 58% of all the investigations we carried out, with the next highest being local authorities at 22%.¹

Across all sectors, we made over 1,500 recommendations for individual redress and to improve the services public authorities deliver. To make our recommendations even more impactful, we have set up a new unit to focus on supporting authorities’ learning from complaints and help them prevent repeat failings and bring about long-lasting improvements.

The overall rate of upheld complaints was 54%, up from 50% in 2014–15, and there continues to be wide variation across and within sectors. Where we can within our resources, we are working with individual public authorities to help them identify issues and develop improvement plans.

We continue to be one of the few Ombudsman offices that publishes a report of almost every investigation. Through this we are making our work as transparent as possible, raising awareness of our service and increasing the opportunities for public service providers and others to learn and improve from our findings.

Improving public sector complaints handling

The cost of failing to deal with complaints well first time round are significant for the public authority and have an impact on SPSO’s finite resources. In 2015–16 we saw a further very welcome drop in the number of premature complaints (complaints that reach the SPSO before completing the authority’s procedure). We believe this reduction is largely attributable to improvements in complaints handling by authorities that have implemented the simplified model complaints handling procedures we have put in place since 2012–13.

Other reasons for the reduction are the focused work we have done with some authorities that have had higher rates of premature complaints than other comparable organisations, and the work of our training unit. Our training unit is designed to teach skills and build confidence in complaints handling by public service frontline staff and complaints investigators, so that authorities deal with the issues properly first time.

In our role of improving public sector complaints handling, our main achievement was in leading the development of a model complaints handling procedure for the NHS in Scotland, which will be implemented in 2017. Our aim is to ensure that people are at the heart of the services they receive, whether from one public authority or several different agencies.

¹ There is a table of decisions closed by stage, outcome and sector at the end of this report.
In our policy work we have underscored the need for easily accessible and joined-up complaints processes, especially where vulnerable people are concerned.

In sectors that already operate model complaints handling procedures, the benefits are continuing to be apparent in the increasing amount and sophistication of the information that authorities are publishing about their complaints. I am delighted to see examples of cross-sectoral sharing of approaches to good complaints handling, and growing ownership of complaints by authorities.

Another achievement in 2015–16 was the setting up of our new function as independent reviewer of the Scottish Welfare Fund. This role began on 1 April 2016, with recruitment, facilities, guidance and our process for carrying out reviews and communications materials in place.

Looking forward

This annual report records the final year of our 2012–16 strategic plan. We put our new 2016–20 strategic plan out to public consultation. The most commented on aspect was the proposal I mention above to set up a Learning and Improvement Unit to further the impact, effectiveness and consistency of our recommendations. I am pleased that we were successful in applying for one-year funding for 2016–17 for this unit, which I believe has the potential to greatly enhance this office’s contribution to public services, going beyond how complaints are handled to the heart of how authorities can use learning from them to bring about genuine and long-lasting change.

Jim Martin, Ombudsman
This section highlights:

- volumes and types of enquiries and complaints
- advice and support
- complaints by sector
- performance of authorities
- our service delivery
- continuous improvement activities and initiatives
- how we involved stakeholders in improving our service

**Enquiries and complaints**

In 2015–16, we received 760 enquiries and 4,598 complaints. This was an overall decrease of 5% compared with the previous year but was offset by the 9% rise in health complaints that we were able to investigate. These cases require sensitive handling and need comparatively more resources than non-health cases, in particular the need to obtain specialist clinical advice.

**Advice and support**

The 760 enquiries were a mix of telephone and online contacts. In responding to them, our advice team provided support and advice and where appropriate referred people to other organisations that may be better placed to help. Only five enquiries were directly for us, and on the remaining 755 we provided the enquirer with information and contact details of relevant organisations.

There is a breakdown of referrals in the table at the end of this report. It shows that while there was a decrease in the number of people who contacted us whom we then referred to Citizens Advice and the Financial Ombudsman Service, there were significant increases in other areas. As was the case in 2014–15, the next highest category of referrals was to the Energy Ombudsman, and there was also a sizeable increase in referrals to the Communications Ombudsman and to the Shelter Housing Advice Line.
The number of enquiries and complaints received fell by 5% on last year.

We handled 4,636 complaints, 3% less than last year.

We made 1,524 recommendations for redress and improvements to public services (6% more than last year).

3,043 people received advice, support and signposting.

1,462 cases were decided following detailed consideration pre-investigation.

We fully investigated 891 complaints with 861* publicly reported to the Parliament.

The proportion of premature complaints dropped again, from 34% to 31%.

The overall rate of upheld complaints investigated rose from 50% to 54%.

* Some of the cases published in 2015–16 will have been handled in 2014–15. In a small number of cases we do not put information into the public domain, usually to prevent the possibility of someone being identified.
Casework performance

Which sectors we received complaints about

As the table below shows, the proportion of complaints received about each sector remained roughly the same as the previous year. The proportion of complaints investigated by sector can be found in the table of all cases determined in the statistics section at the end of this report.

Complaints received by sector in 2015–16 and 2014–15 and as a % of all complaints

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<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority</td>
<td>1,722</td>
<td>37.45%</td>
<td>1,880</td>
<td>38.41%</td>
</tr>
<tr>
<td>Health</td>
<td>1,512</td>
<td>32.88%</td>
<td>1,542</td>
<td>31.50%</td>
</tr>
<tr>
<td>Scottish Government and devolved...</td>
<td>568</td>
<td>12.35%</td>
<td>608</td>
<td>12.42%</td>
</tr>
<tr>
<td>Housing associations</td>
<td>385</td>
<td>8.37%</td>
<td>390</td>
<td>7.97%</td>
</tr>
<tr>
<td>Water</td>
<td>217</td>
<td>4.72%</td>
<td>288</td>
<td>5.88%</td>
</tr>
<tr>
<td>Further and higher education</td>
<td>176</td>
<td>3.83%</td>
<td>159</td>
<td>3.25%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>0.39%</td>
<td>28</td>
<td>0.57%</td>
</tr>
<tr>
<td>Total</td>
<td>4,598</td>
<td>100%</td>
<td>4,895</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Of the complaints in the Scottish Government and devolved administration sector, 331 (58%) were about prisons.

Advice and early resolution

We continued to operate the triage system we introduced in 2013–14, which provides people with answers sooner on whether their case can be resolved early on and whether an SPSO investigation is appropriate. Sometimes people present issues that we cannot look at for legal reasons, and in these cases it is important that we let people know quickly that we cannot help them so they can pursue other options. In other cases, where the organisation has already investigated the issue and taken steps to address the problem, we may decide that we could not achieve a better outcome and it would not be proportionate to use our resources to investigate.

Any cases that are unclear are given detailed consideration, so we can be sure that we are not ruling anything out that we should be looking at. We resolved 82 cases at this detailed consideration stage. By the time cases come to us, the opportunity to resolve them to both parties’ satisfaction has usually passed and positions have become entrenched. Nevertheless, we do try to act on cases where the issue can be quickly resolved.

Investigations

In 2015–16, we gave our decision in 850 cases, compared with 898 the previous year. We published detailed public investigation reports on 41 cases, compared with 46 the previous year.

There is a detailed table with all the outcomes of the complaints we dealt with in 2015–16 at the end of this report.
Performance of authorities

Premature and uphold rates are two key indicators of how different sectors and authorities are performing. The number and type of recommendations we make also shows authorities where they can improve.

Premature complaints

These are complaints that reach us too early, without having first gone through the authority’s complaints process. A low premature rate is a clear indicator of a successful complaints process that is founded on early resolution. The premature complaints proportion of our caseload fell again in 2015–16, by 3% overall, to 31%. This compares with a figure of 45% five years ago, before model complaints handling procedures (CHPs) were operating in many areas of the public sector.

We introduced model CHPs in various sectors, beginning in 2012 with local authorities and housing associations, followed in 2013 by further and higher education and the Scottish Government, Scottish Parliament and associated public authorities. While we recognise that there may be other factors at play, we are pleased to note a correlation between the implementation of model CHPs in these sectors and the fall in premature rates.

The fall in premature complaints is good news for both complaints and public service organisations as it suggests that people are getting their complaint dealt with at the right place and using the SPSO properly as the last stage in the process.

Premature rates by sector in 2015–16 and 2010–11

<table>
<thead>
<tr>
<th>Sector</th>
<th>2015–16</th>
<th>2010–11</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority</td>
<td>37.6%</td>
<td>55%</td>
<td>-17.4</td>
</tr>
<tr>
<td>Health</td>
<td>23.5%</td>
<td>31%</td>
<td>-7.5</td>
</tr>
<tr>
<td>Housing associations</td>
<td>39.3%</td>
<td>64%</td>
<td>-24.7</td>
</tr>
<tr>
<td>Scottish Government and devolved administration</td>
<td>23.3%</td>
<td>29.5%</td>
<td>-6.2</td>
</tr>
<tr>
<td>Water</td>
<td>51.8%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Further and higher education</td>
<td>15.5%</td>
<td>31%</td>
<td>-15.5</td>
</tr>
<tr>
<td>All sector rate</td>
<td>31.2%</td>
<td>44.8%</td>
<td>-13.6%</td>
</tr>
</tbody>
</table>
Upheld complaints

A low uphold rate by SPSO indicates a robustness in the authority’s handling of the complaint at their detailed investigation stage when objectivity and evidence-based decision-making are key. Of the total of 891 complaints that we investigated, we upheld or partly upheld 54%, an increase of 4% from the previous year.

With the exception of the health sector and further and higher education, the rate of upholds in the various sectors changed notably compared with the previous year.

In 2016–17 we are working with a number of authorities where we have seen significant increases in uphold rates over recent years, to support them in identifying improvements they can make to their complaints handling or services.

Uphold rates by sector 2015–16 and 2014–15

<table>
<thead>
<tr>
<th>Sector</th>
<th>2015–16</th>
<th>2014–15</th>
<th>% difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority</td>
<td>55.4%</td>
<td>46.8%</td>
<td>+8.7</td>
</tr>
<tr>
<td>Health</td>
<td>56%</td>
<td>56%</td>
<td>0</td>
</tr>
<tr>
<td>Housing associations</td>
<td>52%</td>
<td>37%</td>
<td>+15</td>
</tr>
<tr>
<td>Scottish Government and devolved administration</td>
<td>52.5%</td>
<td>40%</td>
<td>+12.5</td>
</tr>
<tr>
<td>Water</td>
<td>44%</td>
<td>52%</td>
<td>-8</td>
</tr>
<tr>
<td>Further and higher education</td>
<td>30%</td>
<td>34%</td>
<td>-4</td>
</tr>
</tbody>
</table>

Uphold rates and SPSO powers

To further explain some of the variation in the uphold rate, it is worth repeating a point we regularly make about our powers in different areas. In the health sector we can look at how reasonable clinical judgements are, but outside of health we are more limited, although we can and do make sure that any discretionary decisions were made properly (in the terms of the law, ‘without maladministration’).

Some of the complaints people bring us are about decisions made through the democratic process and, ultimately, the elected decision-makers are democratically accountable. In these cases, we can explain to people the reason for the restriction. In some areas, however, we are unable to test the judgements of non-elected officials where there is no similar line of public accountability. This can be very frustrating for people, particularly in planning services where for objectors there is no alternative route to challenge the decision. This can lead to high levels of dissatisfaction with the complaints process.
Casework performance

**Recommendations**
We use recommendations for three main purposes: to redress individual injustice, to help prevent the problem from happening again and to drive learning and improvement. In 2015–16, we made 1,524 recommendations (up from 1,444 the previous year). We follow up each recommendation, requiring the authority to provide detailed evidence of what it has done to implement the redress or improvement we asked for by the deadline we set.

In 2015–16, 98% of recommendations were implemented within three months of the target date we set, the same positive rate as the previous year.

While we work hard to engage with public authorities to meet the timescales wherever possible, ultimately it is down to individual organisations to implement the recommendations on a timely basis.

**Our service delivery**
We have clear service standards and performance targets that we work to. Key points about our performance and continuous improvement work are set out below.

**Timescales**
We met two of three of our timescale performance indicators and made further progress against the indicator we did not meet, achieving 89% (compared with 88% in 2014–15):

- PI–1 (target: 95% of advice stage complaints handled within 10 working days) 99%
- PI–2 (target: 95% of early resolution complaints decided or moved to more complex investigation stage within 70 working days) 89%
- PI–3 (target: 95% of investigation complaints decided within 260 working days) 97%

With reluctance, we introduced a holding bay in 2015–16. This is the first time we have had to do this since 2009. We said in our draft strategic plan that extending our timescales was one of the options we would have to consider if resources remained static.

**Service improvement**
Our internal service improvement group reviews our service using information we receive from a variety of sources; our quality assurance process; requests for reviews of our decisions; customer service complaints and stakeholder input and feedback.

A significant project in 2015–16 was the introduction of our new rolling customer survey of people who received a decision from us (which we piloted in 2014–15) and this has also become part of the range of information sources used by the service improvement group. There is more about the survey at the end of this chapter. The service improvement group also began to develop plans for surveying other user groups, including public authorities, prisoners and people who call us for advice. We plan to roll these out in 2016–17.
Quality assurance (QA)

As well as senior level review of some case decisions, we ensure quality through our QA process. This involves testing a 10% sample of our work on a quarterly basis. We did not change any decisions following QA in 2015–16. We did give careful, closer consideration to a small number of cases and found some instances where we could have given a clearer explanation or where we could have obtained more evidence to support our conclusions. We were, nevertheless, satisfied overall with the decision reached in these cases. We also identified some administration issues and fed these back to the staff concerned.

Reviews of our decisions

Our review process is open to complainants and organisations and reviews can consider decisions to not look at a complaint, as well as the decisions we make after investigating.

In 2015–16 we responded to 286 requests for review. This was 6% of our decisions. We changed the original decision in six of these (2% of the small number of cases people asked us to review). We re-opened two complaints in light of new information received (i.e. entirely new and relevant information that we did not have during the original investigation). Other reasons for changing those decisions were that we did not have enough evidence to reach the original conclusion, or felt we could have exercised our discretion to consider the complaint. We record and report reviews internally and to our Audit and Advisory Committee, and we publish statistics about them on our website.²

Customer service complaints about SPSO

Our process for people who are unhappy with our service has two internal stages, followed by referral to an external Independent Customer Complaints Reviewer. This reflects the model CHPs used by organisations under our jurisdiction. We record and report customer service complaints internally and to our Audit and Advisory Committee. Our annual service complaints report, including examples of actions we have taken to improve our service, is published in summary form later in this annual report (the full version is on our website).³

Customer satisfaction survey

Following a trial of a survey in 2014–15, we finalised and launched our new survey approach for people receiving SPSO decisions from April 2015 onwards. This does not, however, include prisoners, who have different communication needs and for whom we are developing a specific survey project in 2016–17. The 2015–16 results will be published in 2016–17.

The survey builds on a review and redesign of our service standards undertaken in 2014–15 to ensure they were up-to-date and clearly explained to our staff and those using our service. We re-launched our service standards in April 2015. They are now being developed by the Ombudsman Association in partnership with the British Standards Institution to be used as a common set of service standards which are recommended to all ombudsman schemes and complaints handlers across the UK and Ireland.

² www.spso.org.uk/audit-and-advisory-committee
³ www.spso.org.uk/customer-service-complaints
Casework performance

Involving stakeholders

In addition to the small number of review requests and customer service complaints and our customer survey, we regularly receive formal and informal feedback that gives us a sense of how people perceive our service.

We also have three formal sounding boards, representing customers, local authorities and the NHS, which meet approximately twice a year. These involve two-way discussions on a wide range of issues, including for example the financial challenges the public sector faces; updates on changes to SPSO’s remit; complaints procedures in health and social care including social work; and our preparation for the Scottish Welfare Fund reviewer role. Membership and minutes are posted on our website.

In 2015–16, we gained valuable insights from all three sounding boards into how to best manage our caseload within static resources. The customer sounding board gave us a clear steer that of the proposed initiatives, the one that would most benefit the public was ensuring that recommendations lead to lasting improvement. They also inputted into our redesigned customer standards, which were the foundation of our new customer satisfaction survey.
Impact: Sharing Strategic Lessons

Strategic objective 2: to support public service improvement in Scotland

This section highlights:

- why we make recommendations
- the Learning and Improvement Unit
- publicising our findings
- how we used casework to contribute to policy
- how we prepared for our new Scottish Welfare Fund role.

Recommendations

These are the key tools we use to try to redress individual injustice and help prevent the problem from happening again. In this way, recommendations are both part of administrative justice and a contributor to public service improvement. Of the 1,524 recommendations we made in 2015–16, approximately one third were about a remedy for an individual who had experienced an injustice, and two thirds were recommendations to organisations to prevent the same thing happening to someone else in the future. Two thirds of our recommendations were to health providers, with the next highest being local authorities at a little under a fifth.

To give some examples from 2015–16, we recommended that:

- a health board ensure that their radiology staff have a system in place to notify clinicians of urgent and unexpected results detected during scans
- a health board review their procedures for the care and treatment of patients who live in other NHS board areas
- a council provide a man with more detailed information about how a Complaints Review Committee arrived at their decision on his social work case
- a council review their school excursion policy, taking into account the requirements of the Equality Act and the council’s equality policy
- a GP familiarise themselves with national guidelines on symptoms of possible ovarian cancer, and identify this as a learning need for their yearly appraisal
- a college offer a student an urgent review of their support needs
- a health board conduct an audit of how diabetic patients’ insulin regimes are maintained in a hospital ward to identify whether the action taken in the case that we investigated would be effective for other patients
- a housing association introduce a system to record repair work agreed with tenants, and to record when the work has been completed
- a health board apologise to a man and his family for failing to properly obtain consent, and also to use the man’s case to reflect on the failings we identified with a view to improving their processes for obtaining informed consent
- a dental practice review their disability policy to ensure that the communication needs of patients are being met in line with the local health board’s equality and human rights policy
- a Scottish Government body ensure that their complaints procedure is compliant with the model complaints handling procedure.
Impact: sharing strategic lessons

As well as following up each recommendation with the organisation, we highlight cases to regulatory, scrutiny and other improvement organisations, to help inform their work. A good example of one of our investigations being used in this way was the review of the care of older people carried out by Health Improvement Scotland (HIS) in August this year. It was prompted by our December 2015 report into a complaint about the care of a patient admitted to Borders General Hospital and the handling of the complaint by NHS Borders.

Our report highlighted similarities between the care described in the complaint and findings of a previous HIS care of older people inspection. The review highlighted areas of good practice as well as areas for improvement, and an action plan was produced. We were also pleased to note that complaints formed a key part of the patient feedback that the hospital was learning from.

Proportion of recommendations by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number of recommendations made</th>
<th>% of recommendations made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further and higher education</td>
<td>35</td>
<td>2.3%</td>
</tr>
<tr>
<td>Local authority</td>
<td>286</td>
<td>18.8%</td>
</tr>
<tr>
<td>Health</td>
<td>1,019</td>
<td>66.9%</td>
</tr>
<tr>
<td>Housing associations</td>
<td>45</td>
<td>2.9%</td>
</tr>
<tr>
<td>Scottish Government and devolved administration (including prisons)</td>
<td>96</td>
<td>6.3%</td>
</tr>
<tr>
<td>Water</td>
<td>36</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>0.4%</td>
</tr>
<tr>
<td>All sector rate</td>
<td>1,524</td>
<td>100%</td>
</tr>
</tbody>
</table>
Impact: sharing strategic lessons

Learning and improvement unit

We want to do even more to help authorities to learn and improve. One of the means of support we established in 2015–16 was a self-assessment complaints handling reflective learning form for authorities to fill out at the start of our investigation. The form should provide the authorities themselves, and us, with assurance that complaints file management and the investigation they conducted are of a high standard.

We know that our recommendations should be powerful tools for change. This view is clearly supported by stakeholders, in particular our customer sounding board, the Parliament’s Local Government and Regeneration Committee and our Audit and Advisory Committee. Public bodies should take responsibility for complaints and take action on findings, for the benefit both of the public and authorities. This also saves the public purse.

Our new Learning and Improvement Unit (LIU) aims to help us further focus authorities on taking responsibility themselves for good complaints handling, in particular on organisational learning from complaints to reduce repeat mistakes. The main benefits of the unit are that it will help us:

> support and advise public service organisations on the implementation of recommendations that will lead to lasting improvement
> work with high volume generators of complaints to develop and support improvement initiatives
> reinforce the work currently undertaken by our Complaints Standards Authority to ensure recommendations support principles, model complaints handling procedures and good practice
> advise on, develop and track recommendations for consistency and knowledge management purposes
> publish reports on thematic issues.

The LIU received significant support from organisations that responded to our draft strategic plan consultation, who were mostly public authorities and advice/advocacy organisations. We were very pleased to be awarded one-year funding for the unit and have been providing regular updates on its progress in our monthly e-newsletter. Key to its success is the involvement of public service organisations. In our most recent annual letter (which we send each year to all local authorities, NHS boards, the prison service and water providers) we invited organisations to tell us about the effectiveness of our recommendations, and to suggest how we could improve them. We look forward to progressing this joint work.
Impact: sharing strategic lessons

Publicising our findings

Our annual letters are a reminder to organisations that they are required to gather and report on complaints and the learning from them. In 2015–16, we also sought assurances from organisations on their complaints governance arrangements, specifically to ensure it is being reported to allow them to learn from complaints. We publish all our complaints statistics and the annual letters on our website.5

Publicity is also a good way of ensuring people’s voices are heard and bringing about change. We publish almost all of our decisions and recommendations on our website,6 highlighting any significant issues from the cases in our monthly e-newsletter. We want organisations delivering similar services to use the experience of others to ask themselves ‘Could it happen here?’, to help equip them to prevent problems arising or reduce the likelihood of such problems.

Another reason for publishing almost all of our decisions (we remove those where there is a significant risk of someone being identified) is transparency and accountability. We want people to understand our powers, our process, and the outcomes we can – or cannot – achieve for them. The media often pick up cases, which can also help the public be aware of and understand our work better.

Using casework to contribute to policy

2015–16 saw a higher than usual number of invitations to the Ombudsman and our senior management team to give written and oral evidence to Holyrood Committees. We spoke at five committee sessions – Health and Sport, Local Government and Regeneration, Justice, Education and Culture, and Welfare Reform.

These evidence sessions gave us a strong platform to highlight three of our core messages: the need for good communication in order to deliver good care; the benefits that flow from having the capacity and support to be able to apologise early and do it well; and the need for easily accessible complaints processes where the barriers to complaining are removed.

In addition to evidence sessions, the main written contributions we made included:

> the draft welfare funds regulations and guidance
> comments on a duty of candour proposal
> proposals to revise the procedure for complaints about social work
> a parliamentary committee’s human rights inquiry
> proposals to introduce a role of independent whistleblowing officer for NHS Scotland staff
> a parliamentary committee’s inquiry into palliative care
> the named person and child’s support plan.

We were also invited to provide evidence about the ‘Scottish model’, in particular our complaints standards powers, to other UK legislatures. We gave evidence on the Welsh and Northern Ireland Assemblies’ proposed legislation about new powers for their ombudsman schemes. The Ombudsman also provided evidence on the proposed changes to the UK Parliamentary and Health Service Ombudsman.

A list of evidence sessions and consultation responses is on our website.7

5 www.spsoc.org.uk/statistics-2015-16
6 www.spsoc.org.uk/our-findings
7 www.spsoc.org.uk/consultations-and-inquiries
Scottish Welfare Fund (SWF)

A significant focus in 2015–16 was our new role as independent reviewer of SWF decisions, which began on 1 April 2016. We held a public consultation on significant aspects of this work, and overall the responses to our stated approach were very positive. Our powers in relation to the SWF are different from our usual powers in local authority complaints, in that we can overturn decisions. As well as explaining how we would approach decision-making, we consulted on draft rules for oral hearings and on our approach to undertaking an Equalities and Human Rights Assessment of this new role.

We received 24 responses to the consultation, with the majority from local government and a significant number from the third sector. We also took into consideration feedback from our two SWF sounding boards (one made up of local authority representatives and the other from the third sector). We visited councils to learn about initial decision-making and first tier reviews. Together, this information and feedback helped us develop our new guidance processes and our Statement of Practice. We also used the advice and feedback to ensure that our service would be properly accessible and responsive, confirming that applicants would be able to contact us in different ways such as by using a Freephone number and via an online application form on our new SWF website.

We developed dedicated communications materials in simple and clear language for applicants and advisers.

This is a significant new strand of work, and we are providing updates on this role in our monthly e-newsletters. We will report in full on our first year of SWF reviews in our 2016–17 annual report.
Strategic objective 3: to simplify the design and operation of the complaints handling system in Scottish public services.

Strategic objective 4: to improve complaints handling by public service providers.

This section outlines our work to improve public sector complaints handling through the work of our Complaints Standards Authority (CSA). Key activities were:

- developing person-centred complaints handling in health and social care, including social work
- supporting organisations to monitor, report and learn from complaints handling
- providing advice, support and guidance
- delivering training.

The CSA is a small team within SPSO, which supports public service providers in improving their complaints handling. It has led the development and implementation of model complaints handling procedures (CHPs) across most public services in Scotland, establishing a system with a strong focus on early resolution of complaints.

In 2015–16, the CSA led the development of a more standardised, person-centred NHS model CHP. This was carried out in response to the Scottish Health Council (SHC)’s ‘Listening and Learning’ report on how feedback, comments, concerns and complaints can improve NHS services in Scotland.

Developing a model CHP for the NHS

In 2015–16, the CSA led the development of a more standardised, person-centred NHS model CHP. This was carried out in response to the Scottish Health Council (SHC)’s ‘Listening and Learning’ report on how feedback, comments, concerns and complaints can improve NHS services in Scotland.

The NHS feedback and complaints framework is outlined in The Patient Rights Act and associated regulations, directions and statutory guidance. This provides a sound framework for complaints handling and was the basis of the development of the model CHP. In line with the SHC’s report, we collaborated with the Government, NHS providers and others to work towards a more standardised approach and address inconsistencies in approach that the report identified. This includes a stronger focus on increasing local early resolution.

We established and chaired a Steering Group which co-ordinated the work of three discrete working groups, tasked with:

- developing key parts of the model CHP and how it will be rolled out, including the CHP and associated patient and staff information;
- developing an approach to consistent performance and reporting of NHS complaints (a working group led by NHS National Services Scotland); and
- preparing options for learning and training of NHS staff to support the implementation of the model CHP (a working group led by NHS Education for Scotland, NES).

This work has continued into 2016–17 and we will be providing support to NHS providers to implement the new process from April 2017.

Social work complaints and integration of health and social care

In 2015–16, we continued to engage with the Scottish Government on its review of social work complaints and played an active role in helping to progress and develop new legislative arrangements. This is an area where SPSO had long raised concerns, and had asked for simplicity and consistency about the existing complaints arrangements for often vulnerable social work service users.

The legislative changes for the social work complaints process were introduced and approved by the Scottish Parliament in March 2016 and the new procedure will be introduced from 1 April 2017. As with all of our complaints standards work, we are working in close partnership with a wide range of stakeholders to prepare for this change.

The culmination of a number of years of discussion and debate on the appropriate future arrangements, the legislation removes the Complaints Review Committee stage and allows SPSO to consider professional judgement elements of these complaints. This will bring social work into line with health complaints, where we can already assess clinical judgement. It will also enable the alignment of social work complaints handling with the local government and NHS model CHPs.

Monitoring compliance and performance

We continued to monitor compliance with model CHPs in all sectors and responded to any non-compliance issues by feeding back to individual authorities. We also continued to support organisations in reporting and publishing complaints information in line with CHP requirements, including through complaints handlers networks and key sector and regulatory bodies (such as Audit Scotland, the Scottish Housing Regulator, the Scottish Funding Council, Scottish Government and the Scottish Parliamentary Corporate Body). This reporting is done within existing structures to minimise the regulatory burden.

All organisations operating the model CHP are required to report performance and learning in line with the requirements of the CHP and the agreed performance indicators. Members of the local authority, housing and further education complaints handlers networks used this information to compare, contrast and benchmark their performance against one another. The results continue to be encouraging, with high percentages of complaints resolved at the frontline resolution stage of the model CHP (continuing above 80% across local government).

Sharing best practice

Cross-sectoral conference

We held our first SPSO complaints handling conference in 2015–16. It was a cross-sectoral event, attracting 160 delegates, and was very well received. As well as presentations from speakers from SPSO and the health, water and finance sectors, we held three workshops on the following topics: the Complaints Improvement Framework; Learning from Complaints; and Quality Assuring your Responses.
Improving complaints handling

Complaints Improvement Framework

The Framework\(^{10}\) is a tool we have developed to support organisations to continually improve their complaints handling. Its purpose is to help organisations self-assess the effectiveness of their overall complaints handling arrangements at a strategic level across the six areas of good practice in complaints handling:

- organisational culture
- process and procedure
- accessibility
- quality
- complaints handling performance
- learning from complaints.

The Framework focuses on the quality of the experience for users and the way organisations have used and responded to complaints. Through the Learning and Improvement Unit, described in the Impact chapter, we will be further developing the Framework along with other tools to support specific improvements in quality, learning and root cause analysis.

Advice, support and guidance

A core activity of the CSA is providing guidance and advice to public bodies. The total number of requests made for support during 2015–16 was 621, broadly similar to the number in 2014–15.

Notable differences between the two years were a reduction in requests from the local government sector and an increase in requests from the NHS sector. This was to be expected given the work of the local government network to identify and share good practice and to create knowledge networks between complaints handlers and as we continue to develop a new model CHP for the NHS.

<table>
<thead>
<tr>
<th></th>
<th>2015 – 16</th>
<th>2014 – 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local government</td>
<td>160</td>
<td>219</td>
</tr>
<tr>
<td>Housing</td>
<td>81</td>
<td>97</td>
</tr>
<tr>
<td>Central government agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including Scottish Prison Service)</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td>Further education</td>
<td>52</td>
<td>53</td>
</tr>
<tr>
<td>Higher education</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>NHS</td>
<td>100</td>
<td>26</td>
</tr>
<tr>
<td>Water</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other (including members of the public, students, UK and Ireland Ombudsman offices)</td>
<td>39</td>
<td>23</td>
</tr>
<tr>
<td>SPSO internal case advice on organisations’ complaints handling</td>
<td>80</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>621</strong></td>
<td><strong>603</strong></td>
</tr>
</tbody>
</table>

\(^{10}\) [www.valuingcomplaints.org.uk/complaintsimprovementframework](http://www.valuingcomplaints.org.uk/complaintsimprovementframework)
In 2015–16, the CSA participated in 40 external meetings, events and conferences. These allowed us to support improvements and share best practice, and included, for example, presenting at seven NHS regional masterclass events on developing the CHP, early resolution and apology; delivering a complaints workshop to the new Independent Prison Monitors service; and improving how complaints from prisoners are handled by prison healthcare teams.

**Networks**

We continue to support and facilitate the wider sharing of good practice through complaints handlers networks, which continued to grow and evolve in 2015–16. The networks, covering local authority, housing, further education and higher education sectors, are run by the members and aim to share good practice, develop tools and guidance, support practitioners and facilitate benchmarking of complaints performance information. The CSA website[^11] shares good practice and is used to organise meetings, events and conferences and to provide expertise and advice on good complaints handling. The website also hosts the Complaints Improvement Framework[^12] and other tools on assuring good complaints handling and learning.

**Local government network**

One of the main achievements of the network in 2015–16 was the Improvement Service taking ownership of national reporting of local authority performance information. This came about following collaborative work between the CSA, the Accounts Commission, the Improvement Service, COSLA, SOLACE, the Government and Audit Scotland. The Improvement Service’s report allows the network to benchmark their performance against each other and identify areas of good practice which can be shared across the sector.

The network also looked at issues such as how to ensure the welfare of the staff involved in complaints handling, differentiating between service requests and complaints, and developing a common set of complaints categories.

During 2015–16, North Lanarkshire Council stepped down as chair of the network. The council had successfully chaired the network since its introduction in 2012 and were an integral part of its achievements, and of the successful implementation of the model CHP. We are grateful to the chair and all her team for the immense commitment and energy they brought to the network. The network would not have been as big a success without their major contribution. We are also grateful to South Lanarkshire and Fife councils for taking on joint chairing of the network moving forward.

**Higher education network**

Our attendance at this network allows us to promote the complaints performance culture that the CHPs are developing across the public sector. Our engagement has been more limited in recent times but we remain keen to engage further.

[^11]: [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)
[^12]: [www.valuingcomplaints.org.uk/complaintsimprovementframework](http://www.valuingcomplaints.org.uk/complaintsimprovementframework)
Improving complaints handling

**Further education network**

The network continued to make excellent progress, particularly in benchmarking and developing standardised categories for complaints. In 2013–14, colleges presented their performance data in a standardised format, allowing for consistent and meaningful analysis of performance and, for the first time, a baseline against which to benchmark for improvement. In 2015–16 the network analysed the sector’s second year of annual complaints reporting (covering the academic year 2014–15 from August to September). Performance in the sector continued to be positive and comparable with previous years.

We were also pleased that the network, led in this project by The City of Glasgow College, made significant progress in developing standardised categories of complaints across the sector. This will further improve benchmarking of performance and facilitate the sharing of learning from complaints in terms of wider good practice initiatives performed by colleges. The network also improved how they measure customer satisfaction, basing their work on a questionnaire developed by North East Scotland College.

Finally, we were encouraged by the feedback from the sector’s annual complaints event, where the Framework was used to identify future priority areas for the network.

**Housing network**

This network also analysed members’ complaints handling performance. There was positive feedback about the benefits of the model CHP for the sector and a recognition that recording and reporting against Scottish Housing Regulator (SHR) indicators was taking place. However, there was also some evidence that reporting against SPSO indicators was not being consistently applied by Registered Social Landlords who do not attend the network, and we provided guidance on this issue.

Building on the work of the further education network, a project got underway to standardise complaints categories in the housing sector. We saw this as an excellent example of cross-sectoral sharing and learning. In relation to the Government’s review of the Scottish Social Housing Charter, CSA had early engagement with the Government, the SHR and other strategic stakeholders on the priorities for the charter, including complaints outcomes and indicators.
Improving complaints handling

Training
We delivered 52 training courses across all sectors:
- 29 Complaints Investigation Skills courses
- 20 Good Complaints Handling courses
- three managing difficult behaviour courses.

Our training unit comprises one part-time training co-ordinator and some administration support. We deliver courses directly and through e-learning and in 2015–16 we also developed a DVD with NHS Education for Scotland about nursing care and complaints handling. Demand for the courses is often linked to the introduction of a new model CHP, with organisations looking to increase the confidence and skills of their staff in dealing with complaints. In most cases we go to the location of the organisation to provide them.

Feedback on and demand for the courses demonstrates that they continue to be highly regarded.

E-learning
We continued to promote our e-learning modules in complaints handling. These are free. At the time of writing, over 3,800 registered users have accessed the complaints modules for frontline staff directly from our website, with 422 new users signing up this year. In addition to this, many public authorities, in particular councils, have adapted the e-learning package for use on their own internal systems. We cannot track the numbers who access the e-learning in this way but it is likely to be much larger than the number who register directly.
Corporate Performance

Strategic objective 5: to be an accountable, best value organisation

Our 2015–16 annual audit report to Members and the Auditor General for Scotland was submitted in July 2016 and published in full on our website.\footnote{www.spso.org.uk/sites/spso/files/communications_material/annual_accounts/AuditScotland_AnnualAuditReport_2015-16.pdf} The summary from the independent external auditor, Audit Scotland, is below:

**Key messages from independent external audit:**

**Audit of financial statements**
- We have given an unqualified independent auditor’s report on the 2015–16 financial statements.

**Financial Position**
- All financial targets in 2015–16 were met.
- On an accruals basis there is an underspend of £62,000 against an approved budget of £3.2 million. The underspend relates to a significant increase in additional income from shared services and an increase in training services provided by the Scottish Public Services Ombudsman.
- Financial management was found to be generally sound.

**Governance and Accountability**
- Overall, we found the Scottish Public Services Ombudsman has effective overarching and supporting governance arrangements which provide an appropriate framework for organisational decision making.
- We consider the Scottish Public Services Ombudsman to be open and transparent with the majority of items being available on the website.
- Systems of internal control operated effectively during 2015–16 based on assurances obtained from the acting Head of Internal Audit of Scottish Legal Aid Board.

**Best Value**
Performance against the strategic plan is reported to members and the senior management team on a regular basis and is also available on the website. It is underpinned by detailed annual operational plans and performance measures.
Our corporate performance is detailed in our Annual Report and Annual Accounts which we published on our website in August 2016.\(^{14}\) This document contains our accountability report, which includes an outline of the internal control structure and management of resources that provide assurance about performance and risk management for the Ombudsman; and statutory reporting for example about requests for information under the Freedom of Information and Data Protection legislation.

It also details:

- strategic planning and delivery
- operational efficiency improvements including ICT
- how we support our staff through learning and development
- our Investors in People validation
- environmental and sustainable development commitments
- financial performance (we publish information on our website\(^ {15}\) on specific expenditure areas, as required under the Public Services Reform Act. Our full audited accounts are also published on our website).\(^ {16}\)

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\(^{15}\) [www.spso.org.uk/sites/spso/files/communications_material/annual_accounts/2015-16StatementofExpenditure.pdf](http://www.spso.org.uk/sites/spso/files/communications_material/annual_accounts/2015-16StatementofExpenditure.pdf)

Equality and Diversity

In this section we highlight some initiatives undertaken in 2015–16 to ensure we are meeting our five equalities commitments, which are:

1. To take proactive steps to identify and reduce potential barriers to ensure that our service is accessible to all.
2. To identify common equality issues (explicit and implicit) within complaints or reviews brought to our office and feed back learning from such cases to all stakeholders.
3. To ensure that we inform people who are taking forward a complaint or review of their rights and of any available support, and that we encourage public authorities to do the same.
4. To ensure that we play our part in ensuring that service providers understand their duties to promote equality within their complaints handling and review procedures.
5. To monitor the diversity of our workforce and supply chain, and take positive steps where under-representation exists.

Assessing impact from an equality and rights perspective

In 2015–16, we prepared our first joint equality and human rights impact assessment (EQHRIA) to support our new role with the Scottish Welfare Fund. We have undertaken equalities impact assessment work in the past but, following a review of the available options and given the emphasis in the scheme of rights, we felt there would be benefits from this joint approach. Before we committed to this we consulted on whether we should do this type of assessment and received significant support for the proposal. The assessment gave us confidence that the procedures we were developing for the review process would have no negative or detrimental impact on people with protected characteristics and would help to ensure we are taking human rights into account. We were, however, aware that the procedures were not in practice and no one had real, live experience of our review process. This is why we published our EQHRIA in draft and this document is available for comments for the whole of 2016–17.

Understanding our users and improving our service

It is important that our equalities commitments inform what we do. Each year, we make a number of reasonable adjustments for people who come to us to help them access our service. These adjustments are specific to the person’s needs although we do review them each year to identify whether there are common themes. The most common type of requests made in 2015–16 were to support people who have visual impairments in accessing written correspondence.

Along with most public organisations, we ask people to tell us about themselves when they bring us a complaint. This is voluntary and the information is not linked to their complaint. It helps us to understand who is using our service, and also to see if any particular group is under-represented.

In 2014–15 we reported an improved response rate to the completion of our equalities monitoring form. This was maintained in 2015–16 and, while there was a slight drop in actual numbers, this reflected the overall drop in cases received so the percentage response rate remained similar. The pattern of people complaining to us was similar in both years and our users broadly reflect the population. The one area where we remain out of step with the census figures is around age, where we still have an older user profile. This is an area we continue to monitor closely.

We also reviewed our monitoring form and looked at best practice elsewhere to see if we could improve the information we were receiving. As a result, we made changes to how we gather information on gender and health to help us better understand the people who use, and do not use, our service.
Governance and Accountability

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

Introduction

Each year as part of the SPSO’s annual report, the chair of the SPSO Audit and Advisory Committee (the committee) is required to produce an annual report on behalf of the committee. The purpose of the report is to summarise the committee’s work over the previous financial year and provide the committee’s opinion about:

- the effectiveness of governance, risk management and control;
- the comprehensiveness of assurances in meeting the Ombudsman’s and management needs;
- the reliability and integrity of these assurances;
- reviewing the integrity of the financial statements; and
- advising the Ombudsman as Accounting Officer about how effectively the assurances support him in decision-taking and in discharging his accountability obligations.

In addition the committee has sought to add value to the governance processes within the office of the SPSO.

The core issues examined by the committee are considered through the regular review of the risk management processes undertaken by management, in conjunction with the review and discussion of the work undertaken by internal and external audit throughout the course of the financial year.

The Audit Committee met on four occasions during 2015–16:

- 26 May 2015
- 22 September 2015
- 24 November 2015
- 23 February 2016.

The minutes of these meetings are available on the SPSO website.17

Committee membership and structure

The committee membership during 2015–16 comprised three non-executive directors, and two directors. The chair, Tom Frawley, and Heather Logan were members of the committee throughout the financial year 2015–16. The third member, Douglas Sinclair, was a member of the committee from 1 April 2015 until his resignation on the 24 November 2015. Douglas will be greatly missed for his wisdom and his thoughtful and constructive contribution and challenge. The committee’s full membership was restored in February 2016 when Jim McCormick replaced Douglas Sinclair. All of the audit meetings during 2015–16 were quorate and were chaired by Tom Frawley.

17 www.spso.org.uk/minutes-meetings
Governance and accountability

The committee’s terms of reference are kept under regular review as guidance in relation to corporate governance and audit is constantly developing. The committee at the end of the financial year again used the ‘Audit Committee Self-Assessment Checklist’ as a mechanism for reviewing its effectiveness. Members were asked initially to review the committee individually. We then met together ahead of the committee’s February meeting. We were joined by the internal auditor who supported us in completing our self-assessment process together. Overall we concluded that we were satisfied with our approach and, in particular, the level of engagement from management.

Attendees

Gillian Woolman and Patricia Fraser, Audit Scotland; Nick MacDonald, SLAB Internal Auditor; Jim Martin, Scottish Public Services Ombudsman; Niki Maclean, SPSO Director (Secretary); Emma Gray, SPSO Head of Policy and External Communications; Paul McFadden, SPSO Head of Complaints Standards; Fiona Paterson, PA to the Ombudsman (minutes); Rachel Nicholson, SPSO Executive Casework Officer; Elizabeth Derrington, Independent Customer Complaints Reviewer.

During 2015–16, the committee received reports in relation to internal audit, external audit, risk management and internal control. The core business of the committee during the year included the following:

> review of the final accounts for the financial year 2014–15 prior to their submission for audit;
> the governance statement for the year 2014–15;
> updates and briefings on internal audit reports;
> the internal audit opinion on 2014–15 accounts;
> the internal audit strategy and related periodic work plans;
> the emerging external audit opinion for 2015–16;
> advice to the Accounting Officer in relation to signing off the final accounts;
> the external auditor’s report for 2014–15 – emerging findings from the external audit current in year programme; and
> residual actions arising from previous year’s work of both internal and external audit.

The committee reviewed arrangements implemented by management in relation to identifying, assessing and managing risk.

Work of the committee

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> the internal audit opinion on 2014–15 accounts;
> the internal audit strategy and related periodic work plans;
> the emerging external audit opinion for 2015–16;
> advice to the Accounting Officer in relation to signing off the final accounts;
> the external auditor’s report for 2014–15 – emerging findings from the external audit current in year programme; and
> residual actions arising from previous year’s work of both internal and external audit.

The committee reviewed arrangements implemented by management in relation to identifying, assessing and managing risk.
The committee reviewed the risk register prepared by management at each of its meetings during 2015–16. In relation to strategic processes for developing controls, managing risk and ensuring governance during 2015–16, the committee sought to seek reassurance that:

- the risk management culture was appropriate; there was a comprehensive process for identifying and evaluating risk and for reviewing what level of risk was acceptable;
- the risk register accurately recorded and reflected the risk being faced by the SPSO;
- management had an informed and realistic view of how effective controls were;
- risk management was being implemented in a way that benefitted the SPSO and added value;
- all staff had an awareness of the importance of risk management and the need to proactively identify risk;
- the systems of internal controls were effective; and
- the Accounting Officer’s annual governance statement was realistic and supported by meaningful evidence.

Audit engagements

External audit

The committee again found the proactive approach adopted by Audit Scotland to be effective. This proactive approach enabled the committee to have an early understanding of the remit of the audit by having a particular focus on the organisationally specific risks and priorities facing SPSO; the relevant national risks that were particularly relevant to the environment in which the SPSO is operating; the continuing impact of changing international auditing and accounting standards; the responsibilities of external audit under the terms of Audit Scotland’s Code of Audit Practice; and a limited number of issues that have been carried forward from the previous audit report.

The outcome of the external audit report for the final accounts for the financial year 2015–16 was an unqualified one by Audit Scotland. In the opinion of the external auditors, therefore in all material respects, expenditure had been applied for the purposes intended by Parliament and the financial transactions comply with the authorities that govern them. The external auditor also indicated that they have no further comments or observations to make in relation to the financial statements.

Internal audit

Internal audit provided the committee with assurance in relation to the control frameworks with the SPSO. These assurances are important because they are the foundations which underpin effective risk arrangements and it is by reviewing and evaluating the reports of internal audit that a core aspect of the committee’s accountability role is discharged. During the financial year 2015–16 the internal audit function undertook reviews of business continuity, risk management, efficiency review, quality assurance and payroll. The overall opinion reached by internal audit in all audits undertaken was that of a satisfactory level of assurance.

The internal audit annual assurance report provided the Ombudsman with a ‘satisfactory’ level of assurance based on the conclusions of the audit arrangements during 2015–16.
Commentary
During the financial year of 2015–16 the committee noted that neither external audit nor internal audit identified any serious areas of concern. The committee did indicate that it wished to be advised about which areas of risk management would be examined year on year in order that it could be assured that the proposed programme would over time include all aspects of the Ombudsman’s responsibilities. The members also asked that an examination of the risk profile and risk appetite of the SPSO be completed. It is hoped that these will be included in the programme for 2016–17.

One of the particular strengths of the performance of the office during the financial year being reported on is the effective working relationship that was evident between auditors and the senior management. This is reflected in both the proactivity of management in moving to implement recommendations and the flexibility of auditors to move quickly to address any emerging issues that may be of concern to the committee or to management.

At the end of the financial year 2014–15, the committee was made aware of a number of known unbudgeted liabilities. In the year being reported on this issue continues to be of real concern. There is a significant and developing risk around the challenges for the SPSO to balance expenditure and staffing levels against a reduced budget, especially when there is the potential for an increasing workload both from the current jurisdiction and significant extensions to jurisdiction. The committee noted that the unbudgeted liabilities had been notified to the SPCB.

The committee continues to be concerned that the SPSO is required to continue to absorb unbudgeted liabilities from its existing budget. This is a situation that will require to be addressed going forward.

The future
The committee continues to monitor progress across all areas under its remit, clearly with significant extensions to the jurisdiction of the SPSO. This is clearly going to continue to be a period of significant change and adjustment for the office. As was indicated in last year’s report, the committee believes the office is well placed to respond to these challenges. However, its capacity to do so will be adversely impacted if it is not adequately resourced to fulfil its statutory responsibilities. If it is not fairly resourced, its current performance in both offering remedy and redress to some of the most vulnerable while at the same time supporting the improvement in public services will be put at serious risk.

The committee will continue to support the Ombudsman in meeting the governance and accountability requirements of his office. The committee is committed to ensuring the levels of performance across all functions of the office are maintained and enhanced where that is judged necessary.

In conclusion, the committee would wish to express its thanks to the external and internal auditors and to the management and staff of the SPSO who facilitated the work of the committee during the financial year of 2015–16, in particular those who provided administrative support to the committee and its members.
Complaints about SPSO

We operate a (non-statutory) customer complaints scheme. It has two internal stages, and complainants can ask for a final external review by our independent reviewer.

Customer complaints handled by SPSO

We record and report details of all customer service complaints on a quarterly and annual basis. We publish the reports on our website, along with a note of any actions taken in response. The reports show the volumes and types of complaints, plus their outcomes and key performance details. The main points are:

- we received 47 customer complaints in 2015–16 (representing 1% of our caseload), a small reduction on the previous year.
- we responded to a total of 60 customer complaints, a slight decrease on the previous year’s figure of 61.
- upheld/some upheld rates were 15% for those complaints responded to by SPSO, a reduction from 29% the previous year.

The independent external reviewer responded to 18 complaints, upholding 44%, a large increase from 18% the previous year. Small numbers mean such fluctuations in percentages can be expected and we look very closely at the reasons for each upheld decision.

- on average, we took 4.4 working days to respond to stage 1 complaints (within our target timescales) and 22.6 for stage 2 (outwith our target timescales, and largely due to receiving a number of particularly complex complaints over the course of the year from one individual). We responded to 73% of complaints at stage 1 and 53% at stage 2 within target timescales of five and 20 working days respectively, which is a reduction on the previous year’s figures of 84% and 77%.

The table below gives a breakdown of closed complaints by stage and outcome, including those determined by the independent external reviewer. Each complaint contains a number of individual issues and the decision represents an aggregate of the outcome.

<table>
<thead>
<tr>
<th>Customer complaints type</th>
<th>Fully upheld</th>
<th>No decision reached</th>
<th>Not upheld</th>
<th>Some upheld</th>
<th>Total</th>
<th>% upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 – Officer / Manager</td>
<td>3</td>
<td>2</td>
<td>24</td>
<td>1</td>
<td>30</td>
<td>13%</td>
</tr>
<tr>
<td>Stage 2 – Senior Management</td>
<td>1</td>
<td>3</td>
<td>22</td>
<td>4</td>
<td>30</td>
<td>17%</td>
</tr>
<tr>
<td>Stage 3 – ICCR</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>18</td>
<td>44%</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>10</td>
<td>51</td>
<td>12</td>
<td>78</td>
<td>22%</td>
</tr>
</tbody>
</table>

www.spso.org.uk/customer-service-complaints
## Complaints about SPSO

### Learning from complaints

The table below provides examples of areas where we needed to take action to improve. The full list of actions is in the annual complaints report on our website.

<table>
<thead>
<tr>
<th>Failing identified</th>
<th>What we did in response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delays and failures in communication in the handling of a complaint, specifically in attempting to understand the basis of the complaint.</td>
<td>We apologised to the complainant that it had taken us some time, and unpicking of the details, to fully understand their complaint and, therefore, reach a decision. We explained that the case was not a straightforward one, which was why it had taken us a number of exchanges to reach a final view. We recognised that this had caused them distress and apologised for this and for the difficulties in communication.</td>
</tr>
<tr>
<td>We had said to a complainant that we would contact them to discuss their complaint. As we did not have their telephone number, we were unable to do so and we issued our decision on the case without doing so.</td>
<td>As a result of the complainant highlighting this issue, we amended our template to remove the suggestion that we would automatically make telephone contact. We agreed that delay in responding to a number of the complainant’s emails was not acceptable. We agreed that the service the complainant received had fallen below that which they should expect from our office, and apologised to the complainant for these failings.</td>
</tr>
<tr>
<td>Our response to a complainant’s request for review took longer than our target time of 20 working days.</td>
<td>We apologised for this, reiterating the Ombudsman’s earlier apology for this.</td>
</tr>
</tbody>
</table>
Complaints about SPSO

Report from Jodi Berg and Elizabeth Derrington, Independent Customer Complaints Reviewers

This report covers the first full year for which the Independent Complaints Resolution Service (ICRS) operated as external reviewer for SPSO.

Our role is to provide a final external stage for complaints about the service delivered by SPSO under its service standards. Where a person has made a service complaint to SPSO and is dissatisfied with the final response, we review SPSO’s handling of matters and give an external opinion on whether SPSO has acted in accordance with its service standards. We aim to provide closure for people who refer their complaint to us by giving thorough, independent assessments of the issues and, if we find any service failures, recommendations for appropriate redress. For SPSO we aim to offer constructive feedback and practical ideas for further improvement.

The number of service complaints referred for external review is very small, and this indicates that the great majority of SPSO’s customers are either content with the service received, or satisfied with SPSO’s response under its service complaints procedure. During the year we received 18 referrals and completed 10 reviews. In 8 cases we did not carry out a review – either because the issues were outside our remit or because the complainant decided not to pursue the matter. At the end of the year there were no cases outstanding.

Our findings in the ten cases we reviewed are set out in the table below. Most of the complaints we reviewed related to SPSO investigations which had been very complex, lengthy and challenging. Such cases always test the robustness of an organisation’s processes and customer service. For the most part we found that SPSO’s systems had stood up well to the challenge. The majority of complaint issues were not upheld and we were satisfied that SPSO had dealt with matters appropriately in line with its published procedures and service standards.

We upheld or partly upheld 11 complaint issues and made 14 recommendations to SPSO. Six were for a formal apology, and eight for SPSO to consider process improvements. We identified potential for improvement in three areas:

- managing expectations regarding the progress of an investigation or review
- ensuring clarity about the issues for investigation
- avoiding any impression of bias.

We know that SPSO has given careful consideration to our recommendations and we believe that it has found them practical, relevant and constructive. SPSO plans for 2016–17 include setting time targets for responding to our recommendations. We welcome this initiative which will help provide further assurance that our recommendations are taken seriously and used to deliver service improvements. We welcome also that SPSO has given us the opportunity to attend meetings of the Audit and Advisory Committee and to report directly to the committee on our work.
Complaints about SPSO

Finally we should like to express thanks to SPSO staff for the assistance they have provided – supplying files and responding to questions about policy and procedure. Without this support we would have been unable to deliver an effective and timely service.

Complaints determined about SPSO by ICCR 2015 – 16

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Compliments about SPSO

We record positive feedback as well as complaints. Some of the comments below are from our customer satisfaction survey; others are examples of unsolicited thanks sent to our complaints reviewers.

I was hugely impressed by the service given by SPSO. It was ‘user friendly’, professional and thorough... Most importantly I FEEL I WAS HEARD.

The SPSO’s ability to comprehend and investigate the problem in such an objective way has been so helpful.

Obviously, I am very happy to hear that you upheld my complaint and that I can finally stop worrying about being in debt. Reading the letter I have noticed the attention to detail and extreme precision in which you handled the case.
We were kept updated on a regular basis and given reassurance when needed. Excellent service from start to finish. Thank you.

I had total confidence in my investigation and although it was not the full outcome I wanted I understood why the decision was what it was.

In these days of blame culture it was not our quest to allocate blame. It was an attempt to improve the shortfalls of a system that has failed. If the result of this investigation is to save one life then it has been a worthy cause.

The communication has been absolutely faultless and I am so grateful for all the updates throughout the process to keep us informed.

The SPSO were very fair and considered my complaint thoroughly. The time taken to investigate and process the complaint was lengthy, due to the complexities of the complaint, but I was kept informed at every stage of the process.

This process has been difficult at times and has brought out a lot of emotions but your incredibly effective and compassionate management of this case has made the whole process that bit easier. I am so grateful for your patience and empathy when we have spoken and would like to thank you for making me feel like our case really mattered.

I was also aware that the investigation was impartial and there was no indication of false hope which is as it should be.

Our family now have the closure which has been denied to us for over two years. For that we thank you from the bottom of our hearts. It has been a long road to determine the truth.

Your efforts on my behalf are very much appreciated and have restored my faith in the Scottish Public Services.
## All cases determined 2015 – 16

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