Thank you for the opportunity to comment on Petition PE1659. I have attached a note which sets out some points which I hope will assist the Committee in their further discussions.

I was concerned to read that the Committee thought our response would be predictable. Please reassure the Committee that since I became Ombudsman earlier this year, I have been taking time (and continue to do so) to look at the work of this office from a fresh viewpoint. It should be clear from the attached note that I have found and continue to develop a deep commitment to service improvement, including improvement to the service that we provide.

I appreciate that this note is considerably longer than the Committee would ordinarily receive, but given the breadth of what is under consideration thought it would be helpful on this occasion. To assist the Committee, I have set out the response in discrete sections with a table of contents so that they can refer easily to specific information.

I hope this response is informative and I would be very happy to provide clarification or respond to questions about the points in the note or on any further discussion that arises from the petition.

The petition raises concerns about inconsistency across Councils when responding to complaints and also comments on the SPSO’s remit. This response addresses each of those areas.
### Contents

**Local Authority complaints handling**  
Background 3  
The Local Authority Model Complaints Handling Procedure 3  

**The SPSO’s remit (in relation to LA complaints)** 6  
Legal restrictions: discretionary decisions 7  
When can the SPSO become involved? 8  
A change of approach to outcomes 9  
Disputes about fact and on-going issues 10  

**Appendix 1- SPSO complaints data** 12  
2016/17 SPSO Cases 12
Local Authority complaints handling

Background

1. The Scottish Government and Parliament have long had an interest in the quality of complaint handling in public services. In 2008, Douglas Sinclair reported\(^1\) to Scottish Ministers on behalf of the Fit for Purpose Complaints System Action group. That report set out concerns about the quality of complaint handling and highlighted inconsistency between Councils as a specific issue.

2. In January 2011, the Scottish Parliament became the first Parliament in the UK to approve a set of Complaint Handling Principles\(^2\) which all public services must apply when handling complaints.

3. Parliament also gave the SPSO new legislative duties and powers as the Complaints Standards Authority (CSA)\(^3\) to publish model complaint handling procedures for each sector, which, in turn, require listed authorities to ensure their complaints handling procedure complies with the published model.

The Local Authority Model Complaints Handling Procedure

4. SPSO worked with Councils to develop a single\(^4\), standardised procedure for the LA sector, for handling complaints. This came into force on 1 April 2012. The model complaints handling procedure (MCHP) both sets out the process that must be followed and sets out requirements for: reporting, performance indicators and the role of governance structures.

5. The MCHP is designed to be simple for complainers and has only two stages.

5.1. At stage 1, the approach is one of empowering front line staff to respond positively to complaints and seek to resolve them as quickly as possible (the aim is within five working days).

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3. Public Services Reform (Scotland) Act 2010

4. Local Authorities includes Councils and both terms are used in this note
5.2. Stage 2 is for complaints which either are not resolved at stage 1 or which clearly require more detailed investigation from the outset (the aim is within 20 working days, with flexibility to extend this if an issue is particularly complex).

6. Local authorities must record and report how they respond to complaints. They must do so internally at least quarterly and publish a public report annually. The SPSO also expects them to scrutinise, analyse and demonstrate that they have learned from complaints to improve the services they provide. The LA-level information means we can build an understanding of LA complaint handling across Scotland. For example provisional 2016/17 figures tell us:

6.1. over 75,000 complaints were received by councils in Scotland
6.2. on average around 88% of these complaints were closed at the stage 1
6.3. around 70% of complaints were upheld or partly upheld at stage 1
6.4. around 60% of complaints were upheld or partly upheld at stage 2.

This indicates to us that Councils identify, and are accepting when failings occurred.

7. The MCHP and associated performance reporting go beyond the reporting of numbers. They include a requirement to produce evidence of learning from complaints and to survey users of their experience of the complaints procedure.

8. The SPSO is not naïve and appreciates that the existence of the procedure will not in itself ensure the quality of response. We strive, both through the complaints that subsequently come to us, and through other stakeholder engagement, outreach, training, support and guidance, to promote and enable improvement in complaint handling standards. Indeed, our legislation requires us to support the sharing of best practice and that commitment is open-ended.

9. The SPSO’s CSA team continues to provide individual support and advice to organisations. We have a website dedicated to supporting good complaints handling,

5 To give some examples Falkirk Council’s annual report can be found here: http://www.falkirk.gov.uk/contact-us/complaints/docs/06%20Complaints%20Annual%20Report%202016-17.pdf?v=201709060936 and South Ayrshire Council here: https://www.south-ayrshire.gov.uk/documents/annual%20complaints%20report%202016%2017.pdf
www.ValuingComplaints.org.uk and we undertake a range of support activities. We report on these activities in our newsletter\(^6\) which we issue monthly and also in our annual report. I would particularly highlight:

9.1. The network of local government complaint handlers (which has had representatives from every single Council) meets around three to four times per year to compare and contrast performance, identify and share good practice, discuss areas of common interest and challenge in complaints handling practice. This is sector-led but SPSO attends.

9.2. Our training unit which has produced free e-learning tools as well as providing more intensive training on investigation skills\(^7\).

9.3. Our good practice guidance including:

9.3.1. guidance on making a good apology\(^8\)

9.3.2. guidance for elected members which we developed alongside the Improvement Service\(^9\).

10. These are only some selected highlights of the significant value-adding work undertaken across Scotland to improve the wider public sector’s (and hence Council’s) complaints handling.

11. Given this, we are concerned that the petition talks of significant differences in respect of the “in-house procedures”. If the petitioner were able to provide more information on this we would be very happy to consider both what could be done and how we may reflect on it in the future work programme of the CSA.

\(^6\) [https://www.spso.org.uk/ombudsmans-newsletter](https://www.spso.org.uk/ombudsmans-newsletter)

\(^7\) [https://www.spso.org.uk/training](https://www.spso.org.uk/training)

\(^8\) [http://www.valuingcomplaints.org.uk/handling-complaints/resources/apology](http://www.valuingcomplaints.org.uk/handling-complaints/resources/apology)

The SPSO’s remit (in relation to LA complaints)

12. SPSO is the final, independent stage of the complaints process for the local authority sector in Scotland.

Comparative data

13. In 2016-17:

13.1. we received 4,182 complaints, of which 37%, 1,528 were about Councils\(^{10}\).

13.2. In 524, 36% of cases we referred the complaint back to the Council as they had not yet gone through the local complaints process. We call these premature complaints (although it should be noted that the SPSO has the discretion to accept the complaint without it having been through the LA process in exceptional circumstances)

13.3. 156 complaints were investigated of which:

13.3.1. 94 were upheld (in full or part)

13.3.2. resulted in 249 recommendations.

14. By way of comparison, appendix 1 contains a summary of the figures for LAs, compared to our next largest sector, health.

15. The most notable differences are we uphold a larger proportion (11%) of LA complaints than we do health complaints. The ratio of premature complaints closed in year to complaints received is also significantly higher for LAs than for health (34%, compared to 21%).

16. While this data is not of itself conclusive, it is indicative of complaint handling issues in LAs. We are currently looking into this to try to identify variances in LA performance across the sector and whether there are opportunities for us to provide more direct support if needed. The point being that the combined functions of complaint handling, the CSA (and associated MCHP) and the focus on learning is enabling the SPSO to gather data about performance which will lead to meaningful interventions.

\(^{10}\) To ensure we report fully we include in complaints contact which does not escalate into a full, detailed investigation but which require action by us. More information and what we receive and what we do with them can be found on our website.
17. Performance is not the only difference between the sectors. There is also a significant difference in terms of what the SPSO can investigate and achieve for complainers. This is a result of legal restrictions on our remit.

**Legal restrictions: discretionary decisions**

18. The issue that causes most frustration when we consider complaints against local authorities is the restriction on our ability to consider LA’s discretionary decisions (those decisions where LAs have full discretion to consider the merits as they see them). The SPSO cannot consider the merits of such decisions unless we identify a procedural failing which undermines or in some way brings that decision into question\(^\text{11}\). (There is one exception to this: since 1 April 2017, the SPSO can look at Social Work professional decisions. This, in part reflects the closer working with health as a result of integration.)

19. The reason given for the limitation (which can be found in section 7 of our legislation)\(^\text{12}\) on discretionary decisions was to ensure that democratic decisions were fully protected.

20. It is perhaps worth explaining that in practice there are two broad “groups” of discretionary decisions:

20.1. Those made as a result of the democratic process and elections, for example, significant decisions about local resourcing. It is important that this remains protected to ensure that democratic matters are dealt with through democratic processes.

20.2. Decisions which are the result of professional judgement, such as those of planners or enforcement officers acting under delegated powers.

21. The restrictions on the SPSO’s legislation mean both broad types are precluded by this restriction. In practice, this means as long as they are founded on appropriate and relevant facts and take into account the correct legislation and guidance, the SPSO

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\(^{11}\) The petition refers to the facts of the complaint not being in jurisdiction. However, our reading of the petition is it that it is this restriction which is the cause of the frustration. For completeness we deal with facts themselves at para 37.

cannot comment on the judgement (including technical judgement) or any decisions based appropriately on that.

22. This is in stark contrast to health complaints where the SPSO can look at and make decisions about clinical judgement. We are aware that it is in areas where our remit, as set out by Parliament, is most narrow, that members of the public are often most dissatisfied with the service we can provide.

23. There are arguments for and against extending our remit to cover more areas of professional judgement and discretionary decision-making. It is not my intention to rehearse them here; it is though a repeated comment about the functions of my office. I make the points, purely for information and to highlight that this is a matter the SPSO or others have raised on a number of occasions. Indeed this limitation was raised as a question by the Convener of the Local Government Committee at the very first evidence session on the proposed Ombudsman legislation in December 2001. Since then it has been referenced in SPSO Annual Reports by both previous Ombudsman.

When can the SPSO become involved?

24. The petition raises concerns about the outcomes the SPSO can achieve and when the SPSO can become involved, suggesting we can only look at a problem when it has stopped.

25. This is incorrect.

26. The SPSO is not restricted from looking at problems that are still happening, and in exceptional circumstances has the discretion to look at them even if the LA hasn’t itself investigated a complaint.


14 To give just a few examples, this limitation was discussed at the annual meeting between the first Ombudsman Alice Brown the then Local Government and Transport Committee on 5 December 2006 at col 4382. Jim Martin highlighted the issues at page 10 of the 2015/16 Annual Report available here: https://www.spso.org.uk/sites/spso/files/communications_material/annual_report/SPSO%20Annual%20Report%202015-16.pdf
27. Even when a complaint has been made and responded to by a LA, issues can still be “live” when complainers come to us.

28. In coming to us, it does not preclude LAs taking legitimate actions to remedy a complaint or settle a dispute. We will take into account any action taken, ongoing or intended, when deciding whether and to what extent to investigate. Our aim is to try to achieve resolution and where appropriate redress for the complainer, and to drive learning and improvement from complaints in LAs.

29. While the SPSO can’t make recommendations without having investigated a complaint, we can, and do consider whether a quick resolution is possible, and if it is, generally pursue it.

30. It is correct to note that the SPSO’s remit can ultimately limit what action and redress we recommend. The general principle is that we try to put the affected person back in the position they would have been but for the error or failing we have identified. The errors or failing we identify are linked to the findings from our investigations. We will also consider the outcome the individual is seeking when making recommendations - often this is for specific action.

A change of approach to outcomes

31. One outcome that complainers often want is to prevent a problem from recurring either to them or to others.

32. The SPSO has significantly changed the approach to the way recommendations are made. Since 1 April 2017, we

32.1. make the link between the failing and the recommendation more explicit

32.2. focus the recommendation on the outcome the LA should achieve (rather than on taking particular action or undertaking particular activity)

32.3. require evidence to demonstrate that the outcome has been achieved (or an action plan if it is over a period of time)

32.4. set the timescales within which that should happen.

33. The focus on the outcome puts the responsibility for the way this is achieved on the LA while still enabling the SPSO to hold them accountable. The greatest value is that it focuses on learning from complaints leading to action for achieving sustainable improvement. We follow up all our recommendations and have also introduced a
process to put additional support in place if any organisation is struggling to meet the recommendation in the timescales we set.

34. The other significant change we have made is in the types of recommendations we make. Since 1 April 2017 we have differentiated and are monitoring whether recommendations are:

34.1. redress for the individual affected
34.2. about learning and improvement in relation to service delivery
34.3. about complaint handling.

35. We also provide feedback on good and poor complaints handling practice we identify but which is not directly related to the findings we make. We now have our first six months data on this, and while it is too early to draw definitive conclusions from it, it is suggesting a variance in how LAs handle complaints, and something we will track as more data becomes available.

36. For the first two quarters (April-Sept) of 2017/18 SPSO’s data the proportion of complaints handling recommendations is marginally higher for LAs than across all sectors (This should be taken with a warning: this is very recent data, in relation to the current year, and there is no historical data with which to compare it).

<table>
<thead>
<tr>
<th>Types of Recommendations: April-Sept 2017</th>
<th>All sectors</th>
<th>%</th>
<th>LA</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (apology, financial or other action)</td>
<td>223</td>
<td>40%</td>
<td>63</td>
<td>54%</td>
</tr>
<tr>
<td>Learning and improvement</td>
<td>283</td>
<td>50%</td>
<td>37</td>
<td>32%</td>
</tr>
<tr>
<td>Complaints handling</td>
<td>56</td>
<td>10%</td>
<td>16(^{15})</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Total recommendations</strong></td>
<td><strong>562</strong></td>
<td><strong>100%</strong></td>
<td><strong>116</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Disputes about fact and on-going issues**

37. The petition raises specific concerns around disputes about fact and we want to confirm that disputes about the facts are not excluded from our remit as they are not discretionary. We can and do consider such disputes. To give just a few examples from recently published decisions:

\(^{15}\) This was one recommendation about complaints handling on each of 16 separate complaints
37.1. Case 201508631 reported in January 2017 where we found that a planning report contained inaccurate information and that the Planning Committee had been misled as a result.

37.2. Case 201602629 reported in May 2017 where, although the Council accepted the errors we were concerned that the system that should have prevented this had failed and upheld the complaint an asked them to audit their process for checking for factual errors.

37.3. Case 201508400 reported in July 2017 where we found that a report did contain factual errors but as these were minor the report did not mislead the Committee and did not uphold the complaint.
Appendix 1- SPSO complaints data

<table>
<thead>
<tr>
<th>2016/17 SPSO Cases</th>
<th>No of complaints received</th>
<th>Premature complaints closed</th>
<th>ratio of complaints: premature</th>
<th>Complaints investigated</th>
<th>Upheld in full or part</th>
<th>% upheld in full or part</th>
<th>No of recommendations</th>
<th>Average recommendations per upheld complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA</td>
<td>1,528</td>
<td>524</td>
<td>34%</td>
<td>156</td>
<td>94</td>
<td>60%</td>
<td>249</td>
<td>3</td>
</tr>
<tr>
<td>Health</td>
<td>1,414</td>
<td>296</td>
<td>21%</td>
<td>507</td>
<td>260</td>
<td>51%</td>
<td>952</td>
<td>4</td>
</tr>
<tr>
<td>Difference</td>
<td>114</td>
<td>228</td>
<td>13%</td>
<td>-166</td>
<td>9%</td>
<td>-703</td>
<td>-</td>
<td>-1</td>
</tr>
</tbody>
</table>

16 Some complaints closed as premature will have been received at the end of the previous reporting year, some will be open at the end of the year. This ratio is provided as an illustration of the difference between the sectors.