Quality Assurance casework quarterly review Q3 2016 – 2017

Assessment

40 cases were selected for Quality Assurance (QA) in Quarter 3 and reviews were carried out by SPSO Executive Casework Officers on all of these cases in May 2017.

Several members of staff were also involved in the QA exercise by either shadowing the process or by QA'ing their own file and discussing with the reviewer afterwards. This was found to be really beneficial for all involved, in order to gain more first-hand knowledge and understanding of the process itself and assessment criteria. It allowed for staff to be self-reflective, and also see good work they had done picked up on. Finally, it allows for the reviewer to ensure the process is accessible, clear and useful for staff.

Process

All cases were assessed under four areas – process, decision-making, communication and delay, and areas of learning were identified. In addition, examples of best practice were recorded.

A few process and decision-making issues were picked up in this QA.

Key Findings

RED – must dos/remember; **AMBER** – to be aware of and **GREEN** – good/best practice.

RED

- Several cases were picked up where we did not acknowledge suffering, hardship or perceived injustice. For example, in one case we did not acknowledge or offer condolences for the complainant's son's death. Please remember to do this and include empathy and/or acknowledgement where appropriate. Questions in QA which relate to this are: *Was the perceived injustice acknowledged? The Complaints Reviewer demonstrated an acknowledgement of the complainant's situation and the impact this had on them?*

AMBER

- In one case which we had closed on basis of proportionality (action had been taken by the organisation being complained about and we perceived that we could not achieve more) we got clinical advice to support this position. However, we had not spoken to the complainant (we had made one attempt to) and had not clarified what they were seeking. The complainant had raised very specific points of clinical/nursing/complaints handling complaints in her complaint form to us, but we did not address these in our closure letter. The letters sent from the complaints reviewer would potentially be confusing or overwhelming to a member of the public, especially one who was clearly still grieving. Jargon and internal terminology such as 'listed authority' were used, and it wasn't clear whether we were 'looking at' , 'investigating', or 'assessing' the complaint. **Be aware that members of the public who are contacting us for the first time will benefit from clear, plain spoken language.** We accept that the process was followed ok in this case, but **when closing on proportionality grounds, complaints reviewers need to provide more reassurance/ensure there is sufficient detail in response to the points raised/not just broad brush**. We have incorporated some small changes to the proportionality guidance to reflect this and make clear what we need to cover.

- **If we decide not to take forwards a complaint handling complaint alone, we can still use the complaint handling marker on our casework management system to highlight if there was an issue**. In one case it had been reasonable of us to determine not to look at complaint handling alone because this would not have gone to what the complainant wanted investigated. However, there was evidence of extremely poor communication between the organisation being complained about and the complainant, verging on rude/dismissive. Going forwards, if we have a case like this, we should use the complaint handling marker and highlight what we've picked up to the organisation being complained about in the closure letter.

- One case that appeared to be handled outwith our process. In our Early Resolution team we said we would initially look at a complaint handling complaint only, but then proposed the case for transfer to our Investigations team. We said it would be for the Investigations complaints reviewer to determine, having sought advice, whether further aspects of the complaint relating to care and treatment should be added and upheld. We cannot see the benefit of this – the complainant might not be left clear on what we can/are investigating and this is not good expectation management. We later decided to add aspects to the complaint, by which point the complaint had been in office 6 months and required multiple pieces of independent advice. Perhaps this could have been progressed quicker if the aspects of the complaint had been agreed as per usual process.

- One case where we incorrectly concluded that the council's decision was a discretionary one that they were entitled to take.

- One case where we said that we would not take the case on because the complainant had not provided evidence that the council had not followed their policy. We need to remember that the complainant only has to bring a claim of injustice as a result of maladministration.

- In one case we sent email updates intended for the complainant to the wrong recipient on two occasions. This was not picked up on until the complainant contacted us to ask for an update. Further, we did not inform Information and Governance Officer about the data breach, which we should have.

- Complaints reviewers should be sure to use the prisoner template letters (with 'Scottish Ombudsman' logo as header) for all prisoner complainants, including prisoner health care cases and for those who have been liberated – the rationale for use of these templates still applies in these circumstances.

GREEN

The following cases demonstrated good practice or exemplary service in a variety of ways – the points highlighted could be used as handy tips/templates etc. This quarter we picked up some excellent examples of investigative work and customer service.

- In one case we found a good example of very helpful signposting and contacting the organisation being complained about on behalf of the complainant. The complainant was having difficulty following the complaints handling procedure and understanding where their complaint was in the process. Several members of the SPSO Advice Team were involved and provided clear written advice each time.

- In one case we found a good example of assisting a complainant through an organisation's protracted complaint process. The complainant then attended our office with their paperwork and an Advice Team member had a lengthy meeting with them discussing the issues they wished us to consider.
- A case was a complaint about a University and the processes followed when reaching a decision about whether to award a student a PhD. This was a complex case and the complaints reviewer carried out a detailed analysis. There was very good communication with the complainant throughout by both the Early Resolution and Investigations complaints reviewers. The complainant's expectations were managed carefully. At one point the complainant said they 'really appreciated the highly professional service'. They said that the decision letter was first class and although it was not the outcome that they were seeking, they told the complaints reviewer they could understand the decision making.
- A case about medical care and treatment provided to the complainant's father. The file was very lengthy as the complainant had transcribed every single conversation, meeting and all text communication between family members, so the file was hundreds of pages. We found good communication with the complainant, detailed telephone calls which were well documented, explanations of what we were doing and why. On transfer from the Early Resolution team to the Investigations team it was identified that there was a conflict of interest, but this was picked up and dealt with within one day. Excellent file management was observed. There was a clear structure to the investigation and good use of an investigation plan. The decision letter was extremely comprehensive and the post decision email from the complainant was hugely complimentary and expressed the family's gratitude regarding a thorough investigation.
- We found an excellent example where the complaints reviewer identified the possibility of resolution and arranged this with the organisation being complained about, who accepted this proposal.
- We found a good example of where the complaints reviewer sent poorly handled complaints back to the organisation being complained about. The results of this were extremely encouraging, with systemic change being made. The evidence shows that we did not receive further contact from the complainant after this.

Other points to note

- One case gave us the idea of some more training to help build staff confidence around the issue of consent to investigate, and also whether/when there is a lack of capacity and what evidence of this would look like, using the case at the next legal training session
- In one case we picked up on an organisation being complained about using a helpful statement writing guide for staff who were asked to respond to a complaint, acknowledging that it can be difficult to receive negative feedback and respond to it. Staff were also told that they could get advice and support from their line manager and/or professional lead. We felt this was good practice in terms of acknowledging the impact of complaints handling on staff – to be shared with Complaints Standards Authority.

Conclusions

All comments and examples will be fed back to individuals by their line manager as part of the performance management process. This summary of key findings is made available to

all teams, managers and the Senior Management team, and is also presented at the quarterly Service Improvement Group meeting.

Recommendations & actions

	Recommendation
1	Ensure complaints reviewers are aware of key summary findings and provide good practice feedback
2	Ensure complaints reviewers receive individual feedback forms and have opportunity to discuss/comment with manager
3	Consent and Capacity workshop should be organised as part of the legal training series