THE PLACE OF COMPLAINT HANDLING IN THE SCRUTINY LANDSCAPE

A Paper by the Scottish Public Services Ombudsman

For the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland

April 2007
PART ONE

COMPLAINT HANDLING, ADMINISTRATIVE JUSTICE AND SCRUTINY

1.1 Complaint handling is recognised to be a key feature of the administrative justice system. The March 2005 National Audit Office report *Citizen Redress: What citizens can do if things go wrong with public services* used the term ‘citizen redress’ to denote all the administrative systems that allow citizens to seek remedies for what they perceive to be poor treatment, mistakes, faults or injustices in their dealings with central government departments or agencies. The report identified the main mechanisms for achieving redress as:

- Customer complaints procedures;
- Appeals and tribunals systems;
- Reference to independent complaints handlers or ombudsmen; and
- Resort to judicial review (and other forms of legal action).

1.2 In a different context the Coulsfield Report (*The Civil Justice System in Scotland – a case for review?*) included a diagrammatic representation of the spectrum of available dispute resolution processes, including ombudsmen.

The Spectrum of Dispute Resolution Processes

1.3 The concept of a spectrum of dispute resolution processes is helpful. Clearly some issues can only be settled by the courts. But there will be many others which cannot be resolved through internal complaints procedures but which it would be inappropriate or disproportionate to take to court. This has been recognised by the Appeal Court in England in a case concerning a claim for damages for maladministration under the Human Rights Act. The Court commented that ‘a claim for damages under the HRA in respect of maladministration … if pursued in court by adversarial proceedings, is likely to cost substantially more to try than the amount of any damages that are likely to be awarded … Before giving permission to apply for judicial review, the Administrative Court judge should require the claimant to explain why it would not be more appropriate to use any available internal complaint procedure or proceed by way of making a claim to the [appropriate ombudsman] at least in the first instance’.

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1 Part One of this paper concentrates on complaint handling by ombudsmen and others external to the body subject of a complaint. However, most complaint handling takes place within bodies subject to a complaint and Part Two of this paper explores the inter-relationship of internal and external complaint processes.  
1.4 The argument for intermediate dispute resolution processes between internal complaints procedures and the courts is even clearer when (as is often the case) what is sought is an explanation or an apology rather than financial redress. The adversarial proceedings of the courts are not well adapted to bringing about such resolutions. Indeed public service providers can be inhibited from providing information by fear of litigation and from apologising by a concern that to do so may be seen as an admission of liability. By contrast, the inquisitorial investigating processes used by ombudsmen and similar complaint handlers are ideally suited to establishing facts and they are able to report on the results of their investigations in accessible language. Similarly, they can encourage public service providers to apologise where appropriate and to do so in terms which are likely to be accepted as genuine and bring about resolution of a complaint.

1.5 The UK government’s 2004 White Paper Transforming Public Services: Complaints, Redress and Tribunals stated an aim ‘to develop a range of policies and services that, so far as possible, will help people to avoid problems and legal disputes in the first place; and where they cannot, provides tailored solutions to resolve the dispute as quickly and cost effectively as possible. It can be summed up as Proportionate Dispute Resolution’. Chapter 4 of the White Paper looked at the lessons which may be learned from what it described as the successful development of ombudsman services in both the public and private sectors. It noted that ‘The key aim of ombudsmen is to improve service delivery and to promote better administration by learning the lessons from effective complaints handling’ and considered how their success in achieving those aims might be translated into the wider administrative justice system.

1.6 The White Paper also aims to improve the entire system of administrative justice in the UK. In addition to the Tribunal Service, it proposes that the Council on Tribunals should evolve into an Administrative Justice Council and that it should have a wider remit. For example, it proposes that: ‘The Council would also be charged with taking full account of the administrative justice landscape and be empowered to make recommendations about it’. The new body would be called the Administrative Justice and Tribunals Council.

1.7 The Scottish Committee of the Council on Tribunals (SCCT) has been working with the office of the Scottish Public Services Ombudsman (SPSO) in considering the impact of this UK legislation on the administrative justice system in Scotland. The SPSO has also held meetings with the Justice Minister in which she gave her support to the setting up of an Administrative Justice Steering Group. This has now been established and is chaired by Lord Philip. Research is currently being conducted with the support of the Scottish Executive and a report is likely to be published in the summer of 2007.

1.8 So complaint handling has a clear place in the administrative justice landscape. Can it also be regarded as a scrutiny activity? The Scottish Consumer Council’s November 2006 Policy Paper Scrutiny and the Consumer stated that scrutiny means ‘examining something closely’ and went on to note the Auditor General

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5 Section 2 of the Compensation Act 2006 (http://www.opsi.gov.uk/acts/acts2006/ukpga_20060029_en.pdf) states that ‘An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty’ but this section does not extend to Scotland.


7 http://www.dca.gov.uk/pubs/adminjust/transformfull.pdf

8 Membership of the Steering Group includes representatives from the SCCT, SPSO, Scottish Executive, Scottish Consumers Council, Scottish Mediation Network and Citizens Advice Scotland.

9 http://www.scotconsumer.org.uk/housing/documents/rp06Scrutinypdf.pdf
for Scotland’s definition of scrutiny activity as inspection, regulation and public audit. In so far as investigating complaints clearly involves ‘examining something closely’, it can be classified as scrutiny but how does it relate to scrutiny activity as defined by the Auditor General?

1.9 The Centre for Public Scrutiny’s June 2006 report on Ombudsmen as independent scrutineers commented that Ombudsmen are scrutineers in the sense that they seek to enable the voice and concerns of the public to be heard by providing redress for injustices arising from maladministration through efficient dispute resolution mechanisms. This is an important point as the work of the Ombudsman is not part of a ‘top down’ scrutiny function but an activity initiated by a member of the public (or their representative) making a complaint. The Ombudsman is the ‘last resort’ in two senses: first, in that it is expected that the body complained about should normally be given the opportunity to respond to the complaint before the Ombudsman becomes involved; and second that the role of the Ombudsman is quasi-judicial and his/her decision can only be challenged by Judicial Review. Perhaps another way of looking at the issue is therefore to see the role of the Ombudsman as a ‘bridge’ between the administrative justice framework and the scrutiny bodies and also as one mechanism for highlighting, through the experience of the service user, areas where improvements can be made in the delivery of public services.

1.10 The Centre for Public Scrutiny’s report also said that ‘the traditional role of Ombudsmen as complaints-handling schemes has evolved to include different remedies and duties, including an increasing role to improve the complaints handling systems as a whole, and ultimately to improve services’ and highlighted different ways in which ombudsmen’s work may be used by other scrutineers.

1.11 In fact this wider definition of ombudsmen’s role is not new. In the mid-1960s when it was proposed to establish the first UK Ombudsman (the Parliamentary Commissioner for Administration) the Prime Minister said that the Ombudsman’s role would be ‘to investigate complaints and to report both on individual cases where an injustice may appear to have been involved, or on defects in the system which have the effect of creating injustice or of failing to provide adequate rights of reconsideration or appeal...’ Just as the reports of the National Audit Office and the Public Accounts Committee are capable both of highlighting individual cases of waste, and of commenting on weaknesses in the system of expenditure control, so the proposed new Commissioner and the related Select Committee would have the same opportunities to highlight individual cases of injustice as well as general defects in the system’. When the Bill to establish the Ombudsman was before Parliament the Lord Chancellor said that it had three purposes. The first was improving the means by which Parliament was able to hold the Executive to account. The second was the investigation of individual complaints and securing appropriate remedies for injustice. The third was stimulating improvements in the general standard of administration. I would endorse that three-fold view of an ombudsman’s role.

1.12 Complaints are one channel through which people can feed back their experience and perspective of public services and often provide early warning of fundamental problems in service design and delivery. It can be argued that of all scrutiny activities complaint handling has the clearest service user focus in that it is activity generated by the concerns of individual service users. Complaint

handling by ombudsmen and other scrutineers can support continuous improvement in public services in a number of ways:

- By promoting good complaint handling within public bodies;
- By identifying wider issues arising from individual complaints and making recommendations for change;
- By making the outcomes of complaint consideration available in a way that allows the learning from them to be understood and acted upon by public service providers generally;
- By informing the work of inspectors, regulators and auditors (for example, complaints can indicate areas where there are problems in service delivery on which other scrutiny activity might usefully focus).
PART TWO

CURRENT COMPLAINT HANDLING ARRANGEMENTS

2.1 One of the conclusions of the Scrutiny Review’s Interim Report to Ministers was that ‘The complaints system is unnecessarily complex and not fit for purpose’. The Interim Report defines complaint handling as ‘the investigation of complaints about public services carried out by a range of commissioners, ombudsmen and other public bodies with specific roles and responsibilities’. I would argue that to address the issues identified in the Interim Report, complaint handling needs to be considered in a wider context.

2.2 In my view, any consideration of issues in ‘the complaints system’ needs to take that term as encompassing both internal and external complaint handling (the first and third of the redress mechanisms identified in the NAO report - paragraph 1.1) and also take account of interactions with other redress and scrutiny mechanisms.

2.3 Effective internal complaint handling processes with robust systems for feeding lessons back into the organisation are key mechanisms for effecting performance improvement within public service organisations.

2.4 As I have noted in Part One of this paper, external scrutineers such as ombudsmen have a role in promoting good internal complaint handling by public service organisations. For example, as part of the SPSO’s Valuing Complaints initiative (to which I return in Part Three of this paper) we have formulated the following statement of the basic features of an effective complaint handling process:

- Complaints should be welcomed with a positive attitude and valued as feedback on service performance;
- The process should be owned by the governing body of the organisation;
- The complaint management function should carry the authority of the Chief Executive, or equivalent;
- There should be clearly defined responsibilities for dealing with complaints;
- The process should be readily available to all customers and staff of the organisation;
- The process should be subject to regular review;
- The process should reflect and enhance the culture of good service delivery;
- The process should be driven by the search for improvement and not the apportionment of blame.

And we suggest ten essential questions (presented visually as a simple ‘back of an envelope’ checklist) which senior managers and board members should ask about complaint handling in their organisation.
2.5 As we say in the **10 Essential Questions** simplicity is a key feature of an effective complaint process. Many processes meet this requirement. NHSScotland for example has one which is admirably straightforward yet adaptable to settings as varied as single-handed GP practices and large hospitals. Other processes are much more complex. And there are startling variations not only between different sectors of the public service but within sectors and even within individual organisations. I do not suggest that a uniform and monolithic complaint process across all public service providers is either achievable or desirable. But the current situation is confusing for service users (and providers), particularly as joint delivery of services by more than one organisation becomes increasingly common. This is an issue which needs to be addressed if the complaints system as a whole is to be fit for purpose. I touched on this in my Annual Report for 2004-2005\(^\text{11}\) where I said:

> `In handling complaints, particularly those that involve different agencies, we are struck by the diversity of complaints procedures across and within the public services in Scotland. Unfortunately in this case, diversity does not add value but rather adds to the confusion that exists for people wishing to bring a complaint when things have gone wrong. This confusion is widely recognised, however, and in a survey we conducted of the complaints processes of public authorities we found that there is a willingness to improve and to seek advice on developing new systems… We would wish to see a ‘model’ complaints process expanded to all areas under the remit of the SPSO. Indeed, taking into account the shift towards more joint delivery of services, we would also propose a ‘model’ for the whole of the public services in Scotland. This would not only simplify matters for members of the public but would assist the accountability process when things go wrong with the delivery of services either separately or collectively. we will be working with others to achieve this aim.’

The **Valuing Complaints** initiative referred to above is part of this process.

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\(^{11}\) See http://www.spso.org.uk/foi/article.php?id=86
2.6 Another issue which needs to be considered is what might be described as the point of transfer from internal to external complaints processes. In other words, when is it appropriate for consideration of an unresolved complaint to move from the organisation complained about to an ombudsman or other external scrutineer? In *Valuing Complaints* we offer a basic four-step model:

1. Informal Resolution
2. Formal Internal Investigation
3. Appeal
4. Referral to the SPSO (or other independent adjudicator)

This is not to say that all complaints processes must follow this model. Some organisations will successfully operate systems with fewer steps. In others there may be good reasons for having more. The key point is to ensure that systems are straightforward, fit for purpose and achieve a balance between allowing the organisation concerned a proper opportunity to resolve complaints and giving complainants access to a genuinely independent scrutineer when local resolution does not prove possible. This is not always an easy balance to achieve, as can be illustrated by a comparison of arrangements for dealing with complaints about the NHS in England and Scotland.

2.7 The NHS complaints procedure introduced across the UK in 1996 provided for local resolution by the organisation or practitioner concerned and then, if the complainant remained dissatisfied, a second stage under which a Convener (usually a non-executive director of the relevant NHS body) decided whether an independent panel should review the complaint. A UK-wide review of the system in 2001 found widespread dissatisfaction. Reasons for this included the time taken to complete the process; and perceived bias and lack of true independence in the second stage.

2.8 In light of these findings changes were introduced in both England and Scotland. In England on 31 July 2004 responsibility for the independent review stage passed to the Healthcare Commission. In her annual report for 2004-05 (written in her joint capacity as UK Parliamentary Ombudsman and Health Service Ombudsman for England) Ann Abraham noted: "The Healthcare Commission had to develop a major complaints handling function from scratch in a very short period of time, a highly challenging task... the Healthcare Commission has received more than twice the forecast number of complaints and almost four times the number handled by NHS Trusts under the previous arrangements. As at June 2005, the Commission had a significant backlog of complaints where the service standard, of resolution of the complaint within six months, could not be met. This is clearly serious for complainants and we have received several complaints about delay and poor communication". In her annual report for 2005-06 Ms Abraham noted that problems continued; that the Healthcare Commission was implementing a recovery plan; and that her office was continuing to monitor the situation.

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12 An English NHS body the other functions of which are broadly similar to those undertaken in Scotland by NHS QIS.
13 http://www.ombudsman.org.uk/pdfs/ar_05.pdf
14 http://www.ombudsman.org.uk/pdfs/ar_06.pdf
2.9 In Scotland two options were considered for replacing the independent review process: setting up a National Complaint Authority; or involving the Ombudsman at an earlier stage. Following a consultation process, to which my Office contributed, the Scottish Executive announced that they were in favour of the second option. They considered that this offered the simplest and most robust approach to the final stage of the complaints process, and guaranteed independence. This change was implemented on 1 April 2005 and has not been accompanied by the problems experienced in England. The simpler more streamlined process has been generally welcomed and one of the significant benefits it has brought is a marked reduction in the average time taken to complete the process.

2.10 The difficulties experienced by the Healthcare Commission also illustrate the problems which can occur when complaint handling responsibilities are grafted onto a body the core functions of which are inspection or regulation. This is not to say that it is never appropriate for such bodies to deal with complaints. I see considerable force in the argument advanced, for example, by the Care Commission that a clear link between service complaints and regulation provides an opportunity for the information gathered through complaints activity to be used in the assessment of service quality and the measurement of service improvement. But consideration needs to be given to whether the different functions can be combined in a single body, and if so, how; and also whether establishing a clear link between service complaints and regulation necessarily requires both functions to be undertaken by the same organisation. I return to those issues in Part Three of this paper.

2.11 Finally in this part of the paper I would like to address the issue of what might be called the crowded complaints landscape as identified in the Interim Report to Ministers. Annex B to the report noted that 18 out of 36 Scrutiny bodies mentioned that they handle complaints in some form. However, as Annex B also noted, some organisations have discrete responsibilities that do not duplicate each other so to that extent the landscape may not be as crowded as the figures suggest. Nor do I think it is self evident that what has been identified as the burden of some scrutiny activities necessarily applies in relation to complaint handling. Given the millions of transactions that take place in public services on a daily basis, there are in fact relatively few complaints made to the service providers and fewer still to the SPSO. Nevertheless I entirely accept the proposition that duplication of responsibilities should be avoided and that a simpler complaints system is desirable. In Part Three of this paper I offer some thoughts on achieving that objective.
PART THREE
OPTIONS FOR CHANGE

3.1 In this part of the paper I explore three main themes:

- The scope within current legislative and organisational arrangements for addressing problems identified in the Interim Report. I draw on examples from work by the SPSO.
- Barriers to further improvement and suggestions for how they might be removed.
- Possible models for change elsewhere in the UK and overseas.

Scope for change within current frameworks

3.2 One of the key aspirations underpinning the SPSO’s founding legislation – the Scottish Public Services Ombudsman Act 2002 – was to simplify the system for members of the public wishing to bring a complaint about public services. Creating what was billed as a one-stop-shop for handling complaints – replacing three previously separate ombudsman offices and absorbing some other complaint handling systems - was seen as a prerequisite for achieving this aim.

3.3 As I noted in Part One of this paper, information from complaint handling can make a valuable contribution to other scrutiny activity. The legislation governing my work allows me to share information with certain other scrutineers in specified circumstances. We have supplemented this through Memoranda of Understanding (MoUs) with a range of bodies including the Mental Welfare Commission, the Standards Commission, NHS Quality Improvement Scotland; and Communities Scotland. Much useful sharing of information has been achieved in this way and it provides a model for how scrutineers can inform and focus each others’ work.

3.4 A key part of informing other scrutineers, and of contributing to wider service improvement, is to make the outcomes of our work available in an accessible way. It was with this in mind that the SPSO radically changed its reporting process in October 2005. We revised our process to define our consideration of every complaint within our remit as an investigation. This means that decisions on all complaints that are investigated are now laid before the Parliament on a regular basis. We delivered our first set of reports under the revised process in December 2005 and since then have laid over 300 reports. In addition to the Parliament, a copy of each report is sent to the complainant, the body complained about, and to Ministers.

3.5 When they are laid before the Parliament, the reports become public documents. We post them on our website, and send a newsletter summary of the month’s reports (the Ombudsman’s Commentary) to over 800 individuals. The distribution list includes Chief Executives of the more than 500 bodies under our jurisdiction, MSPs, clerks of Parliamentary Committees; other ombudsmen and commissioners; voluntary and advocacy organisations; members of the press and other stakeholders. We know that this material is

15 The Scottish Public Services Ombudsman Act 2002 (asp 11) sections 20 and 21 and schedule 5.
widely accessed by public service providers, is used as learning material, and informs the work of other scrutineers.

3.6 Another key area in which ombudsmen can promote performance improvement within public service organisations is in fostering good internal complaint handling and preventing the escalation of complaints. To this end my Office has developed a website\(^\text{16}\) to support bodies in the good management of complaints. The site encourages bodies to see complaints as a core responsibility of the governing body and the senior management team who should use complaints data to inform their corporate governance and drive improvement. As well as the technical elements, the site focuses on cultural elements such as openness and attitude. This reflects a key belief that an organisation can only deliver a high quality service and lever the benefits of complaints if it has a positive, collective attitude towards them. The response from bodies to *Valuing Complaints* has been overwhelmingly positive, and we look forward to developing the material further.

**Barriers to further improvement**

3.7 While much has been done to foster cooperation and joint-working within current frameworks there are real, but not insurmountable, barriers to achieving true service user focus. In the context of complaint handling this is most clearly manifest when legislative requirements and/or administrative structures mean that what, to a member of the public, is a single complaint, has to be separated out into elements which will be considered by two or more organisations. This can be illustrated with at least two examples.

3.8 *Related functions:* Members of the public might have engagement with a local authority involving contact with both councillors and officials which leaves them feeling they have grounds to complain about ‘the council’. To whom do they complain? The SPSO can only consider complaints relating to alleged maladministration or service failure by the authority. The Standards Commission considers complaints that councillors have breached their code of conduct. It is unreasonable to expect members of the public to grapple with these esoteric distinctions and while cooperation and mutual signposting by the organisations can help the fact remains that the division is, from the public’s point of view, artificial and unhelpful. Might a different arrangement, such as that operated in Wales (see paragraph 3.14), achieve better service user focus?

3.9 *Complexity of landscape:* My second example draws on a case on which I reported in March 2007\(^\text{17}\). The report was of the investigation of a complaint from a woman (referred to in the report as Mrs C) that an NHS Board had failed in their duty of care to her mother (referred to in the report as Mrs A) in the seven months prior to her death. Mrs C raised a number of specific concerns about medical and nursing care in an NHS hospital and in an independent sector care home where Mrs A was placed as an NHS funded Continuing Care Patient. As the investigation progressed, I identified issues concerning the overall nature and complexity of the complaints processes involved where NHS care is provided in the independent healthcare sector. A significant number of

\(^{16}\) [http://www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

bodies had an interest in the care Mrs A received from the NHS and the Care Home. A complex inter-relationship exists between these bodies and their approach to complaint handling of which a diagram annexed to the report (and reproduced as an annex to this paper) provided an overview. This complexity caused considerable frustration and distress to Mrs C.

3.10 Some of this complexity results from inflexibility in legislation. For example, although as I note in paragraph 3.3 the legislation governing my work allows me to share information with certain other scrutineers in specified circumstances the wording of that provision is quite narrow and restrictive. It does not allow for sharing of case-related information, or joint investigation by the SPSO and the Care Commission. I see a strong case for amending legislation to enable appropriate information sharing and joint working.

3.11 Turning to barriers created by administrative structures, it may be helpful if I refer to evidence I have given to Parliamentary committees. In written evidence to the Finance Committee’s Inquiry into Accountability and Governance I stated:

‘The Ombudsman does not operate in isolation. Since devolution, new bodies have been created and it is important that the different roles complement one another. We have done much to reduce potential duplication - for example, through memoranda of understanding with other organisations and publishing guidance for the public such as the Route Map guide to complaining about public services in Scotland produced in cooperation with Audit Scotland and others.

In my view office-holders have a responsibility to explore all opportunities for joint working, not least to lower the cost of delivering our services. Real savings have already been made …

However, our scope for joint working and sharing services has been limited by the lack of a framework design for the administrative architecture in the first years of devolution. This limitation has become more evident as more bodies are proposed. I addressed such issues in my recent evidence to the Justice Committees on the Scottish Commissioner for Human Rights Bill and the proposal in the Police, Public Order and Criminal Justice (Scotland) Bill for an Independent Police Complaints Commission for Scotland.\(^{21}\)

3.12 In additional written evidence to the Committee, I expanded on my proposal to create a governance framework design. It would, I believe, achieve a number of objectives. First, it would facilitate more joint working; second, it would identify any gaps or duplication in the current jurisdictional framework; and third, it would avoid the likelihood of overlap and confusion of roles when creating new functions or office-holders. I suggested six ‘design principles’:

1. **Clarity of Remit**: a clear understanding of the office-holder's specific remit

\(^{20}\) [http://www.scottish.parliament.uk/business/committees/justice1/reports-06/j1r06-01-vol02-02.htm#3](http://www.scottish.parliament.uk/business/committees/justice1/reports-06/j1r06-01-vol02-02.htm#3)  
\(^{21}\) [http://www.scottish.parliament.uk/business/committees/justice2/reports-06/j2r06-02-vol02-04.htm#15](http://www.scottish.parliament.uk/business/committees/justice2/reports-06/j2r06-02-vol02-04.htm#15)  
\(^{22}\) [http://www.scottish.parliament.uk/business/committees/finance/reports-06/fir06-07-Vol02-02.htm#supsbvgf](http://www.scottish.parliament.uk/business/committees/finance/reports-06/fir06-07-Vol02-02.htm#supsbvgf)
2. **Distinction between functions**: a clear distinction between different functions, roles and responsibilities including audit, inspection, regulation, complaint handling, advocacy

3. **Complementarity**: a dovetailing of jurisdictions creating a coherent system with appropriate linkages with no gaps, overlaps or duplication

4. **Simplicity and Accessibility**: simplicity and access for the public to maximise the 'single gateway'/'one-stop-shop' approach

5. **Shared Services**: shared services and organisational efficiencies built in from the outset

6. **Accountability**: the establishment of clear, simple, robust and transparent lines of accountability appropriate to the nature of the office.

Models elsewhere

3.13 It is clear from the Interim Report that the Scrutiny Team has looked at scrutiny models elsewhere. I agree that it can be instructive to observe and learn from the practice in other countries. In this section I shall limit myself to a couple of specific practice examples of direct relevance to issues raised in this paper. There are, however other interesting overseas models about which my staff would be very happy to provide information to the team if that would be helpful. For example, I note that the Review's literature review refers to Australian examples but the team may be interested in very recent developments in the New South Wales Ombudsman's office to focus their work and increase its value in bringing about improvements in the delivery of public services.

3.14 My first example concerns the handling of complaints that a local authority member has broken the code of conduct. In Wales these are dealt with by the Ombudsman alongside other complaints about public services. I suggest it is worth considering whether this provides a better service user focus than the current split of responsibilities in Scotland (paragraph 3.8).

3.15 My second example concerns `own initiative' investigations by ombudsmen. In its consultation, prior to the setting up of the SPSO, the Scottish Executive noted that 12 of the 34 ombudsmen they had researched outside the UK had powers to initiate their own investigations without a complaint being made. Having such a power addresses a concern sometimes expressed that an ombudsman’s effectiveness as a scrutineer may be lessened if s/he can only act on the basis of complaints received, which may or may not be an accurate reflection of the incidence and seriousness of problems with the delivery of public services.

3.16 In the event the Scottish Executive decided not to adopt the `own initiative' model in Scotland, noting concerns that to do so could trespass on internal audit arrangements and distract from the Ombudsman’s primary role of investigating individual complaints. I do not find either of those arguments particularly compelling and I think the `own initiative' option, although not likely to be much used, could be a useful contribution to joined-up scrutiny. Certainly

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23 See Public Services Ombudsman (Wales) Act 2005 (section 35 and schedule 4) and http://www.ombudsman-wales.org.uk/content.php?mID=27;lang=1


that has proved the case in Ireland where the Ombudsman has such a power\textsuperscript{26}.

Professor Alice Brown  
Scottish Public Services Ombudsman  
April 2007

\textsuperscript{26} See, for example:  
http://ombudsman.gov.ie/en/Publications/InvestigationReports/LocalAuthorityHousingLoans/Name_2555_en.htm  
where, having investigated and upheld a complaint against one local authority (where problems had resulted from  
computer software that was widely used across Irish local authorities), the Ombudsman then conducted an own-  
initiative investigation which found the same problem in many other authorities.
Overview of complaint procedures followed by 'Mrs C' in pursuing a complaint about the care of her elderly mother

NHS commissions care from Independent Sector Care Home. NHS is clinically responsible for "care and treatment".

Care given by Care Home

Death of Patient

Complaint made about care given by Care Home (and NHS Board)

Procurator Fiscal – consideration of FAI

NHS Complaints Process:
- Local Resolution – concerns addressed by those immediately responsible for care and treatment then;
- Independent Review (abolished April 2005) then;
- Referral to the Ombudsman (may result in a report being laid before the Scottish Parliament)

Where can complaint go?

Care Commission:
- regulates Care Home;
- can investigate breaches of Care Standards;
- does not make report public or provide to NHS (or Local Authority etc.)

Professional body (NMC or GMC)

Care Home complaints process:
- must be equivalent to NHS process and must co-operate with NHS process
- NHS