ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2402 – IJB Complaints Handling
REPORT NUMBER	IA/AC2402
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on the IJB Complaints Handling.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of the IJB Complaints Handling.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. RISK

7.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.

8. OUTCOMES

8.1 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

8.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit report AC2402 – IJB Complaints Handling

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit

Assurance Review of IJB Complaints Handling

Status: Final
Date: 15 November 2023
Risk Level: Corporate

Report No: AC2402
Assurance Year: 2023/24

Net Risk Rating	Description	Assurance Assessment
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**

Report Tracking	Planned Date	Actual Date
Scope issued	12-May-23	15-May-23
Scope agreed	26-May-23	25-May-23
Fieldwork commenced	8-June-23	8-June-23
Fieldwork completed	28-July-23	22-Sep-23
Draft report issued	11-Aug-23	22-Sep-23
Process owner response	1-Sep-23	18-Oct-23
Director response	8-Sep-23	15-Nov-23
Final report issued	15-Sep-23	15-Nov-23
Audit Committee	1-Feb-24	

Distribution	
Document type	Assurance Report
Director	Sandra MacLeod, Chief Officer (ACHSCP)
Process Owner	Fraser Bell, Chief Operating Officer (ACHSCP)
Stakeholder	Martin Allan, Business and Resilience Manager (ACHSCP)
	Paul Mitchell, Chief Finance Officer (ACHSCP)
	Alison Macleod, Strategy and Transformation Lead
	Caroline Howarth, Clinical Director (ACHSCP)
	Lucy McKenzie, Interim Chief Officer People & Organisational Development and Customer Experience (ACC)
	Alice Goodrum, Customer Feedback & Access to Information Ops Lead (ACC)
	Michelle Grant, Transformation Programme Manager – Digital and Data (ACHSCP)
	Linda Lever, Team Leader Adverse Events & Feedback (NHS Grampian)
	Isla Gray, Feedback Quality Improvement & Assurance Advisor (NHS Grampian)
	Heather Sheen, Quality Infomatics Facilitator (NHS Grampian)
	Catriona Sim, Data Protection Officer (ACC)*
	Alan Bell, Data Protection Officer (NHS Grampian)*
	Dr June Brown, Executive Nurse Director (NHS Grampian)*
	Vikki Cuthbert, Interim Chief Officer – Governance (ACC)*
***Final only**	Ronnie McKean, Corporate Risk Lead (ACC)*
	External Audit*
Lead auditor	Andrew Johnston, Audit Team Manager

1 Introduction

1.1 Area subject to review

Under the Scottish Public Services Ombudsman (SPSO) Act 2002, Scottish public sector organisations are required to establish a complaints procedure that complies with the SPSO's statement of complaints handling principles. This statement states, an effective complaints handling procedure is:

- **User-focused** – It puts the complainant at the heart of the process.
- **Accessible** – It is appropriately and clearly communicated, easily understood and available to all.
- **Simple and timely** – It has as few steps as necessary within an agreed and transparent timeframe.
- **Thorough, proportionate, and consistent** – It should provide quality outcomes in all complaints through robust but proportionate investigation and the use of clear quality standards.
- **Objective, impartial and fair** – It should be objective and evidence-based and driven by the facts and established circumstances, not assumptions, and this should be clearly demonstrated.
- **Seeks early resolution** – It aims to resolve complaints at the earliest opportunity, to the service user's satisfaction wherever possible and appropriate.
- **Delivers improvement** – It is driven by a search for improvement, using analysis of outcomes to support service delivery and drive service quality improvements.

To help ensure the above principles are achieved, the SPSO has published various sector specific model complaints handling procedures (MCHPs), which include:

- A shared definition of what is and is not a complaint.
- A two-stage process where complaints are resolved, with the customer's agreement, as close to the frontline as possible.
- Frontline response to complaints within five working days.
- An investigation stage of 20 working days, which provides the organisation's final decision.
- Recording of all complaints.
- Active learning from complaints through reporting and publicising complaint information.

The SPSO Local Authority MCHP implementation guidance requires health and social care partnerships (HSCPs) to adapt and adopt this procedure for complaints relating to adult social care services delivered by a HSCP. In addition, under the NHS MCHP, NHS staff are required to work with health and social care partnership staff to resolve complaints raised with the NHS that relate to integrated health and social care services. Furthermore, for complaints relating to the actions and processes of the IJB itself, IJBs are expected to adopt the MCHP for Scottish Government, Scottish Parliament, and Associated Public Authorities.

In 2022/23 the Aberdeen City Health and Social Care Partnership received 199 complaints[1] (153 health, 46 social care) relating to delivery of health and social care services (249 2021/22 – 207 health, 42 social care). No complaints were received in 2022/23 or 2021/22 relating to the actions of the IJB itself.

1.2 Rationale for the review

The audit objective is to ensure that the complaints procedures are being complied with for all matters and that data generated is used by Management to monitor and improve performance.

The area has not been subject to review previously by Internal Audit. It has been included in the 2023/24 Internal Audit plan following consultation with Senior Management due to the risk of reputational damage and potential financial loss, should complaints be mismanaged and / or associated control weaknesses addressed.

1.3 How to use this report

[1] Complaint numbers are based on complaints recorded in the respective complaints handling systems.

This report has several sections and is designed for different stakeholders. The executive summary (section 2) is designed for senior staff and is cross referenced to the more detailed narrative in later sections (3 onwards) of the report should the reader require it. Section 3 contains the detailed narrative for risks and issues we identified in our work.

2 Executive Summary

2.1 Overall opinion

The full chart of net risk and assurance assessment definitions can be found in Appendix 1 – Assurance Scope and Terms. We have assessed the net risk (risk arising after controls and risk mitigation actions have been applied) as:

Net Risk Rating	Description	Assurance Assessment
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**

The organisational risk level at which this risk assessment applies is:

Risk Level	Definition
Corporate	This issue / risk level impacts the IJB as a whole. Mitigating actions should be taken at the Senior Leadership level.

2.2 Assurance assessment

The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the IJB's approach to complaint handling.

The following governance, risk management and control measures were generally fit for purpose:

- **Governance arrangements** – Delegated authority for complaint handling is formalised and the NHS and Council Feedback teams maintain good oversight of complaints, with systems in place for progressing complaint investigations and responses with relevant lead officers. In addition, regular monitoring of complaints takes place by the Health and Social Care Partnership (H&SCP) Clinical and Care Governance Group and the H&SCP Clinical and Care Governance Committee.
- **Written procedures, guidance, and training** – Written procedures and guidance for staff are comprehensive and comply with the relevant SPSO model complaints handling procedures. In addition, online training, shared learning events and regular staff newsletters covering complaints handling are in place. Furthermore, complaints handling procedures and reporting arrangements are adequately advertised to members of the public.
- **Complaint handling** – Complaints are generally being well handled based on a sample of 20 H&SCP complaints reviewed (nine NHS patient, eight social care service users, three directly to the Chief Officer) reviewed. Correspondence with complainants was generally of a good standard and lessons had been learned and improvement action taken where complaints were upheld.
- **Annual performance reporting** – Mandatory annual reporting on complaints key performance indicators was in line with SPSO requirements for all Council and NHS Grampian complaints, which cover Aberdeen City H&SCP complaints.

However, the review identified some areas of weakness where enhancements could be made to strengthen the framework of control, specifically:

- **Early resolution** – Complaints in general could be resolved quicker. In 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable[2] for early resolution within five working days, only 46 (29%) (41 NHS and 5 Social Care) achieved early

[2] Complaints are classified within the NHS complaint handling system (Datix) by the Feedback team and service complaint lead, according to customer severity and complexity. This determines if suitable for early resolution within five working days of receipt or if investigation is instead required over a 20-working day period where more complex / higher risk. A similar process is adopted by the Council's Feedback team with complaints suitable for early resolution which have taken longer specifically identified as 'S2-Esc'.

resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days).

- **Management monitoring** – The SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage is not being reported at all to senior management as required, despite complaint handling timeliness needing improvement. Also, whilst some lessons learned are being reported for some services to the Aberdeen City H&SCP Clinical and Care Governance Group, this reporting was not observed to the H&SCP Clinical and Care Governance Committee nor the H&SCP Senior Leadership Team (SLT). The H&SCP SLT identified the need for complaints and enquiries performance reports to be reported to the monthly SLT meetings in November 2022. Prior to the commencement of this audit, work to collate this data from across NHS Grampian, Aberdeen City Council and the Integration Joint Board is underway and scheduled for completion during 2023/24.
- **Public reporting** – The SPSO requires anonymised quarterly external reporting on complaints outcomes and actions taken to improve services however this is not taking place. This is qualitative in nature and can be addressed for social care complaints by 'You Said, We Did' notifications or case studies. Similar reporting is required for health complaints with an additional requirement to report on complaints 'trends' e.g., overall number of complaints received by quarter. The April 2023 Aberdeen City H&SCP Clinical and Care Governance Committee complaint report reviewed covered the required content to some extent with a case study example of action taken to address a complaint. However, these Committee reports are unavailable to the public.
- **System data and dashboard reporting** – Lessons learned, and improvement actions are not always recorded in the Council complaints handling systems despite being captured in the related correspondence with complainants. In addition, multiple systems are in use to handle complaints as described at Appendix 3, some of which are spreadsheet based. These issues mean system data available to H&SCP SLT members is incomplete for dashboard reporting purposes.

It is acknowledged that there are challenges; requirements to capture complaints information across three different organisations, that use different systems, meaning the task of coordination and presenting data can be more onerous. However, the above issues increase the risk of continued complaint handling delays, and poor service delivery where reasons for complaints are not addressed. This increases the risk of repeat complaints, complainant dissatisfaction and escalation to the SPSO, with resulting reputational damage for the H&SCP where complaints are publicly upheld by the SPSO.

Recommendations have been made to address these matters including establishing senior management complaints reporting that covers SPSO requirements as a minimum; publishing necessary complaint outcome and actions taken reports; reviewing mandatory reporting requirements for complaints handling systems to ensure lessons learned and necessary corrective action are captured; and establishing senior management H&SCP complaints handling dashboard reporting.

Severe or major issues / risks

Issues and risks identified are categorised according to their impact on the Board. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
1.1	**Management monitoring** – It is a mandatory requirement of SPSO model complaints procedures for complaints key performance indicators (KPIs) to be reported to senior management on a quarterly basis. However, performance needs improvement, since in 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable for early resolution within five working days, only 46 (29%) (41 NHS and 5	Yes	**Major**	9

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	Social Care) achieved early resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days). Regular performance reporting intended to cover all Aberdeen City H&SCP complaints, is taking place through the H&SCP Clinical and Care Governance Group and H&SCP Clinical and Care Governance Committee. However, reporting does not include the SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage, which needs addressed. Also, whilst some lessons learned are being reported for some services to the Aberdeen City H&SCP Clinical and Care Governance Group, this reporting was not observed to the Clinical and Care Governance Committee nor H&SCP Senior Leadership Team (SLT). Where Senior Management complaints key performance reporting is incomplete there is a greater risk complaint resolution will continue to be delayed, lessons will not be learned, and that complaints will be escalated to the SPSO, resulting in reputational damage to the H&SCP where upheld.			

2.3 Management response

The Senior Leadership Team (SLT) welcome the findings of the audit. SLT are currently working on a governance dashboard which will include data on complaints (including the quarterly SPSO data outlined in this audit). This dashboard will allow SLT to be sighted on key data sets on a regular basis. SLT will also work with colleagues in Aberdeen City Council (ACC) and NHS Grampian to ensure consistency across templates, response letters etc.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Major
1.1	**Management monitoring** – It is a mandatory requirement of SPSO model complaints procedures for complaints key performance indicators (KPIs) to be reported to Senior Management on a quarterly basis. Required KPIs cover complaint volume and average time at the various stages of resolution, investigation, and conclusion. Regular performance reporting intended to cover all Aberdeen City H&SCP complaints, is taking place through the H&SCP Clinical and Care Governance Group and H&SCP Clinical and Care Governance Committee. However, performance needs improvement, since in 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable for early resolution within five working days, only 46 (29%) (41 NHS and 5 Social Care) achieved early resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days). The H&SCP C&CG Group receive 'Sector Reports' from each service area with the H&SCP, with the Sector Report template covering various matters, including complaints. However, the level of detail reported varied by service area, based on the February 2023 meeting papers reviewed, with some blank returns without explanation, and some without actions taken / lessons learned. This could in part be due to the reporting template lacking guidance on required information. The H&SCP C&CG Group is aware that all necessary information is not always being received and the Sector Reports are under review as a result. Whilst the H&SCP C&CG Committee reporting is generally comprehensive, it was noted that it does not include the SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage, an area which needs improvement as detailed above. In addition, it was noted there was no reporting on lessons learned and improvement actions at the April H&SCP C&CG Committee meeting. At the time of review, there was no separate Council, NHS Grampian, or H&SCP Senior Leadership Team (SLT) quarterly reporting covering H&SCP complaints KPIs. However, SLT identified the need for this reporting in November 2022 and work has commenced to address this. Where senior management complaints key performance reporting is incomplete there is a greater risk complaint resolution will be delayed or not achieved, lessons will not be learned, and that complaints will be escalated to the SPSO, resulting in reputational damage to the H&SCP where upheld. **IA Recommended Mitigating Actions** a) Mandatory quarterly SPSO complaints KPIs should be reported as required. b) Sector Reports for the H&SCP Clinical and Care Governance Group should be standardised to capture all necessary information including lessons learned and improvement actions. **Management Actions to Address Issues/Risks** *a) Agreed. The development of the Senior Leadership Team governance dashboard will include the mandatory SPSO details moving forward.* *b) Agreed.*		

Risk Agreed	Person(s)	Due Date

Ref	Description		Risk Rating	Major
	a) Yes b) Yes	a) Business and Resilience Manager and Strategy and Transformation Lead b) Business and Resilience Manager	a) 30 June 2024 b) 30 June 2024	

Ref	Description	Risk Rating	Moderate
1.2	**Systems and dashboard reporting** – Complaints handling systems should facilitate management oversight, to ensure complaints are being handled in a timely manner in accordance with procedure and any necessary improvements are addressed. Complaints are handled using multiple systems as described in Appendix 3. Relevant officers within the H&SCP SLT have access to complaints recorded in the NHS complaints handling system Datix, and the spreadsheet-based logs used to handle H&SCP complaints received directly by the H&SCP Chief Officer. However, H&SCP SLT officers do not have access to the Council's complaints handling system for monitoring progress with social care complaints, since this is recorded in spreadsheets, with access restricted to the Customer Feedback and Access to Information (Feedback) team, who lead on investigating and responding to social care complaints. In addition, lessons learned, and improvement actions are not always recorded in the spreadsheet-based log used by the Council's Feedback team, as detailed at 1.3 below. These data recording and access issues act as a barrier to H&SCP SLT dashboard reporting, reducing senior management oversight of complaints, which risks wider lessons not being learned and addressed, poor service delivery, complaint resolution delays, and escalation of mishandled complaints to the SPSO.		

IA Recommended Mitigating Actions

a) Mandatory fields within the Council's social care complaints handling system should be reviewed to ensure all necessary complaint handling data is captured.

b) Dashboard reporting covering relevant complaints KPIs should be established for H&SCP SLT members.

Management Actions to Address Issues/Risks

a) Agreed. ACHSCP will work with ACC and NHSG to capture all necessary complaint handling data. Manual updates will be maintained of lessons learned and improvement actions which will be systematically shared on a regular basis with necessary stakeholders.

b) Agreed. The development of the Senior Leadership Team governance dashboard is ongoing and will capture complaints KPI's. The dashboard is intended to be reported to SLT on a quarterly basis.

Risk Agreed	Person(s)	Due Date
a) Yes b) Yes	a) Business and Resilience Manager and Customer Service Manager, ACC b) Business and Resilience Manager and Strategy and Transformation Lead	a) 30 June 2024 b) 30 June 2024

Ref	Description	Risk Rating	Minor
1.3	**Complaint handling** – SPSO model complaints handling procedures describe how the NHS and local authorities should handle complaints, including means and timing of acknowledgement, early resolution, investigation, and associated correspondence requirements. A sample of 20 complaints (nine NHS Datix, eight Council Feedback team social care log, three Chief Officer spreadsheet log) were reviewed. In general, complaints had been well handled, with complaint issues identified at the acknowledgement stage and responses to complainants covering reasons for outcomes, and where upheld, complaint causes, lessons learned, and action taken. However, whilst lessons learned, and improvement actions had been reported as required to complainants these were not captured for three of six (50%) upheld social care complaints reviewed in the related Feedback team spreadsheet log. This data recording risk has already been covered at 1.2 above. It is an SPSO requirement to acknowledge complaints requiring investigation within three working days of receipt. Complainants were generally kept informed of any delays, However, two (13%) of 15 complaints reviewed at the investigation stage were formally acknowledged in line with SPSO requirements late risking reputational damage. The Service advised that due to the complex nature of complaints such as these it can take longer than anticipated to establish the basis of the complaint and if indeed it is a complaint. A general acknowledgement was issued for one of these prior to the three day SPSO deadline whilst conducting this process. Whilst all responses to complainants at the investigation stage had been approved by a relevant manager, eight (40%) (four social care, four NHS) had not been approved by an H&SCP SLT service lead with the necessary delegated authority. This is contrary to Council complaints handling procedure and reduces H&SCP SLT oversight and control over complaints handling. Correspondence with complainants was generally of a good standard and complied with most SPSO requirements, However, one (13%) of eight NHS acknowledgment letters for complaints that reached the investigation stage did not include reference to the role and contact details for the SPSO nor did they include details of advice and support available, including Professional Advocacy Advice and Support Service Scotland (PASS).The Feedback team advised this was due to the respective service responding by email without Feedback team involvement and the use of a standard pro-forma acknowledgement template. In addition, it was noted one (13%) NHS response omitted an apology for the complaint despite the complaint being fully upheld and the letter also being issued a day late. Whilst reasons for one (33%) of three delayed complaint investigations were not explained in the related correspondence acknowledging delays as required. The Feedback team advised that this was due to no explanation being provided by the related service when requested. The NHS Feedback team have a helpful checklist for staff to follow when preparing a written response to complaints following investigation. This includes the need for an apology where appropriate. It may further help staff if examples of when it is appropriate to apologies are included on the checklist, such as when a complaint is upheld. Finally, Council complaint responses were of a good standard, but it was noted they omitted the SPSO requirement to notify complainants that a member of staff is available to clarify any aspect of the letter. These matters, whilst relatively minor, increase the risk complainants will refer a response they are dissatisfied with directly to the SPSO.		

Ref	Description	Risk Rating	Minor

IA Recommended Mitigating Actions

a) Delegated authority should be adhered to or reviewed.

b) The Council's acknowledgement process should be reviewed to ensure timely response.

c) Council template complaint response letters should be reviewed to ensure they cover all SPSO requirements.

d) NHS services should be reminded of complaint handling requirements (including acknowledgement requirements and reasons for delays), and the Feedback team's complaint response sign off checklist requirements should be reviewed and reissued.

Management Actions to Address Issues/Risks

a) Agreed.

b) Agreed. ACH&SP will work with ACC on a review of the acknowledgement process.

c) Agreed.

d) Agreed

Risk Agreed	Person(s)	Due Date
Yes	a) Business and Resilience Manager	a) and c) 30 June 24
	b) Customer Service Manager, ACC	b) December 2023
	c) Customer Service Manager, ACC	c) December 2023
	d) Business and Resilience Manager & Team Leader Adverse Events & Feedback (NHS Grampian)	d) 30 June 24

Ref	Description	Risk Rating	Moderate
1.4	**Public reporting** – It is a mandatory SPSO requirement for quarterly publishing of complaints outcomes and actions taken to improve services, with a focus on positive communication with customers on the value of complaints.		

This can be addressed by case study examples of how complaints have helped improve services or 'You Said We Did' notifications. The April 2023 Aberdeen City H&SCP Clinical and Care Governance Committee complaint report reviewed covered this to some extent, with a case study example of action taken to address a complaint. However, these reports are unavailable to the public.

Furthermore, there is no equivalent NHS Grampian or Council reporting which is covering this for the H&SCP complaints.

IA Recommended Mitigating Actions

SPSO mandatory public reporting should take place as required for the H&SCP.

Management Actions to Address Issues/Risks

	Agreed.		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Business and Resilience Manager and Strategy and Transformation Lead	30 June 24

4 Appendix 1 – Assurance Terms and Rating Scales

4.1 Overall report level and net risk rating definitions

The following levels and ratings will be used to assess the risk in this report:

Risk level	Definition
Corporate	This issue / risk level impacts the IJB as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net Risk Rating	Description	Assurance Assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	**Substantial**
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	**Minimal**

Individual Issue / Risk Rating	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, which could result in, for example, a material financial loss. Action should be taken within three months.
Severe	This is an issue / risk that could significantly affect the achievement of one or many of the IJB's objectives or could impact the effectiveness or efficiency of the IJB's activities or processes. Action is considered imperative to ensure that the IJB is not exposed to severe risks and should be taken immediately.

5 Appendix 2 – Assurance review scoping document

5.1 Area subject to review

Under the Scottish Public Services Ombudsman (SPSO) Act 2002, Scottish public sector organisations are required to establish a complaints procedure that complies with the SPSO's statement of complaints handling principles. This statement states, an effective complaints handling procedure is:

- **User-focused** – It puts the complainant at the heart of the process.
- **Accessible** – It is appropriately and clearly communicated, easily understood and available to all.
- **Simple and timely** – It has as few steps as necessary within an agreed and transparent timeframe.
- **Thorough, proportionate, and consistent** – It should provide quality outcomes in all complaints through robust but proportionate investigation and the use of clear quality standards.
- **Objective, impartial and fair** – It should be objective and evidence-based and driven by the facts and established circumstances, not assumptions, and this should be clearly demonstrated.
- **Seeks early resolution** – It aims to resolve complaints at the earliest opportunity, to the service user's satisfaction wherever possible and appropriate.
- **Delivers improvement** – It is driven by a search for improvement, using analysis of outcomes to support service delivery and drive service quality improvements.

To help ensure the above principles are achieved, the SPSO has published various sector specific model complaints handling procedures (MCHPs), which include:

- A shared definition of what is and is not a complaint.
- A two-stage process where complaints are resolved, with the customer's agreement, as close to the frontline as possible.
- Frontline response to complaints within five working days.
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- Recording of all complaints.
- Active learning from complaints through reporting and publicising complaint information.

The SPSO Local Authority MCHP implementation guidance requires health and social care partnerships (HSCPs) to adapt and adopt this procedure for complaints relating to adult social care services delivered by a HSCP. In addition, under the NHS MCHP, NHS staff are required to work with health and social care partnership staff to resolve complaints raised with the NHS that relate to integrated health and social care services. Furthermore, for complaints relating to the actions and processes of the IJB itself, IJBs are expected to adopt the MCHP for Scottish Government, Scottish Parliament, and Associated Public Authorities.

In 2022/23 the Aberdeen City Health and Social Care Partnership received 199 complaints[3] (153 health, 46 social care) relating to delivery of health and social care services (249 2021/22 – 207 health, 42 social care). No complaints were received in 2022/23 or 2021/22 relating to the actions of the IJB itself.

5.2 Rationale for review

The audit objective is to ensure that the complaints procedures are being complied with for all matters and that data generated is used by Management to monitor and improve performance.

The area has not been subject to review previously by Internal Audit. It has been included in the 2023/24 Internal Audit plan following consultation with Senior Management due to the risk of reputational damage and potential financial loss, should complaints be mismanaged and / or associated control weaknesses addressed.

5.3 Scope and risk level of review

[3] Complaint numbers are based on complaints recorded in the respective complaints handling systems.

This review will offer the following judgements:

- An overall **net risk** rating at the Corporate level.
- Individual **net risk** ratings for findings.

5.3.1 Detailed scope areas

As a risk-based review this scope is not limited by the specific areas of activity listed below. Where related and other issues / risks are identified in the undertaking of this review these will be reported, as considered appropriate by IA, within the resulting report.

The specific areas to be covered by this review are:

- Written Policies and Procedures
- Training
- Systems and Record Keeping
- Data Sharing
- Complaint Management
- Monitoring and Reporting
- Lessons Learned and Improvements

5.4 Methodology

This review will be undertaken through interviews with key staff involved in the process(es) under review and analysis and review of supporting data, documentation, and paperwork. To support our work, we will review relevant legislation, codes of practice, policies, procedures, guidance.

Due to hybrid working across the Council, this review will be undertaken primarily remotely.

5.5 IA outputs

The IA outputs from this review will be:

- A risk-based report with the results of the review, to be shared with the following:
  - Council Key Contacts (see 1.7 below)
  - Audit Committee (final only)
  - External Audit (final only)

5.6 IA staff

The IA staff assigned to this review are:

- Andy Johnston, Audit Team Manager **(audit lead)**
- Jamie Dale, Chief Internal Auditor

5.7 Partnership key contacts

The key contacts for this review across the Partnership are:

- Sandra MacLeod, Chief Officer
- Fraser Bell, Chief Operating Officer **(process owner)**
- Paul Mitchell, Chief Finance Officer
- Martin Allan, Business Manager

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	12/05/2023

Milestone	Planned date
Scope agreed	26/05/2023
Fieldwork commences	08/06/2023
Fieldwork completed	28/07/2023
Draft report issued	11/08/2023
Process owner response	01/09/2023
Director response	08/09/2023
Final report issued	15/09/2023

6 Appendix 3 – Complaints Handling Systems

	NHS Patients	Social Care Service Users	Chief Officer Complaints
Complaint Handling System	Datix	Spreadsheet Logs and GovService (for reference number)	Spreadsheet Logs
Complainants / Complaint Enquiry Source	Service Users or representatives, Patient Advice and Support Service (PASS), Advocacy Service, MPs, MSPs, Councillors, Care Opinion	Service Users or representatives, Advocacy Service, MPs, MSPs, Councillors	NHS Grampian Chief Executive (non-patient related complaints) MPs, MSPs, Councillors, Scottish Government, SPSO, Service Users
Nature of Complaints	Service User Specific	Service User Specific	Various - Service User Specific Redirected to Feedback Team
Complaint Route to Feedback Team	Email, Letter, Telephone, Freepost Feedback Card, Patient Advice and Support Service (PASS), Advocacy Service	Email, Letter, Telephone, GovService webform	Email, Letter
Investigating Officer	Service Manager	Feedback Team	PA to Chief Officer
Authorised Signatory Complaint Response	H&SCP SLT Service Lead	Chief Officer - Social Work (Adults)	Chief Operating Officer