Annual Report 2009–2010

SPSO
Scottish
Public
Services
Ombudsman

contents

SPSO Scottish Public Services Ombudsman

Ombudsman's Introduction

A year of change — and more to come

Looking back over 2009 – 10, it is clear that the SPSO is a fundamentally different organisation from the one I took over in May 2009. While we remain fully committed to our corporate values, many of our practices and processes have changed. We are now a tight ship, with a lean management structure and efficient business practices in place. This annual report provides ample evidence of our marked improvement in casework performance, especially in shortening the time we take to handle complaints. We are focussed on delivering a high quality service to all our stakeholders, especially the public, complainants and public bodies, and are determined to improve still further the speed, quality and impact of our decisions.

My first priority on taking office was to reduce our backlog of 'old' cases. We reviewed all the cases that had been at the SPSO for over 12 months at the end of June 2009. We implemented a strategy to complete all of these by December 2009, and we achieved this target. We then began a process of organisational change with an in-depth review of every aspect of our complaints handling service, leading to a radical overhaul of our business process. Efficiency and effectiveness were the watchwords of the review, and we were particularly mindful of the responsibility all public bodies have to deliver the best value they can, especially given prevailing and future economic constraints. During the review, new targets and case management priorities were put in place which reduced our open on-desk cases by over 50%, despite an increase in demand for our service over the year.

We implemented our new business process in May 2010. It has not been an easy journey, but I believe that reform was essential because our role is so vital. Each year, the public in their thousands ask us to look into their concerns. Dozens of public bodies request support in developing complaints handling processes and ask us how they can use complaints to improve how they provide and deliver services.

A key element of the review was to assure the role of the Ombudsman as the final decision maker in complaints processes. This role must be understood, however unpopular on occasion with some authorities and some complainants.

Widening remit

In the past year, legislation was passed that will have a significant impact on our work. The Scottish Parliamentary Commissions and Commissioners etc Act 2010 widens our jurisdiction by transferring to our office responsibility for complaints from prisoners. We are taking on this duty from 1 October 2010, without increasing our headcount. Under the Public Services Reform (Scotland) Act 2010, complaints from water customers should transfer to us next year.

The Public Services Reform Act also gives us the responsibility of leading the development of simplified and standardised complaints handling procedures across the whole public sector. This is a very ambitious programme, and one that will radically change our business in the coming years. We used to have one core function – handling complaints. In future we will have two functions, the second being to establish and maintain what we are calling the Complaints Standards Authority.

Better complaints processes will strengthen the public's voice about how services are delivered.

Parliamentary relations

At Westminster, a Select Committee has oversight of public administration. The standing orders of the UK Parliament specify that the Select Committee has direct responsibility for receiving reports made by the Parliamentary and Health Service Ombudsman (PHSO). The most frequent point of contact is their review of the PHSO's annual report. It is up to the Committee how to proceed when an investigation or annual report is laid before them. In some cases, they may hold their own inquiry and take evidence on a particular matter. As I said in my evidence to the Scottish Parliament's Local Government and Communities Committee in May this year, I am interested to explore with the Parliament a mechanism that would help MSPs and Committees reap the benefits of our work more fully than I believe is currently the case. There is more we could and should be doing to share the learning from complaints and drive improvements in public services. A stronger link with a Committee would also allow the Parliament to hold the Ombudsman to account more effectively.

Equalities

One final area I would like to highlight is the work we have begun to make our service more accessible. This annual report is the first to contain a chapter about our Equalities and Diversity work. It explains the changes we have made to ensure that a wider range of material is available to meet the different needs of our community. It also has examples of the way we are bringing awareness of different needs into our investigations work and into how and what we feed back to organisations.

Looking Ahead

I recognise that there are serious financial challenges ahead for all of us in the public sector. The SPSO has already taken steps to do more with less. I believe that we now have the right systems and people in place to allow us to successfully manage our existing casework and the additional prisons and water complaints. I am confident that we are now in a good position to undertake any further increase in our responsibilities, if Parliament should so decide. I am also convinced that by working in partnership with others to simplify and standardise complaints handling procedures in the public sector we have an opportunity to make overall savings to the public purse.

Better complaints processes will strengthen the public's voice about how services are delivered. Better complaints processes will support providers in responding more effectively to complaints and using the learning from them to improve services. These are valuable outcomes at any time: at a point when our public services have to be as effective and efficient as they possibly can, they are simply essential.

Jim Martin
Ombudsman

Making a Difference

As an organisation that handles complaints about public services, we are anticipating and preparing for an increasing volume of complaints from the public about cuts in services. It is more important than ever that the recommendations that flow from our investigations are realistic, measurable and demonstrably contribute to public sector improvement.

This chapter outlines our work in these areas, which we have carried out mindful of the economic conditions in which the public sector is currently operating. Like all public bodies we have a responsibility to spend wisely and, along with others, we have been asked to look at the broad scrutiny, inspection and regulation landscape and think creatively about possible efficiencies. In pages six and seven we describe how we have been preparing for our new duties to standardise public service complaints handling procedures.

Handling a rise in complaints

The SPSO is one of the channels the public can use to voice views about the services they receive or would wish to receive and how these are delivered. We fully expect to see an increase in complaints about cuts in services. Where we receive multiple complaints about the same issue, and decide to investigate, it has been our practice to investigate one representative complaint, and inform others of the outcome of that complaint. This makes handling large volumes of complaints about single subjects more manageable and is a practice we will continue to follow. At the same time, we will carefully monitor any changes in the volume of complaints we receive. It is vital that we clearly explain to the public our limited role and powers in relation to handling complaints about decisions made by public authorities. As we said earlier this year in connection with a report we published about cuts in council leisure facilities:

'There is much discussion about the potential impact on services of possible public sector cuts. The SPSO has no locus in councils' decision-making about where any axe might or might not fall. Local authorities are democratically elected, and answerable not to this office but to the public.

There are, I think, two main lessons from this investigation – one for us, and one for councils generally. For the SPSO, the complaint highlights how important it is that we communicate as best we can to the public that this office cannot alter decisions properly made by local authorities: what we can look at is whether the decisions were, in fact, made properly. This is an important distinction and not an easy one to put across but we will step up our efforts to do so. … The lesson … for local authorities is to be open and consistent about engaging and communicating with the public, especially when it is clear that opposition from residents is likely.'

Ombudsman's Commentary May 2010

It is more important than ever that the recommendations that flow from our investigations are realistic, measurable and demonstrably contribute to public sector improvement

To improve our own communication, we have added to our suite of leaflets about specific subjects. The leaflets explain the extent of our remit and powers in relation to each subject. Where people have concerns that by law we cannot look at, the leaflets signpost them to the right place for advice and support. We now have fifteen information leaflets based on common areas of enquiry to our office. They are available to download from our website and include:

- Planning (applicants and objectors)
- Council tax banding
- NHS Continuing Care
- Antisocial behaviour / neighbour problems
- Social work
- Council tax benefit and housing benefit
- Removal from a dental or a GP practice list

The second message in the Ombudsman's Commentary warrants further emphasis – at this time especially authorities must fully engage with the public on the decisions they are taking about services, and communicate those decisions clearly. Prior public consultation will not always be possible or necessary but where it does take place it should be meaningful and in accordance with any relevant statutory provision or guidance and policies.

Our recommendations

While we cannot question properly made decisions, our investigations nonetheless play an important role in holding public bodies to account. Our reports add value by ensuring that service providers adhere to high standards of public administration. The recommendations we make translate this aim into practical measures – asking bodies to make specific changes to their policies, practices and procedures to improve how they deliver services. In the health sector in particular, where we are specifically empowered by the Scottish Public Services Ombudsman Act 2002 to look at issues of clinical judgement, we are able to make far-reaching recommendations. Some of the most significant recommendations we have made are detailed later in this report, in the chapters devoted to individual sectors.

Our 2009 –10 investigation reports alone contained over 400 recommendations about more than 300 issues in over 50 different bodies. Our revised business model allows for a complaint to be upheld (where appropriate) and recommendations to be made (again where appropriate) without necessarily requiring the publication of a report. In future, we plan to make public many more of the complaints that conclude in a decision letter rather than an investigation report. We shall continue to preserve the anonymity of the complainant, but by putting more cases into the public domain we aim to provide more evidence to drive improvement.

To bring about the desired improvement, our recommendations must be realistic and meaningful. When we do find failings, we specify the actions that we expect bodies to take to remedy them and the timeframe within which we expect the recommendations to be implemented. We track compliance through our complaints reviewers' follow-up with service providers and through formal reporting at Senior Management Team level.

Looking Ahead

Much of 2009 – 10 was spent preparing for legislation that would impact on our service in significant ways.

Prisons complaints

The Scottish Parliamentary Commissions and Commissioners etc Act set out a target date of 1 October 2010 to transfer the functions of the Scottish Prisons Complaints Commission (SPCC) to the SPSO. Our staff have been working with the Government, the Scottish Prison Service, the SPCC and the Parliament to prepare for a smooth transition. This includes ensuring IT system compatibility, how we communicate with stakeholders (especially prisoners), knowledge transfer, setting up archiving and retrieval systems and training our staff in handling enquiries and complaints in this new area of responsibility.

The transfer of prisons complaints to our office makes significant savings to the public purse. We will absorb these complaints without increasing our headcount.

Paragraph 319 of the Financial Memorandum accompanying the Scottish Parliamentary Commissioners and Commissions etc Bill states: *'Savings in the region of £37k will be made in 2010/11 when the functions of the Prison Complaints Commission are put on a statutory basis and transferred to the Ombudsman's office. The work currently undertaken by the Commissioner will be undertaken by the Ombudsman and his senior management team. That figure rises to £163k in 2011/12 and £174k in future years once staff systems and processes are fully assimilated.'*

We are confident that these savings will be realised.

Water complaints

As part of the Public Services Reform Act, MSPs voted to transfer the complaints handling functions of Waterwatch to the SPSO. This transfer will make the SPSO the final stage of the complaints process for water complaints throughout Scotland, including those relating to private suppliers and business consumers. The existing Waterwatch function of providing customer representation for water customers will be transferred to Consumer Focus Scotland.

The Government has estimated that the transfer of Waterwatch's combined functions to the SPSO and Consumer Focus Scotland will, following a transitional period, result in annual savings of over £300K on an ongoing basis. We are working with Waterwatch, the Government, the Parliament and Consumer Focus Scotland to prepare for a smooth transition on the target transfer date of 1 July 2011.

Simplifying complaints handling in the public sector

The Public Services Reform Act also provided the SPSO with new powers and duties to oversee the development of standardised model complaints handling procedures in Scotland. These powers take forward some of the most significant recommendations made by the Crerar review of independent scrutiny (The Crerar Report[1]) and the Fit For Purpose Complaints Systems Action Group (The Sinclair Report[2]) with the aim of simplifying complaints procedures.

The Act makes a number of proposals which alter or add to the remit and functions of the SPSO, providing authority to publish model complaints handling procedures for service providers and giving us powers to require bodies to comply with these procedures. The Act also provides the SPSO with a duty to monitor and promote best practice in complaints handling for relevant public service delivery staff.

The Sinclair Report made clear that as complaints escalate through a complaints procedure, the costs of dealing with them increase disproportionately. The provisions in the Act present real opportunities to achieve greater efficiencies through better complaints handling.

Support for complaints handlers — the SPSO Training Unit

Our Training Unit opened for business in September 2009. It was developed in response to requests for specific support for staff on the front line of complaints handling and it will play a key part in the 'support for practitioners' role described above.

The Unit provides training to support frontline complaints handlers and to share the learning from complaints dealt with by our office. Our Complaints Handling and Investigation Skills courses are designed for both frontline staff with immediate responsibility for resolving complaints, and for staff responsible for investigating complaints.

Between September 2009 and March 2010 we held seven training sessions involving ten different organisations. Several local authorities have already booked courses with us for 2010–11.

So far, we have worked mainly with local authorities. In the future, though, we are extending our courses to areas such as health and housing. We are working with NHS staff throughout Scotland and with the Improvement Service to develop sector-specific models to deliver complaints handling training.

1 Report on *The Crerar Review: The Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland.*

2 Fit For Purpose Complaints Systems Action Group – Report to Ministers, July 2008

Casework Trends and Performance

Improving our service

As a result of reviewing our business processes we radically overhauled our complaints handling service. As we carried out the review, we were very mindful of the need to adhere to our corporate values and to ensure that we held true to our vision. Our values and vision are at the end of this annual report, along with our corporate strategic plan.

The most significant change to our process is a greater emphasis on early resolution of complaints. We made organisational changes to support the review's findings, and now have a two-team structure for handling enquiries and complaints. Our Advice and Early Resolution team provide information to the public and to complaints handlers in public sector organisations, with a focus on discussing possible solutions at an early stage. This team is also charged with establishing if a complaint is 'fit for SPSO' i.e. whether it is about a body and a subject which we can, by law, consider and whether or not other criteria are satisfied, such as how old the issue is and whether there are alternative remedies available.

Where we can consider the complaint, our Investigations team take it up by detailed examination of the issues. This team continues to carry out the activities of collecting and analysing evidence in much the same way as under our previous business process model.

We have also revised our processes for dealing with complaints about how we have delivered our service, and about the decisions we have reached.

How the complaints break down[3]

The vast majority of the complaints we receive are handled by the Advice and Early Resolution team. During the year 2009 –10, we determined just over 4,400 enquiries and complaints. We resolved over three quarters of the cases by providing advice and guidance to the complainant or the public body concerned.

We conducted an in-depth examination in just under 1000 cases, and of these we prepared 123 investigation reports about a total of 134 complaints. In accordance with our legislation, these reports were laid before the Parliament, and therefore appeared in the public domain. The rest of the cases were concluded without the issue of a published report. Some critics of our service use the low number of cases decided by published report to suggest that we are not as effective as we could be. We believe, however, that our criteria for publication are the right ones. They follow public interest criteria: we publish where there is precedent or where we believe there is significant benefit to be derived through sharing the case widely. As we have said in the previous chapter, we plan in future to make public many more complaints that conclude in a decision letter rather than an investigation report. This will help identify trends and build a picture of where improvement in public service delivery needs to be targeted.

3 For a full breakdown of the outcome of all complaints, see the Statistics section.

Key facts and figures (year to 31 March 2010)

- We received **3,307** complaints, 12% more than 2008 – 09
- We resolved **3,524** complaints, over 22% more than in 2008 – 09
- We published **123** investigation reports which included our findings on **134** complaints
- We issued **850** decision letters
- Our open caseload at 31 March 2010 had reduced from **500** open cases at 31 March 2009 to **241**, a reduction of 52%
- We dealt with **906** enquiries, helping people decide whether to take their complaint further, and directing them to the right place to make it
- We circulated the Ombudsman's Commentary to **1,300** stakeholders each month
- Our website received an average of **5,000** visits each month
- We held **190** outreach meetings with a wide variety of organisations
- Our new Training Unit began operations and delivered **seven** training events
- We operated on a budget of **£3.27 million** with **47** full-time equivalent staff. Three quarters of our staff are directly involved in handling cases

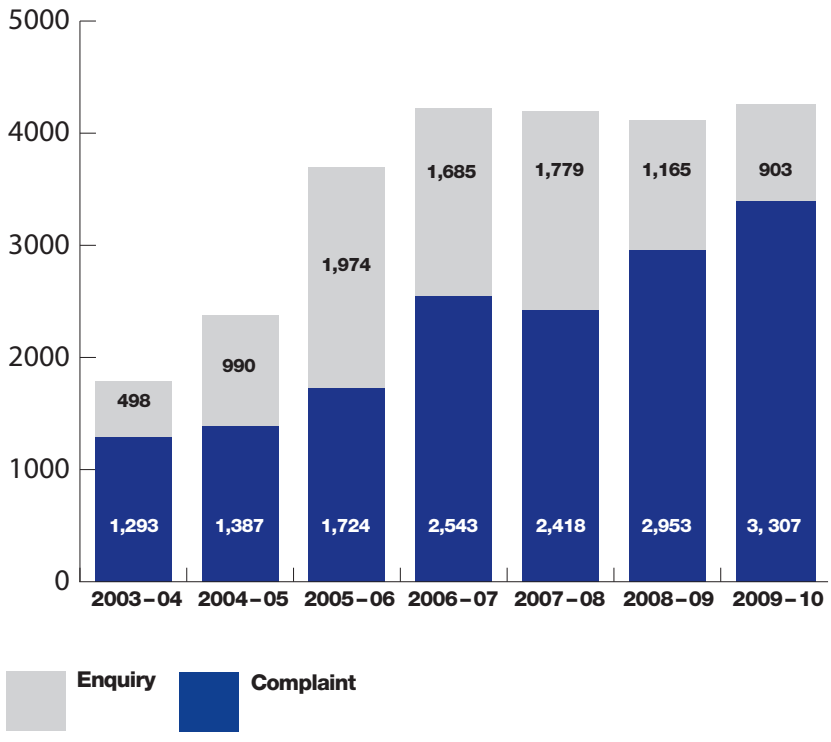
The enquiries and complaints we received

We received 4,210 contacts (enquiries and complaints) in 2009 –10. Of these we classified 3,307 as complaints, an increase of more than 12% on 2008 –9. We classified 903 as enquiries. This was a reduction of over 30% on the previous year's enquiries, and continued the downward trend in these sorts of approaches to us. This may reflect the work that we have done to try to help the public and service providers understand at which point a complaint should come to us, and the extent of our role and remit.

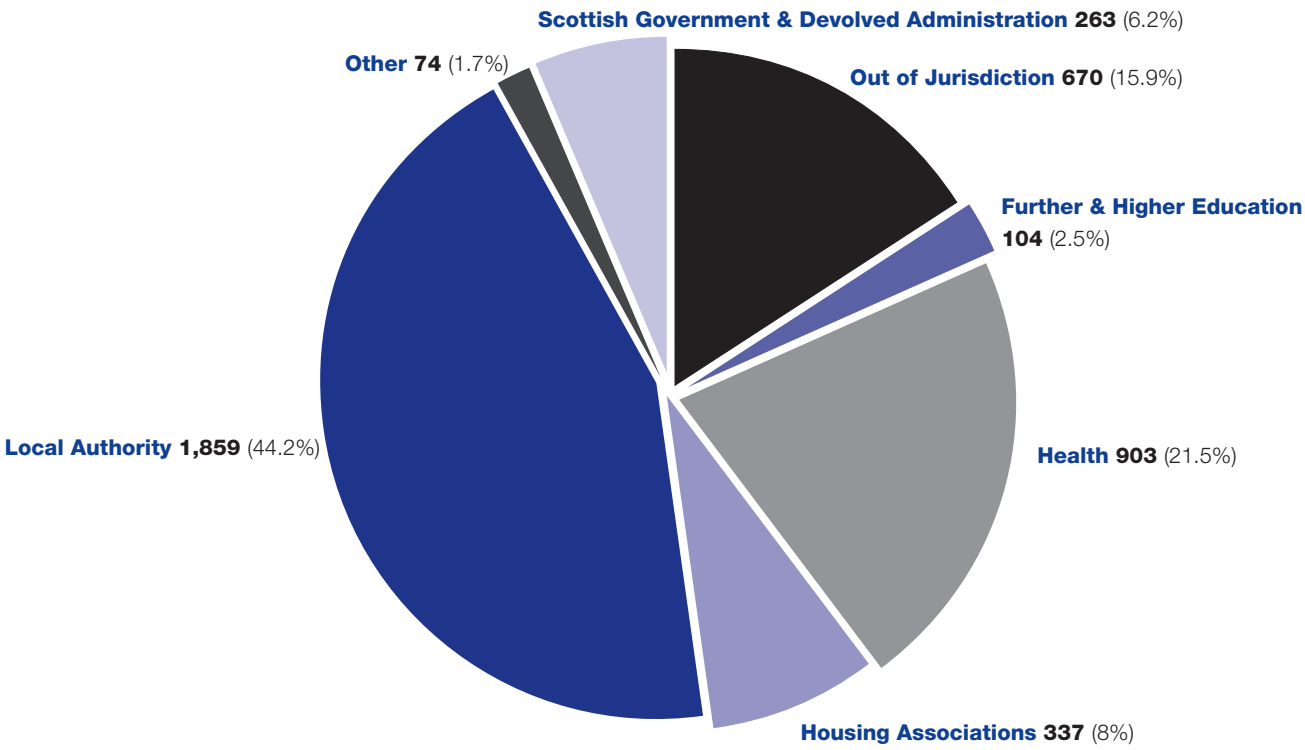
There is little change in the sectoral breakdown of contacts received. Around 45% are about local authorities, reflecting the wide range of services provided by councils and again, as in previous years, the NHS formed the next largest section of the caseload, followed by housing associations.

Total contacts received by year (enquiries and complaints)

Complaints received **3,307**
Enquiries received **903**
Total **4,210**



Total contacts received by sector in 2009 – 10

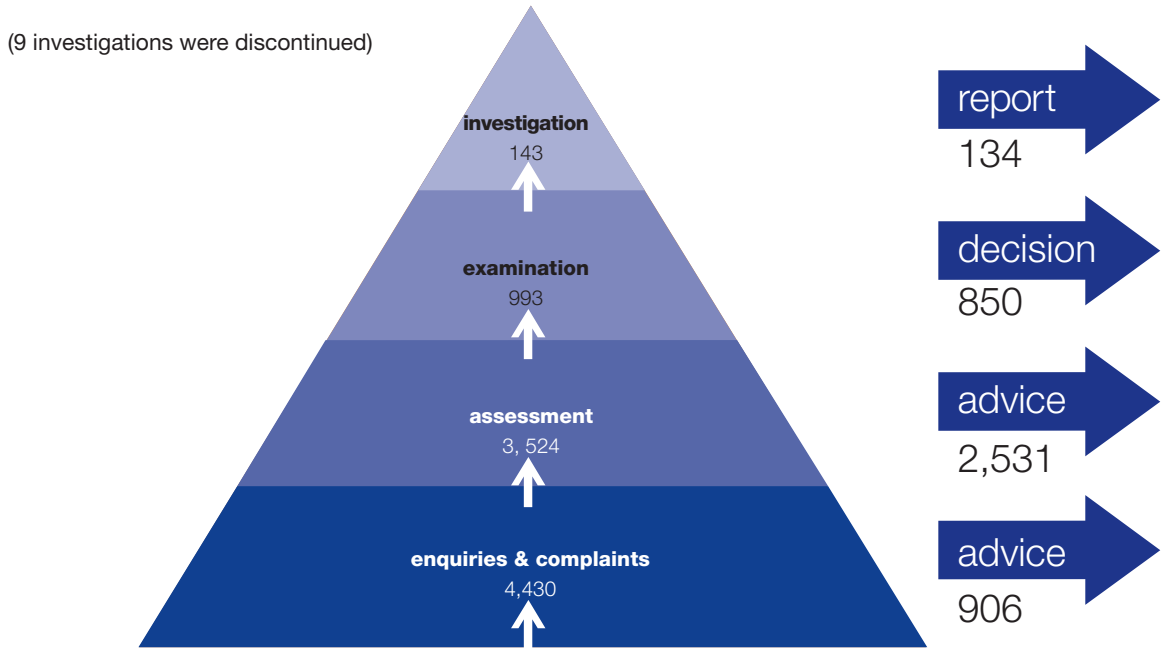


How we handled the enquiries and complaints

In 2009 – 10 we dealt with 906 enquiries – helping people decide whether to pursue a complaint, and directing them to the right place – and we considered and reached decisions on 3,524 complaints.

Enquiries and complaints resolved at different stages 2009 – 10

(figures include some cases carried over from the previous year)



Enquiries

At this stage we give support and guidance to people who contact us about their problem with a public service. We give advice about complaining and, where appropriate, direct people to an organisation that may be better placed to help them. In 2009 –10 we gave advice on 906 enquiries.

Assessment

In 2009 –10 we resolved 2,531 complaints at this stage. Many of these had come to us too early (we call these 'premature' complaints) and needed to be made first to the organisation concerned. Others could not be examined because the subject was out of our jurisdiction, or because the complainant withdrew it or didn't provide us with enough information to allow us to take it forward.

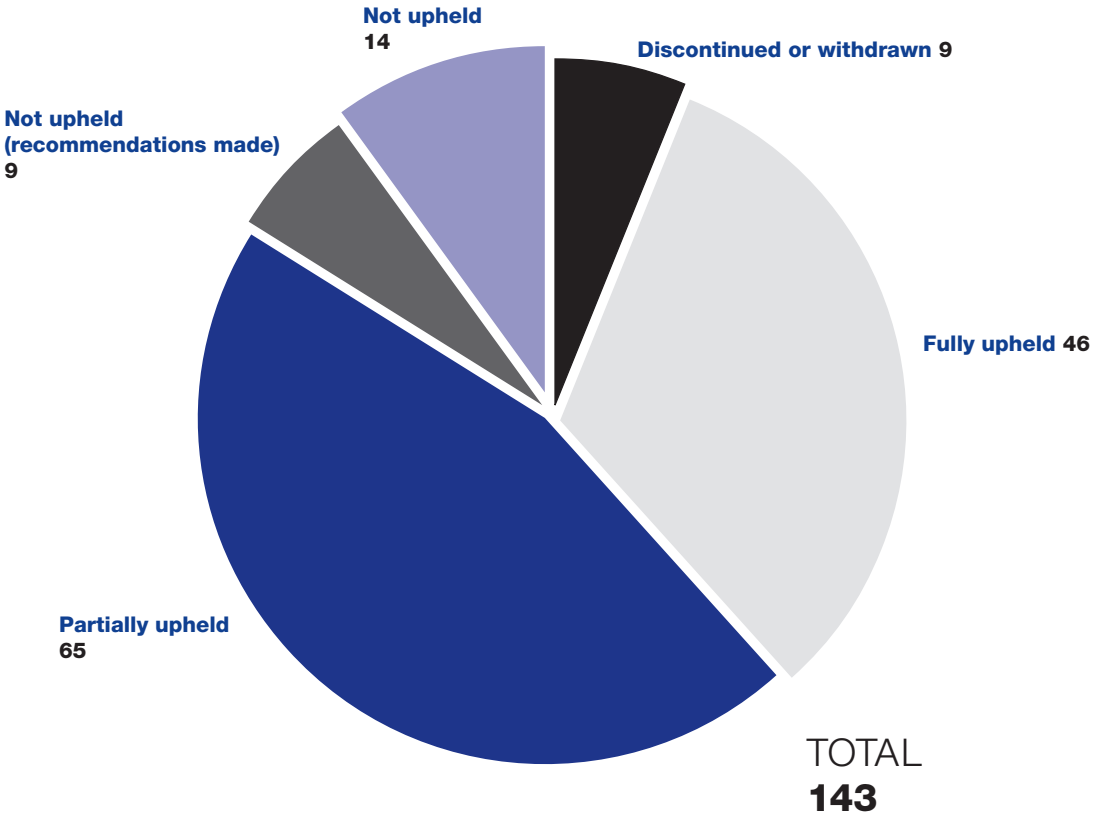
Examination

At this stage we gather and examine evidence. This includes getting expert advice and carrying out interviews or site visits where appropriate. In most cases we then report our conclusions in what we call a decision letter. This normally happens if the organisation concerned accept that things went wrong, apologise and take action to prevent the problem happening again. It also happens when, from the evidence we see, it seems the organisation didn't do anything wrong or there is not enough evidence for us to reach a conclusion, and we think it unlikely that further investigation would uncover more. In 2009–10 we resolved 850 complaints at this stage.

Investigation

We may decide to move a case to investigation if we need more evidence to reach a conclusion and it would be both practical and proportionate to investigate the matter in more depth. We may also decide that there is a public interest issue involved and that the facts of the case should be made public. In these cases we publish an investigation report. Such reports are normally about complex, technical matters and involve explaining legislation, clarifying facts and drawing conclusions based on these facts. In these cases, we frequently make recommendations to the authority concerned to try to ensure that the problem does not recur and to drive up standards of performance more widely. In 2009 –10 we published 123 reports about a total of 134 complaints. Nine further cases that we took to investigation did not end in a report being published, as they were discontinued before reaching that point. The outcome of all our investigations is shown in the next chart.

Investigation outcomes 2009 – 10



Improvements in performance

Last year we reported an improvement in performance in terms of the speed with which we dealt with complaints. In 2009 –10 we took an even bigger step forward in this respect. Some key figures illustrate this improvement:

- The volume of complaints received in 2009 –10 increased by 12% compared with 2008 – 09 and the number of cases resolved increased by 22%.
- The number of cases open at 31 March 2010 was 241, less than half the number open at the end of the previous year.

It is of course vital that the quality of our decision-making does not suffer as a result of the changes in our processes that have improved the speed of our complaints handling. Our cases are subject to regular and rigorous spot checks, and we are continually seeking to further improve our quality assurance mechanisms.

Customer service - feedback from public bodies and complainants

In August 2009 we posted on our website the results of our survey on public service organisations' views of our service. An independent company carried out the research for us, and received a response rate of 54% (82 returns from a total of 152). Satisfaction with our case handling service and our general advice and guidance on complaints handling was high. There were three areas where satisfaction levels were slightly lower and where we have taken steps to improve. The full survey results and our actions are available on our website.

In 2009 –10 we began a project to begin collecting data on complainants' views of our service in the first quarter of the year. The data will be compared with the feedback from complainants in the first quarter of 2010 –11.

Local Government

Local authorities are responsible for delivering a wide range of services to communities across Scotland. More and more often they now do so in partnership with other organisations, some of which are directly within SPSO jurisdiction, some of which are not. Local authorities also use other organisations to provide services on their behalf. Where an organisation over which we do not have jurisdiction, such as a charity or a private contractor, is delivering a service for a local authority we can look at a complaint about maladministration in the delivery of that service. So the range and type of bodies into whose activities we may enquire is also very wide.

Enquiries and complaints received

In 2009 –10 we received 1,734 complaints about local authorities. This figure represents almost 53% of the total complaints we received, maintaining similar proportions to those recorded in the last three years.
We also received 125 enquiries about local authorities, half the number received in the previous year and reflecting the overall trend towards a decrease in enquiry numbers.

Top 10 subjects of local government complaints received 2009 – 10

Housing	**434**
Planning	**265**
Social work	**199**
Finance	**142**
Education	**94**
Roads & transport	**94**
Legal & Admin	**90**
Environmental health & cleansing	**71**
Recreation & Leisure	**73**
Building Control	**36**

What happened to these complaints?

During the year we determined a total of 1,837 complaints about local authorities. This included a number of cases carried forward from 2008 – 9. As we say in the casework performance section of this report, the majority of complaints we handle are concluded without the issue of a published report[4]. We published 50 reports about local authority complaints. Of these, we fully upheld 12 (24%), partially upheld 25 (50%) and did not uphold 13 (26%).

4 For a full breakdown of the outcome of all complaints, see the Statistics section.

Recommendations in council complaints

As a result of determining these complaints, we asked 21 different councils to take action to sort out individual problems and to reduce the risk of them happening again. These included:

- improving communication with clients about needs assessments
- improving Social Work Complaint Review Committee procedures and improving guidance for Committee members
- reviewing and improving procedures for investigating allegations of bullying in schools
- putting in place a policy and guidance for dealing with requests for support for home-educated children
- taking immediate action in respect of planning enforcement notices
- discussing a future care package with a complainant
- discussing and agreeing required home repairs with a complainant
- apologising fully for failings in council procedures, complaints handling and timescales
- auditing complaints procedures and improving on them
- apologising for failures in referral to mediation
- ensuring staff understand the relevant procedures

The case studies at the end of this chapter give more information about some of the investigations that resulted in these recommendations.

Issues in local authority complaints

We commented in last year's annual report on the number of complaints we handled that were premature (i.e. that had not fully completed the complaints process of the council complained about). This year the number of premature cases rose to 1,043, although as a percentage it remained steady, at 60% of the total. We know that complaints brought to us too early signal potential frustration for both complainant and council. We have continued to work with authorities to reduce the number of complaints that reach us prematurely.

There has been little change in the type of issues complained about. Complaints about housing, planning and social work still top the list. Housing is discussed in a separate section on page 24 of this report. Both that section and the Equalities and Diversity section on page 34 contain case studies drawn from complaints about local government.

More elements of the Planning etc. (Scotland) Act 1996 were implemented in the course of the year and the resultant changes to the planning system may affect future complaint numbers. Some established practices changed during 2010 – for example, planning officers, rather than council committees, now handle a larger proportion of applications; the planning authority are now responsible for telling neighbours that a planning application has been made; and the range of minor developments (usually to private homes) that do not need specific planning permission will increase. These are all issues about which we can and do receive complaints.

During 2009 –10 we produced new leaflets for the public about various areas about which we often receive complaints, including planning. The leaflets are intended to help explain the sort of things that we can and cannot look into, and to highlight to the public some of the areas where things have changed.

We have always received relatively high numbers of complaints about planning. In 2009 – 10 planning complaints were second only to housing issues in terms of those received about local authorities. This repeated the pattern of the previous year. It is not yet clear what effect the changes to the planning system will have, as planning complaint numbers had not increased significantly by March 2010. This, however, may change as new complaints about these and other issues work their way through the system in 2010 – 11. If so, we will reflect on this in next year's annual report.

In his introduction, the Ombudsman refers to a case that illustrates the kinds of issues we anticipate will be raised with us in these straitened times. A Council decided to close leisure facilities including a popular local theatre and this became the subject of a strong local public campaign opposing the closures. We received 54 complaints from local residents who complained that the Council had failed to consult properly on the closures, and as is our practice, we selected a representative complaint to investigate in more depth. We reported on this complaint in May 2010 (Ref: 200803019). We did not uphold the complaint as we found that there was no specific duty on the Council to consult the public about such decisions, although we did recommend that they reviewed their engagement and communications strategy.

Case Studies

All of these reports can be read in full on our website. There are more local authority case studies in the Equalities and Diversity section of this report.

Housing benefit > Case: 200800154

Mr C raised a number of concerns about the Council's administration of housing benefit for one of his tenants. He complained that they failed to properly investigate the tenant's personal circumstances or follow the correct procedures when paying housing benefit and that he suffered financial loss as a result. We upheld all his complaints and recommended that the Council apologise and pay him an amount equal to the relevant outstanding rent arrears from his tenant. We also recommended that they remind staff of the Council's internal procedures for telling interested parties about decisions relating to Local Housing Allowance accounts.

Case Studies

Handling of planning application > Cases: 200701748 & 200801358

Mr and Mrs C and Mr and Mrs D are two sets of neighbours whose properties sit either side of a residential property for which planning permission for an extension was granted. They complained about the Council's handling of the planning proposals for the development and subsequent amendments to the consent. We upheld the complaint about the planning proposals as the report that council officers submitted to the planning committee was flawed. We recommended that the Council review their procedures to ensure they contain clear advice on reporting to the relevant committee where premature works have been carried out; that the Council apologise to the complainants for the shortcomings identified in our report, and that they pay towards the complainants' expenses. Although we did not uphold a complaint that the Council delayed and failed to reply to Mr and Mrs D, we recommended that in any ongoing service review the Council examine and consider improvements in how they handle correspondence.

Planning: enforcement > Case: 200801806

Mr C complained that the Council did not take effective enforcement action against unauthorised works by the owners of a disused quarry site next to his home. In particular, he was concerned that the Council failed to ensure that the site owners complied with conditions in the Council's 2004 Planning Enforcement Notice. The Council had been actively involved in these issues over many years. However, despite the serving of the Enforcement Notice, the terms of which had to some extent been complied with, they had in fact failed to take effective enforcement action. We upheld Mr C's complaint and the Ombudsman recorded his serious concerns about this failure. We recommended that the Council take immediate action to obtain and act upon an independent consultant's report, which we said should recommend steps to ensure final compliance with the existing Enforcement Notice. We further recommended that the Council write to those neighbouring the site to apologise for these failures, and carry out a full review of enforcement practice taking into account relevant planning circulars and advice.

Social Work: Complaints handling > Case: 200600993

Mrs C and her daughter, Ms B, complained to the Council about care services provided to Mrs C's parents. Mrs C and Ms B raised a number of concerns about their complaint, and eventually complained to me that the Council failed to handle it properly. We upheld the complaint and recommended that the Council reflect on their handling of it, and on the specific communications failings identified in the report, and that they remind staff of the importance of effective communication. We also recommended that they apologise to Mrs C and Ms B.

Case Studies

Bullying at school > Case: 200700224

Mrs C said that her daughter had been the victim of bullying at school. She complained that the school had not recorded incidents of reported bullying clearly or managed the reports of bullying in line with the Council's procedures. She also complained that the Council failed to convene a Complaints Review Committee (CRC) to consider aspects of a complaint against the Council's social work department. We upheld all Mrs C's complaints and made several recommendations to the Council as a result. These included: supporting the school in reviewing and clarifying their recording criteria and record keeping and development of appropriate contingency plans for the future; ensuring local policies are adhered to, and reviewing their own practice to ensure that CRCs can be held within set timescales. We also recommended that they apologise to the family.

Home education > Case: 200701741

Mr C's son, Child A, was being home-educated, and Mr C asked the Council if they could arrange access to formal exams. It was agreed that Child A could attend specific classes at the nearest school and sit exams there at the end of the school year. Child A attended school but teaching staff objected and he was sent home. Mr C complained to the Council and was unhappy with the delay in their response and the response itself. When investigating the complaint, we found that the information the Council provided was incomplete, lacked evidential backing and was contradictory. We fully upheld Mr C's complaints. We found that the Council failed to honour a commitment to admit Child A, acted unreasonably in refusing to consider enrolling him in individual classes and handled Mr C's complaint inadequately. In saying this we noted our existing concerns about complaints handling within the Council, expressed in previous reports. We recommended that the Council apologise to Mr C and Child A separately and in full for the failings; consult appropriately and put in place policy and guidance to handle future requests for support for home educated children, and undertake a significant audit of their complaints handling processes and procedures, reporting the results to SPSO at quarterly intervals. We further recommended that they remind staff of the need to ensure that statements about Council decisions, and the Council's investigation of complaints and responses to the SPSO, are evidence based. In view of these findings, the Ombudsman met the Chief Executive and the Leader of the Council to discuss his concerns, and to seek reassurance about the implementation of the recommendations.

Statutory repairs notices > Case: 200801344

Mr C complained about the way in which the Council administered repair works to a private tenement. These were instructed as a result of statutory notices served under local legislation. When the owners failed to carry out the works, the Council were requested to intervene. There was a considerable delay before the works were carried out, and Mr and Mrs C ended up with a much larger bill than they expected for a property that they no longer owned. As the Ombudsman's jurisdiction is restricted by the terms of the Scottish Public Services Ombudsman Act 2002, we could not comment on the contractual elements of this case. It was, however, clear that there were significant delays while the scope of the work was decided and that costs rose partly as a result of that. We partially upheld the complaint and recommended that the Council review the extent to which they were responsible for the delays and increase in contract price, and commute part of their administration charge to Mr and Mrs C as a result.

Health

Like local authorities, healthcare providers deliver a huge range of services to the people of Scotland. They too are increasingly involved in partnership working, often with social work departments through mechanisms such as Community Health and Care Partnerships.

We work with the Health Directorates of the Scottish Government and with individual Boards and healthcare providers to help identify issues and their solutions. The Ombudsman's health advisers, who provide him with specific professional advice on the medical and nursing elements of complaints, are part of that process.

Enquiries and complaints received

In 2009 – 10 we received a total of 904 contacts about the NHS. This was an increase of 18% on the previous year. 45 of these contacts were enquiries and 859 were complaints, reflecting the trend of a reduction in enquiries and an increase – in this case 25% – in the number of complaints received compared to the previous year.

As last year, the top area complained about in health was General Practitioners and GP practices, with 24% more complaints received than in 2008 – 09. As primary health care is the contact that people are most likely to have with the NHS, it is not surprising that this is also the main area about which we receive complaints.

Top areas of health complaints received 2009-10

General Practitioners and practices	**189**
NHS Boards (including special boards and NHS 24)	**117**
Hospitals – General Medical	**81**
Dental and Orthodontic Services	**74**
Hospitals – Care of the elderly	**60**
Hospitals – Psychiatry	**52**
Hospitals – General Surgical	**37**
Hospitals – Gynaecology and Obstetrics	**29**
Hospitals – Orthopaedics	**23**
Hospitals – Oncology	**19**
Accident and Emergency	**19**

Drilling down a little more into the figures of the complaints we received, we find that there has been little change in the type of specific issues complained about, compared with previous years. Complaints about clinical treatment and diagnosis, policy and administration and communication/staff attitude/dignity/confidentiality still top the list. It is worth noting that although it is a subject that has received a lot of media attention, we received very few complaints specifically about hospital hygiene. The subject of dignity in care, however, featured in a large number of our reports this year, particularly those about older people, and is of considerable concern. We frequently receive complaints where the dignity that should be afforded to older people is absent and we illustrate two examples in the case studies section below.

Top 10 subjects of health complaints received 2009 — 10

Clinical treatment/diagnosis	412
Policy/administration	158
Communication/staff attitude/dignity/confidentiality	91
Appointments/admissions	48
Complaints handling	20
Admission, discharge and transfer procedures	15
Nurses/nursing care	9
GP/Dentist lists	8
Hygiene, cleanliness and infection control	7
Record keeping	7

What happened to these complaints?

During the year we determined a total of 951 complaints about health authorities. This included a number of cases carried forward from 2008 – 09. As we say in the casework performance section of this report, the great majority of complaints we handle are concluded without the issue of a published report[5]. We published 74 investigation reports about NHS-related complaints. Of these, we fully upheld 33 (45%), partially upheld 32 (43%) and did not uphold 9 (12%). Many of these complaints were about multiple issues, with only the main issue registered shown on the table to the left. The actions that we asked Health Boards and healthcare providers to take were, therefore, diverse.

Recommendations in health complaints

As a result of determining these complaints, we recommended that 30 different practices or hospitals in 13 different Health Boards (or indeed the Boards themselves) carry out various actions. These included that they:

- ensure a proper multi-disciplinary approach to patient care
- review pain management documentation and recording
- ensure that relevant staff understand the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance
- analyse why pressure ulcers developed and why there was then no proactive treatment
- undertake an external peer review of nursing care
- improve supervision arrangements for junior staff
- develop more effective and practical policies for dealing with a breakdown in doctor-patient relationships and for referring patients between services
- consider how hygiene standards can be tracked and monitored
- review and improve clinical and administrative record keeping
- review and improve policy and guidance for staff and show that relevant training has been provided
- review and improve communication with patients and their relatives
- apologise for poor complaints handling and improve processes
- apologise for poor treatment/misdiagnosis/inadequate nursing care
- apologise for failing to obtain informed consent for clinical procedures

5 For a full breakdown of the outcome of all complaints, see the Statistics section.

The following case studies provide more information about some of the investigations that resulted in these recommendations. In particular we highlight a case where the Board took significant and meaningful action to address the failures that our investigation highlighted. Many health complaints tell a story of things going wrong, sometimes with tragic consequences. It is important to point out that the fact that we have highlighted a case in this annual report does not mean that other cases are of less importance or are less valid. Each person who complains has their own reasons for doing so. Most often they say they do not want anyone else to suffer in the way they or their relative did.

The cases below, some of which make harrowing reading, show the positive things that can happen when a complaint highlights failures in care and treatment, if the mistakes are then treated as learning experiences for the wider healthcare community. The first case (Ref: 200702913) is a particularly good example of this.

Every month we issue the Ombudsman's Commentary to all the authorities under SPSO jurisdiction, MSPs and the Scottish Government plus many other stakeholders, in order to more widely share the learning and good practice that emerges from complaints.

Case Studies

The Equalities and Diversity section on page 34 also contains case studies drawn from complaints about healthcare providers. All reports can be read in full on our website.

Pressure sores and care of the elderly > Case: 200702913

Mr C's late father, Mr A, suffered serious pressure sores (clinically known as pressure ulcers) in hospital after an operation on both knees. Mr C felt that the decision to operate was not taken appropriately and that postoperative care was inadequate. Mr C was also unhappy about communication with him and his family. Our nursing adviser, who gave advice on this case, said these were the worst such sores she had seen in her career. We upheld all the complaints and made eleven significant and detailed recommendations. As well as asking the Board to provide a full apology, the recommendations included analysing the reason for the sores developing, providing policy and guidance on the assessment and treatment of pressure sores and providing details of an audit made in response to an SPSO report in an earlier case where communication problems were identified. We also recommended that the Board fully audit documentation in the ward concerned, undertake an extensive external peer review of nursing care there and provide details of all the audits and action plans resulting from the recommendations. We partially upheld Mr C's complaint about the way the Board responded to him, to the extent that there was a delay in responding with no reasonable explanation provided.

In September 2009 the Ombudsman was pleased to issue a press release in which he commended the Board for the actions they had since taken in learning from the lessons of this particularly harrowing complaint. He said *"I am very pleased with the way the Board have started to implement the recommendations in my report. Their response has been swift, thorough and systematic. Their actions demonstrate that the report has been studied in detail, lessons have been learned and steps put in place to improve health services not only in the hospital concerned, but across [the Board area]. We will be following up with the Board to ensure that they carry through the actions to which they have committed. I commend their response to date and would encourage other bodies to adopt a similar approach when presented with the findings and recommendations of my complaint investigations."*

Case Studies

Genetic testing > Case: 200800801

Mr C was tested and diagnosed in his early thirties as a likely sufferer of Huntington's disease (HD), an incurable hereditary neurological condition causing deterioration in later life. The understanding that Mr C would develop HD, and that his daughters had a 50 per cent chance of being affected by the condition, caused a great deal of anxiety for the family and led them to make certain life choices. The test in which Mr C tested positive for HD in 1989 carried a four per cent probability of error. In 1993 a more accurate test was introduced but Mr C was not re-tested with this until 2007. When tested, he did not have the disease. Mr C and his wife complained that, had re-testing been routinely provided when more accurate tests became available, much stress would have been avoided and different decisions made about their daughters' future. Although we found that the general position of the Board on re-testing was reasonable, we found that in Mr C's particular case it was far too long before he was offered a re-test, especially as he was not displaying symptoms of HD. We therefore upheld the complaint that the Board did not act reasonably in failing to re-test Mr C for HD after the introduction of more accurate tests. We recommended that the Board remind clinicians of the importance of open discussions of new genetic tests with affected patients in order to enable them to make informed choices and of the importance of recording such discussions and the information provided to patients.

Cancer diagnosis and treatment, complaints handling > Case: 200801379

Mr C was diagnosed with cancer, and had part of a lung removed. After the operation, it was found that the tissue removed was not cancerous. Mr C complained that the operation was unnecessary, and that hospital staff delayed in telling him of the change in diagnosis and did not fully answer his questions. He also complained that there was a delay in putting him back on the kidney transplant waiting list and that the Board's response to his complaints had been inadequate. We upheld all his complaints and noted our medical adviser's view that it would have been possible to diagnose the problem more accurately before operating. In this case, the Ombudsman also noted his personal concern about the use of a particular procedure, which our adviser said might not have been the best way to diagnose the problem. We asked the Board to apologise to Mr C, carefully reflect on his case and quickly audit and review the use of the procedure in the hospital. We recommended that they emphasise to staff the importance of documenting a full clinical history, and the importance of appropriate communication and file management. We also recommended that they urgently review the operation of their complaints process and the relationship of this to clinical governance; ensure that staff who handle complaints follow the relevant procedure, and establish why no incident review was considered as a result of this complaint.

Case Studies

Palliative care; care and treatment; staff attitude; complaints handling

> Case: 200602412

Mrs A was admitted to hospital with breathing difficulties, but did not respond to treatment. It was decided, with the agreement of Mrs A and her family, to pursue palliative care only. Mrs A's daughter, Mrs C, raised several concerns about the care and treatment provided to her mother after that decision was taken, and about the actions of some members of staff, particularly an inappropriate conversation initiated by bed managers in Mrs A's room. We upheld all Mrs C's complaints. We recommended that the Board apologise to Mrs C for all the shortcomings identified in the report, particularly for the actions of the bed managers; and that the incident is discussed with both bed managers at their annual appraisals. We found that a proposal to move Mrs A to a six-bedded bay where her family were unlikely to have unrestricted access to her was inappropriate. We recommended that the Board review the operation of the Palliative Care Manual in relation to the bed management of terminally ill patients. We also recommended that the Board review their pain management documentation and recording and remind staff of the importance of documenting in the patient's clinical records concerns raised by patients and their families. We found the adequacy and delivery of medication and a failure to review medication to be inappropriate and made recommendations including conducting an audit in prescription chart recording over a six month period, and ensuring that night staff recognise when there is a need to contact on call staff to review medication for patients in pain. Finally we found the Board's response to Mrs C's complaint to be inadequate and that specific staff directly involved in some of the incidents reported had not been approached. We recommended that in future the Board ensure that information is obtained from the staff involved to allow complaints to be investigated appropriately and that all issues raised in complaints are addressed.

Still birth and treatment of bereaved parents > Case: 200800763

Mr C and his partner, Ms C, were unhappy about the care provided to Ms C during pregnancy. Their daughter was, sadly, stillborn. Mr and Ms C said that a number of warning signs were missed and, in particular, that a scan which showed the umbilical cord near their daughter's neck should have been followed up. They also said that post-natal care and the response to their complaint were inadequate. We upheld their complaint that Ms C's care and treatment was inadequate as we found that a deceleration of the fetal heart rate was not noted or followed up. However we also noted that it was not clear from the evidence that the outcome would have been any different had follow-up taken place. We also upheld the complaint that inadequate support was provided to Mr and Ms C after their bereavement, and partially upheld the complaint about the Board's response as full information was not provided to Mr and Ms C at the time of their complaint. We recommended that the Board review the following: midwives' training; the use and purpose of telephone call records; supervision arrangements for ante-natal clinics, and their standard care pathway for bereaved parents. We also recommended that the Board take into account the need to provide the fullest possible information when responding to complaints. Finally, we recommended that the Board apologise to Mr and Ms C for their failures to respond appropriately to the fetal heart rate deceleration and to communicate properly with Mr and Ms C's GP, and for the time taken to provide them with information about counselling.

Housing

We use this section of the annual report to provide information about social housing issues. This covers homes rented from both councils and registered social landlords (RSLs). Housing is the area where we find both the highest number of complaints received prematurely, and the largest number where we can make an impact at an early stage after the complaint reaches us. As already explained, we do not normally take a complaint to a formal report if we can intervene and achieve a suitable outcome. This both saves public money and resolves the complaint. Where we find something has gone wrong and think it can be fixed by a call from us, we will always try and do that. Our new process of early resolution should help further with this in the year ahead.

The rate of complaints reaching us too early (premature complaints) dropped this year to just under 59%, although this is still higher than in other sectors. And there was a difference between councils and RSLs in the rates of premature complaints received (see across).

Looking forward, it seems likely that public sector budget reductions will impact on this sector, and may affect complaint numbers in future. The Chartered Institute of Housing recognise this in their report *New Climate, New Challenges* (March 2010) when, talking about RSLs, they say '*There is no question that the … sector is in a challenging place right now with a formidable mix of factors to contend with – the economic climate, legislation, compliance, regulation and competition being just the most obvious of these.*' This, of course, was written before the emergency Budget of June 2010, in which reforms to housing benefit were announced. Cuts to the Housing Association Grant, further restrictions on Right to Buy and the passage of the Housing (Scotland) Bill are also likely to have an impact. So the way ahead is one of more change and of authorities adapting and reviewing their strategic focus to meet these challenges. Despite all of this, however, good complaints handling should still be a focus and we hope that we will help with this in our future role as Complaints Standards Authority, and by providing support through our Training Unit.

Local Authorities and Housing Associations

33 enquiries and 755 complaints about housing issues reached us during the year, totalling 788 contacts. This is a decrease of more than 8% on the previous year. Most of this, however, was due to a reduction in the number of enquiries we handled, with the number of actual complaints remaining fairly steady, dropping by only seven during the year. The categories most complained about also remained much the same, with another rise in the number of complaints about neighbour problems and a welcome drop in those about complaints handling. Complaints about housing benefit and council tax benefit rose by 44%.

Top subjects of housing complaints received 2009—10

Repairs and maintenance of housing stock	200
Policy/administration	143
Neighbour problems/ anti-social behaviour	124
Applications, allocations, transfers	79
Capital works, renovations, improvements, alterations, modifications	47
Housing Benefit/Council Tax benefit (Local authorities only)	36
Homeless person issues	31
Rents and tenancy charges	23
Complaints handling	21
Factoring and other services	17
Right to buy	10

What happened to these complaints?

We determined a total of 782 complaints (local authorities and RSLs) during 2009 –10, including some carried forward from the previous year. As we say in the casework performance section of this report, the great majority of complaints we handle are concluded without the issue of a published report[6]. 85% of the complaints were determined in the early stages of our process, most because they were premature (i.e. the complaint had not yet gone through the complaints process of the authority complained about). Of the remaining 15%, 107 complaints were determined at the examination stage, and nine at the investigation stage. Of the nine, one was discontinued as the complainant did not respond to enquiries, and the remaining eight were the subject of reports to the Parliament. One was not upheld, five were partially upheld and two were fully upheld.

Recommendations in housing complaints

Our investigations resulted in SPSO recommending that housing providers act on the following:

- consider asking insurance agents to revisit a claim from a tenant
- improve their policy on compensation claims
- refund part of the rent paid over a 14 month period during which required remedial work was not carried out
- use the learning from complaints to improve procedures
- apologise for disruption and inconvenience caused to a tenant
- discuss and agree required home repairs with a tenant

6 For a full breakdown of the outcome of all complaints, see the Statistics section.

Issues in housing complaints

Anti-social behaviour/neighbour complaints again take third spot in the top twelve subjects of complaint made to us, and again the numbers rose slightly this year. We recognise that such complaints can be very hard to handle, as often it simply comes down to one person's word against another. The case about this issue that we investigated and published during the year revealed record keeping issues rather than maladministration in handling the anti-social behaviour issues.

As mentioned above, in 2009 –10 the highest numbers of premature complaints we received were about Registered Social Landlords. 77% of these complaints arrived with us at a point where we could do nothing with them as the person had either not complained at all to the RSL, or had not completed its complaints process. As we have been working with authorities in the sector and with the Scottish Housing Regulator and other relevant bodies to try to reduce the rate of premature complaints, it is disappointing to find this reflected in the statistics.

We cannot say exactly why this happens, but anecdotal evidence suggests that it is do with people feeling angry, upset or frustrated. People's homes are very important to them and so they try to take early steps to do something when a problem arises. When we get these kinds of complaints, we do what we can to make sure the person knows the right way to go about complaining. We recognise that the staff of housing providers take this very seriously. But RSLs must continue to do whatever they can to make sure that members of the public know how to complain to them. It is vital that frontline staff are aware of the importance of the messages that come from complaints. Proper signposting through the relevant complaints process can mean a much earlier resolution of a problem for the tenant, and a reduction in the number of complaints that we receive too early.

It is, however, encouraging to note that the premature rate for complaints about local authority housing issues has dropped from 71% to 45%, albeit against a background of a drop in premature complaints in the local government sector more generally. Of the total of 1,859 contacts we received about local authorities in 2009 – 10, almost 25% related to housing. Nineteen of these were enquiries and 432 were complaints. 27% of the complaints concerned repairs and maintenance.

Not all local authorities, of course, have housing within their remit, as stock transfers have taken place and housing stock has moved into the ownership of RSLs. One example of where this has happened is Glasgow Housing Association (GHA). Here second stage transfers of housing stock originally transferred from Glasgow City Council to GHA have also been taking place, although at a slower rate than originally envisaged.

Case Studies

All the reports can be read in full on our website.

Time taken to repair damage to property > Case: 200602445

Mr and Mrs C were tenants of a housing association. When the Association carried out renovation work to neighbouring apartments, Mr and Mrs C complained that their property sustained substantial internal and external damage. Although the Association held a Committee hearing, then took action to repair the damage and to reimburse Mr and Mrs C, the couple were unhappy that all repairs were not then completed in good time. We upheld this complaint as, although the Association eventually took commendable action to resolve the situation, the disruption around, and the completion of repairs to, Mr and Mrs C's property took far longer than anticipated. We did not, however, uphold a complaint about the Association's communication. We recommended that the Association refund part of Mr and Mrs C's rent for the further 14 month period during which they were waiting for the repairs to be completed, and review the case to see if procedures could be improved to avoid this happening to anyone else in future. We also recommended that they apologise to Mr and Mrs C for the disruption and inconvenience experienced.

Record keeping in relation to anti-social behaviour > Case: 200602882

Mr and Mrs C complained that the Council failed to respond appropriately to complaints they made about a neighbour's alleged behaviour; mainly to do with noise. We upheld Mr and Mrs C's complaints that their telephone calls to the Neighbour Complaints Unit and meetings with Housing Department officials were either not recorded or not fully recorded, but as the Council had already taken steps to improve practice in these areas, we recommended only that the Council apologise to Mr and Mrs C for this. We did not uphold the complaint that the Council failed to take appropriate action in response to Mr and Mrs C's complaint of anti-social behaviour.

Liability for damage > Case: 200701713

Mrs C was the tenant of a house owned by an Association. She complained that a faulty boiler in her kitchen caused soot damage requiring redecoration and the replacement of blinds and curtains. She complained that the Association dismissed her claim for recovery of these expenses without adequately investigating the damage caused by the faulty boiler. She was also unhappy with the Association's complaints handling. We partially upheld her complaint about the investigation of the damage, to the extent that the Association could have done more to investigate the source of the soot that had caused it. We recommended that the Association introduce a policy of seeking third party liability determination for compensation claims where the claim is for amounts higher than the insurance policy excess, and for all claims that require expert technical opinion; and that they consider asking their insurers to reinvestigate Mrs C's claim.

Homeless procedures > Case: 200800711

Mrs C was made homeless when she was evicted from a privately rented property. She was unhappy about the service that the Council provided to her at that time, in that they did not collect her belongings for storage and did not compensate her for their loss. We found this to be the result of an internal failure to pass on relevant information. We upheld Mrs C's complaint that the Council made inadequate arrangements to uplift and store her personal belongings when she was made homeless. As they have since reviewed all their homeless procedures, we recommended that they tell us about the measures introduced as a result of that review. We also said that they should share the investigation report with their insurers, so that they could reconsider whether the Council were in any way liable for the loss of Mrs C's property; and apologise to Mrs C for the poor service experienced.

Scottish Government and Devolved Administration

This sector includes all the departments and directorates of the devolved Scottish Government, which handle the broad range of policy issues involved in government. It covers Scottish non-departmental public bodies, other devolved Scottish public bodies, and cross-border authorities when they are acting in a Scottish capacity. These organisations handle a wide range of diverse issues, from housing to environmental protection, from enterprise to crofting, and beyond. As we pointed out last year, the administrative activities of these bodies are generally within our jurisdiction but numbers of complaints received tend to be lower in this sector because they deliver far fewer direct services to the public. Also, as the complaints brought to us are often about aspects of these authorities' work that is outwith our jurisdiction, this is an area where there will always be a substantial number of complaints that we cannot take further after they reach us. This is demonstrated by the statistics below.

Enquiries and complaints received

In 2009 – 10 we received 22 enquiries and 241 complaints about bodies in this sector. This represents 7% of the contacts received over the year and a 9% increase on the 2008 – 9 caseload for this sector. The table shows the broad subjects of complaint along with the total of enquiries and complaints received under each heading. Some contacts were made with too little specific information for us to be able to categorise them.

There was a significant reduction in the number of complaints about planning, which reduced from 39 (top of last year's list) to only ten. This year financial matters topped the list, followed by issues about courts administration. Financial matters include complaints about legal aid, student awards and bankruptcy issues, and courts administration relates to the Crown Office and Procurator Fiscal Service and the Scottish Courts Service. Although in 2009 – 10 we received an increased number of complaints in both areas, it is worth noting that unless the complaint is about administrative matters, we are very limited in what we can take further. This is because of restrictions on the Ombudsman's jurisdiction as set out in the Scottish Public Services Ombudsman Act 2002. Put very simply, we are generally prohibited from investigating anything involving court cases, legal matters or where there is a legal solution.

This is demonstrated by the fact that although we determined 250 complaints about the Scottish Government and devolved administration, we completed 247 of these without the need for a formal investigation. None of those we investigated related to either of the two main subjects of contacts received. We investigated and reported on only three complaints from this sector, of which we fully upheld one, partly upheld one and did not uphold the third.

Top 10 subjects of Scottish Government and devolved administration complaints received 2009—10

Financial matters	40
Courts administration	36
Care & health	28
Justice	24
Education	17
Agriculture, environment, fishing and rural affairs	17
Ombudsmen/Commissioners	13
Planning	10
Enterprise bodies	7
Roads & transport	7

Scottish Government

We received 114 complaints about departments or directorates of the Scottish Government. 43 of these were either about courts administration or financial matters. As explained above, these are areas where we can rarely investigate.

We determined 127 complaints, of which three were the subject of a formal report to the Parliament. We discontinued one complaint at the investigation stage.

Scottish public authorities and cross border public authorities

We received 105 complaints about Scottish public authorities, and five about cross-border authorities acting in Scotland on Scottish matters. The main areas complained about were financial matters and care and health. We determined a total of 123 complaints for Scottish public or cross-border authorities. None of these was the subject of a report to Parliament.

Recommendations in Scottish Government and devolved administration complaints

Our investigations resulted in recommendations that the relevant bodies act on the following:

- review a specified complaint to see where communication could be improved
- ensure that agencies acting on their behalf fully understand their responsibilities
- apologise for confusion and delay in handling an application
- apologise for poor complaints handling

Case Studies

All of the reports can be read in full on our website.

Handling of grant application and communication > Case: 200800277

Mrs C complained about the handling of her application for a Rural Home Ownership Grant (RHOG). She complained that the grant provider and their local agents failed to follow the correct procedures, or to communicate with her properly, when processing her application. We upheld both complaints as the local agents had clearly failed to properly provide information to the grant provider on Mrs C's behalf. This both impacted adversely on her application in terms of time and misled her about her chances of success. We also found that communication from the agents to the grant provider and Mrs C was unclear and, indeed, caused confusion. We recommended that the relevant Directorate formally apologise to Mrs C for the confusion and delay and that they take steps, including producing clear guidelines, to ensure that their agents clearly understand all their responsibilities in respect of RHOG applications. We also recommended that they review this particular application to identify areas where communication with the agents could be improved.

Complaints handling > Case: 200702113

Mr C raised concerns about the handling of his appeal in respect of a proposed 'Alteration or Removal of Buildings or Works Order'. He was unhappy with the actions of the enquiry reporter and the conduct of a hearing. We did not uphold his complaints that the hearing and site visit were not conducted in a proper and fair manner and that documentation relating to the hearing was mismanaged. We did, however, uphold his complaint that his subsequent complaints were not fully considered, and recommended that the relevant Directorate apologise to Mr C for the lack of clarity in responses to his complaints. We also reminded them of the importance of clearly explaining their role and remit to members of the public, and any restrictions that may apply to these.

Further and Higher Education

We received a total of 13 enquiries and 91 complaints about authorities in this sector. The number of contacts was on a par with the previous year and represents just 2.5% of the total contacts received over the year. The tables show the subjects about which we received complaints, and the total complaints received under each heading.

Further Education

All subjects of further education complaints received 2009 – 10

Policy/administration	11
Grants/allowances/bursaries	5
Complaints handling	4
Personnel matters	3
Teaching and supervision	3
Academic appeal/exam results/ degree classification	2
Admissions	2
Student discipline	2
Facilities	1

We received 33 complaints about further educational establishments in 2009 – 10. We determined a total of 40 complaints including some carried forward from the year before. We reported to the Parliament on one of these. This is very similar to the 2008 – 09 statistics, when we commented on the difficulty of identifying trends or themes from such small numbers of complaints.

Higher Education

All subjects of higher education complaints received 2009 – 10

Policy/administration	20
Academic appeal/exam results/ degree classification	18
Teaching and supervision	7
Accommodation	2
Complaints handling	2
Welfare	2
Admissions	1
Grants/allowances/bursaries	1
Personnel matters	1
Student discipline	1
Other	1

We received and determined 56 complaints about Higher Education (HE) in 2009 – 10. Of these, we reported to the Parliament on four, and discontinued two cases at the investigation stage.

Although we receive a number of complaints about academic appeals, exam results and degree classifications in the HE sector each year, we cannot investigate academic decisions. We can, however, look at the process that the university followed when taking the matter through their appeal procedures. Although we only received two complaints that were specifically about complaints handling, this often features as an issue within a complaint. The four HE cases on which we reported all contained issues about complaints handling and, in two of the cases, this was the only part of the complaint that we upheld. This demonstrates a different ratio to other sectors, where the substance of the complaint tends to be the part that is upheld or partially upheld.

Issues about complaints handling often surface as a complaint progresses, and an SPSO investigation can highlight issues about the way in which an organisation's complaints processes have operated. The evidence from our published reports suggests that in this sector appeals processes tend to work well, but there may be some work to do on the actual handling of complaints as opposed to taking a matter through the organisation's academic appeals processes.

Recommendations in further and higher education complaints

Our investigations resulted in the following recommendations to five different educational establishments:

- review complaints procedures to accommodate situations where a combination of complaints of bullying and harassment, academic concerns and academic appeals are active at the same time
- review record keeping processes and processes for appeal hearings
- ensure that feedback from a student's supervisor or placement is clearly communicated, especially where there are concerns about the student's performance
- implement a policy for managing unacceptable behaviour
- ensure that accurate information is supplied when handling a complaint
- apologise for poor complaints handling

Case Studies

All the reports can be read in full on our website.

Supervision of PhD student and complaints handling > Case: 200801939

Mr C was a PhD student, and was not awarded the university qualification that he had hoped to attain. He was concerned that his Director of Studies said that Mr C had been made aware that his supervisory team had doubts about the quality of his work following a meeting he had with them. Mr C said that he was not made aware of any concerns. He was also unhappy that the Director of Studies had made allegations of research misconduct. Mr C said that he only became aware of these issues later, when he saw a letter written by the Director of Studies to a third party. He was also unhappy about the way the University handled the investigation of his complaint. We upheld the complaint about the claim that Mr C was aware of his supervisory team's concerns as there was no evidence that the University had ensured that Mr C was made adequately aware of these. We recommended that they apologise to Mr C for this failure; reinforce with supervisory staff the importance of properly handling such concerns, and ensure that supervisory staff are fully aware of the University's new Code of Practice when it is published. We did not uphold complaints about the allegation of research misconduct or about complaints handling. We did, however, make a general recommendation that the University reinforce to all staff involved in responding to student complaints the importance of providing a full response and, in particular, that the response includes details of any evidence considered during their investigation.

Complaints handling (supervision issues)

> Case: 200702441

Mr A, a university student, was on a teacher training placement at a primary school. His father complained that Mr A's supervision was inadequately monitored, and that the University failed to respond appropriately to Mr A's reports of bullying by the teacher in whose class he was placed. He also complained about the University's handling of appeals and complaints about these matters. We did not uphold the complaints about supervision or that the University failed in their duty of care to Mr A. We did, however, uphold a complaint about the way in which the University responded to the complaint about bullying and harassment and partially upheld a complaint about the conduct of Mr A's appeals. We made several recommendations including how the University might in future work with schools when a placement student gives cause for concern; reviewing relevant policies and procedures with particular regard to timescales, recording information and adopting a holistic approach to matters where there are a number of appeal and complaint policies involved; and that the University apologise to Mr A and Mr C for the shortcomings in complaints and appeal handling.

Complaints handling (academic appeals)

> Case: 200702367

Mr A failed a final year art college module and appealed this, first to the College and then to a University under a special arrangement. Mr A's father complained about the College's handling of these appeals. We did not uphold most of his complaints, but did uphold a complaint that the College's responses to the University were inadequate. We recommended that in future the College should comply with requests for comment. We partially upheld complaints about the College's handling of Mr A's initial approach and about the time taken to deal with the appeals, and made several recommendations including providing appellants with specific appeal-related information at an early stage; ensuring that information provided by the College to the University can be substantiated, and devising a policy for managing behaviour considered unacceptable.

Equalities and diversity

We are committed to making our service as accessible as we can. Like all public bodies, we have a duty to ensure that we anticipate and meet people's individual needs. One way of doing this is by monitoring who uses our service, as this gives us an indication of who we are reaching and who we are not. Revising our business processes provided an opportunity for us to review how we deliver our service and take steps to ensure that this is in line with best practice on equalities.

We also want to ensure that any learning from complaints about equality and diversity matters is shared as widely as possible. This year we reported on several complaints involving such issues. Some of these are featured in the case studies in this chapter. The evidence from these shows that public sector workers may not always be aware of their responsibility to take full account of the member of the public's needs in their particular situation.

Our actions on equality

Last year the Plain English Campaign approved our website, and awarded it Crystal Mark status. We added the Browsealoud facility, allowing the website to 'talk' to service users and to highlight information on screen. We also added audio versions of our five most requested leaflets. We produced an 'easy read' leaflet about what we do and how to complain, to improve accessibility for a range of service users, especially those with learning difficulties.

Monitoring our service

We continue to monitor information about who brings complaints to us. After taking advice from the Equality and Human Rights Commission we revised our complaints form and added further diversity monitoring categories. Our form also now specifically asks complainants to tell us if there is anything we can do to adapt our service to meet their needs.

In 2009 we had a 23% return rate on these forms. From these we found that:

- 52 per cent of complainants were male and 42 per cent female (6 per cent did not disclose their gender)
- about 25 percent of those who come to us described themselves as having a disability
- the number of people describing themselves as 'Black, Black Scottish or Black British – African' has doubled since 2008 but is still only 0.02%
- the single largest identifiable group of complainants was the 50 – 64 age group. This is a change from the last three years when the 35 – 49 age group were top.

Our monitoring data indicates that the make-up of our service users is broadly the same as the population of Scotland in gender and age, but there is variance in the area of disability and ethnic group.

Revising our business processes provided an opportunity for us to review how we deliver our service and take steps to ensure that this is in line with best practice on equalities.

According to the most recent census in Scotland (2001), the percentage of people who were classified as having a limiting long-term illness was 20.31%. This makes our figure of 25% higher than that of the general population. Our monitoring forms ask people to specify their disability, so that we can be sure that we are able to adapt our service to their needs. The national figure for Black Scottish or Other Black and African combined is 0.12%, and we have committed this year to working with other bodies to raise awareness of our service to ethnic groups and others that are under-represented, as well as to vulnerable groups.

We have reviewed our Procurement Policy to ensure that potential providers meet their equalities obligations. To ensure our own awareness of – and contribution to – the wider landscape, we are members of the Scottish Government's Scrutiny Bodies Equalities Group.

In 2010 – 11 we will take forward an equalities action plan including:

- continuing to build equalities into our processes, including accessibility of our service and reporting of areas of discrimination
- using our rapid equalities impact assessment on SPSO projects and policies
- scoping the possibility of podcasts and easyread versions of other leaflets
- working with equalities bodies for mutual understanding and improved partnership working, including how we can reach under-represented and vulnerable groups.

Case Studies

The following case studies illustrate some of the areas of diversity in which we have handled complaints. They include an important case involving a misunderstanding of the provisions of the Adults with Incapacity Act, which should be of interest across all sectors. The complaint involved a young man with a learning disability who was deeply upset by dental treatment he received, to which his mother ought to have been asked to consent. She was not, because staff misunderstood the provisions of the Act. We bring this to attention in this annual report because of the importance of understanding these provisions when considering issues involving adults with incapacity. As mentioned earlier in this report, authorities are more and more involved in joint working and another of the cases below illustrates our view on this. Where authorities need to work together to provide a care package, they should ensure that they collaborate to provide an effective multi-agency service.

The case studies come from across the various sectors about which we receive complaints. All the reports can be read in full on our website.

Case Studies

Consent to medical procedures on behalf of an adult with mental incapacity

> Case: 200700789

Mr A, who was 19, had a learning disability. This meant he did not have the mental capacity to make decisions about treatment or consent, nor to understand much of what was happening to him in hospital. He had a dental operation, under general anaesthetic, in a hospital's Department of Special Care and Sedation. His disability also meant that it was difficult to say in advance of the operation what work would need to be done, as Mr A found it difficult to sit still for examination or x-rays. During the operation a great deal of work was carried out, including nine extractions. After the operation, his mother complained that before the operation she had not been told about the possibility that so much work was needed. She felt that so much had to be done that it should have been spread across more than one surgical session, and complained that she did not have the chance to withhold her consent to all the work being done at once. The dental work had caused her son such distress that, amongst other things, he had been chewing his lip, which had become an open, infected sore. We found that the relevant staff did not appear to have properly understood the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance, and that the Board did not, therefore, properly seek Mrs C's informed consent to the operation as they should have done. We fully upheld the complaint and made several recommendations. These included an apology for the failure to properly seek consent and that the Board share the learning from the complaint across all their hospitals and disciplines, and use it as an example in induction and other training programmes. We also recommended that the Board consider revising their consent form in respect of adults with incapacity, ensure their own Consent Policy is followed in future, and satisfy themselves that relevant staff have an appropriate knowledge and understanding of the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance.

Education Maintenance Allowance > Case: 200800480

Mr C is a young man with severe learning difficulties and special educational needs. His mother, Mrs C, complained that his school did not tell her that Mr C was entitled to apply for an Education Maintenance Allowance (EMA), causing him to lose the opportunity to do so. We upheld the complaint as the Council were unable to say with certainty that the relevant information had been provided to the family. We recommended that the Council pay Mrs C £1,140 in lieu of the basic allowance payment and £300 in lieu of the bonus payment to which Mr C would have been entitled had he applied for and received an EMA for that session. We also recommended that the Council apologise to Mrs C.

Case Studies

Care package for adult with multiple disabilities > Case: 200801246

Mrs C raised concerns about the accessibility of further education for her son, Mr A, who is blind and has learning difficulties. She complained that a Council failed to take her son's specific needs into account when deciding what further education and personal care package they would fund. She felt that they had unreasonably dismissed funding a residential placement at a specialist college in England. They instead offered a local option, which Mrs C considered less suitable. Although we did not uphold her specific complaint, we recognised that as a result of the events described in the report Mr A encountered significant delay to the provision of his personal care package. This resulted in a gap in his personal development. We recommended that the Council apologise for this and pay Mr A a sum to adequately reflect the hardship and injustice caused to him and his family by the considerable delay in putting in place his care package. We also recommended that the Council review their procedures to ensure that in future service users are provided with details of proposed packages before they are asked for acceptance.

Adult with learning difficulties – care, treatment and communication

> Case: 200802400

Miss C, who was 28, suffered from myotonic dystrophy and had learning difficulties. She died in hospital after minor surgery on her parotid gland. Her father, Mr C, complained about the care provided to his daughter before and after surgery. He said that she was not properly assessed by a consultant before her operation and that her post-operative care and treatment was inadequate. He was also unhappy about the way in which staff communicated with the family. We upheld all of his complaints as we found that there had been significant failings by staff, especially given Miss C's learning difficulties. We made a number of detailed recommendations about the Board's arrangements, policies and procedures, particularly in relation to people with learning difficulties, which are described in full in the report. We also recommended that the Board provide an explicit, unambiguous and meaningful apology to Miss C's family for all the failings identified, and that they detail what they have done to try to avoid any similar occurrence.

Collaborative working between Council and Health Board

> Cases: 200701747 & 200800670

Mr C's oldest son has Autism Spectrum Disorder. Mr C said that the Board failed to provide a programme of intervention to meet his son's needs. He said that this caused considerable distress to the whole family because of the effects of his son's disability. He also said that the Council did not properly assess the family's needs or provide appropriate support. We did not uphold most of these complaints as we found that, in the main, both the Board and the Council acted appropriately. We did, however, find that the Council did not tell Mr C that from a particular date his son would lose his right to his 'banked hours' (i.e. unused support hours allocated to him that had been carried over from one financial year to the next). We recommended that the Council re-instate the unused hours of support for a period of time. We also recommended that both the Council and the Board note the Ombudsman's advisers' comments on the importance of multi-agency working in this case, and implement the advisers' suggestions on effective collaborative working. In particular, we recommended that stakeholders 'regroup' to re-establish and commit to effective future collaborative working arrangements in respect of Mr C's family, including a set of principles on which future care should be based.

Independent Service Delivery Reviewer's Report

Introduction

In 2009 – 10 we received service delivery complaints on 21 cases. Of these, 12 were fully or partly upheld and nine were not upheld. Six cases were escalated to the Independent Service Delivery Reviewer. The Reviewer's report below provides her account of those six cases, and the outcome of an additional four complaints that had been accepted in the previous year. We post the outcomes of all of the complaints we receive about our service on our website on a quarterly basis. Although it is difficult to identify systemic issues on the basis of such small numbers, we do have in place mechanisms to ensure that the lessons from service delivery complaints are fed back to the organisation. This takes place through formal reporting and action planning at Audit and Advisory Committee and Senior Management Team level.

Reviewer's Report

This is my first full year as Independent Reviewer, having been appointed in January 2009. I reviewed a total of 10 complaints. Most of the complaints I handled related to how the SPSO handled complaints about various public bodies in Scotland.

The issues raised included:

- Delays and the time taken to complete a report
- Issues regarding the Ombudsman's remit
- Lack of clarity regarding the detail of the complaint being considered by the SPSO
- Confusion in the period prior to SPSO deciding whether to investigate a complaint or not
- Use of SPSO advisers
- Issues regarding the transition period prior to the appointment of a new Ombudsman
- Perception of the independence of SPSO
- The SPSO's failure to follow its own policies and procedures for handling complaints about public bodies
- Signposting to the Independent Service Delivery Reviewer

Findings

Throughout my investigation of the various complaints certain themes reoccurred. These indicated areas of concern regarding the complaints handling process within the office. The major themes that arose were:

- Significant delays in the handling of complaints about public bodies
- Confusion regarding the detail of specific complaints (one complaint was changed four times during the investigation process)
- Confusion between the outcome (decision of the Ombudsman) and the process of investigation (service delivery)
- Lack of transparency in the process
- Categorisation of service delivery complaints
- Impact of controlling email contact

Recommendations

Following my investigation of a number of complaints I made a range of recommendations which I discussed with the Director of Complaints and Investigations and the then Director of Policy and Development. The key recommendations that I made for the office were:

- Greater clarification regarding what exactly is being investigated
- SPSO to agree a contract with the complainant at the beginning of the process
- Separation, at an earlier stage, of customer dissatisfaction regarding the outcome (decision of the Ombudsman) from process (service delivery)
- SPSO to resist making unrealistic promises regarding the completion of reports
- When delays arise, SPSO to keep the complainant informed and amend timescales accordingly
- SPSO to establish a policy for handling unacceptable behaviour in relation to email contact
- SPSO to streamline the initial stages of the process, prior to the decision to take on an investigation
- SPSO to conduct a review of current policies and procedures to highlight the separation of customer dissatisfaction with outcomes from complaints about process
- SPSO to ensure that all service delivery complaints include signposting to the Independent Service Delivery Reviewer
- In response to service delivery complaints, SPSO to ensure that the reply reflects the complainant's initial concerns
- SPSO to provide for an annual review and update for the Independent Service Delivery Reviewer

During this year I have worked closely with Jim Martin, the Ombudsman. I have been impressed by his commitment to quality and consistency. I applaud his efforts to provide a listening organisation that feeds back learning in order to improve. I have noticed that the level of complaints being referred to me recently has declined which I believe reflects the effect of the improvements put in place during the last year.

Ros Gardner
Independent Service Delivery Reviewer

Governance and Accountability

The Ombudsman, as Accountable Officer for the SPSO, is responsible for ensuring that resources are used economically, efficiently and effectively. The Office is subject to scrutiny by external auditors (currently Grant Thornton who were appointed by Audit Scotland in 2006), internal auditors (currently provided by the compliance team of the Scottish Legal Aid Board under a shared services arrangement) as well as through the laying of an annual report before the Scottish Parliament. The Ombudsman also gives evidence annually to the Parliament's Local Government and Communities Committee following the publication of the annual report, and holds discussions with the Scottish Parliamentary Corporate Body (SPCB) about the SPSO budget submission each year.

The Audit Advisory Committee (AAC) was established in June 2007 by Professor Alice Brown, who was Ombudsman until she demitted office in March 2009. The Committee evolved to become the Audit & Advisory Committee (A&AC) in February 2010 to reflect the development of the purpose of the Committee. Our remit is to work with the Ombudsman as a non-executive group, advising on the discharge of the functions of the Accountable Officer.

The Committee's purpose and duties are set out in the SPSO Scheme of Control. We support the Ombudsman (as Accountable Officer) and the Senior Management Team in monitoring the adequacy of the SPSO's governance and control systems through offering objective advice on issues concerning the risk, control and governance of the SPSO and associated assurances provided by audit and other related processes. The A&AC also provide a source of advice and feedback on SPSO Strategic Objectives and annual Business Plans.

I have continued to be accompanied on the Committee by Baroness Rennie Fritchie (Deputy Chair) and Mr David Thomas. This year we were joined by Mr John Vine. Rennie Fritchie is the former UK Commissioner for Public Appointments and a former Civil Service Commissioner. David Thomas is Corporate Director and Principal Ombudsman for the Financial Ombudsman Service. John Vine is Chief Inspector of the UK Border Agency. I am grateful to them for the quality of their contribution.

The Committee met four times in 2009 –10. Representatives from the SPSO's external and internal auditors attend our meetings and advise us in private each time, before we discuss with the Ombudsman the key operational priorities and risks. There were a number of key areas of focus for the Committee in 2009 –10 including supporting the new Ombudsman in office, reviewing the organisation's case handling process and making changes to the organisational structure.

The A&AC look forward to continuing their work with Jim Martin to further strengthen the effective monitoring of financial and governance policies and procedures, and support the integration and development of new services provided by the SPSO. The Committee greatly appreciates the support received from senior staff in carrying out its duties.

Sir Neil McIntosh
Chair of the SPSO
Audit and Advisory Committee

Financial performance

SPSO makes an annual budget application to the Scottish Parliamentary Corporate Body (SPCB). This is considered by 1st March each year (as part of the SPCB's expenditure plan) by the Parliament's Finance Committee and the Scottish Government. The SPCB's final expenditure proposals (including the SPSO's budget) then appear in the annual Budget Bill which is voted upon by the Parliament.

In 2009 – 10 we operated on a budget of £3.309 million with a total of 47 staff (full time equivalent). This equated to 79% of our total net expenditure being spent on staff costs, with three quarters of staff being directly involved in case handling. The table below details our major costs as per our statutory accounts over the past three years. In cash terms, the Scottish Parliament awarded the Ombudsman a budget of £3,277,000 for the financial year 2009 – 10, excluding depreciation. The Ombudsman's actual funding of £3.268 million was below budget.

Analysis of expenditure (summary)	actual year ended 31 March 2010	actual year ended 31 March 2009	actual year ended 31 March 2008
	£000s	£000s	£000s
Staffing costs	2,610	2,419	2,325
Other operating costs			
Property costs*	296	287	261
Professional fees**	149	148	195
Office running costs***	267	271	244
Total operating expenditure	3,322	3,125	3,025
Capital expenditure	2	160	28
Other income	-15	-11	-17
Net expenditure for the year	3,309	3,274	3,036
Staff employed (FTE Average)	47	47	47

* Including rent, rates, utilities, cleaning and maintenance
** Including professional adviser fees
*** Including ICT, Annual Report and publications

Full audited accounts are available on the SPSO website **www.spso.org.uk**.

Statistics

Cases determined in 2009 – 10 by sector, stage and outcome

Report Case Type	Stage	Closure Reason Group	FE & HE	Health
Enquiry	1 – Receipt	Enquiry	13	45
		Out of Jurisdiction (OOJ)		
Total Enquiries			**13**	**45**
Complaint	1 – Receipt	Discontinued	10	129
		OOJ		2
		Other		
		Premature	23	222
		Total	**33**	**353**
	2 – Initial Assessment	Discontinued	2	25
		OOJ	6	27
		Other		7
		Premature	14	75
		Total	**22**	**134**
	3 – Consideration	Body out of jurisdiction (not decided previously)		
		Discontinued	3	6
		Discretionary decision not to pursue		1
		Matter out of jurisdiction (discretionary)	1	21
		Matter out of jurisdiction (non-discretionary)	4	10
		Premature – Local process formally tried but not exhausted	1	18
		Premature – Local process not formally tried		4
		Total	**9**	**60**
	4 – Examination	Discontinued	1	16
		Discretionary decision not to pursue	24	314
		Total	**25**	**330**
	5 – Investigation	Discontinued	2	
		Report issued: complaint fully upheld		33
		Report issued: complaint not upheld (with recommendations)		3
		Report issued: complaint not upheld (without recommendations)		6
		Report issued: complaint partly upheld	5	32
		Total	**7**	**74**
	Total Complaints		**96**	**951**
Grand Total			**109**	**996**

Authority Sector

	Housing Associations	Local Government	Scottish Gov & Devolved Admin	Other	OOJ	Total
	14	127	22	38	11	270
					636	636
	14	**127**	**22**	**38**	**647**	**906**
	21	175	29	16		380
	2	10	4	4	19	41
	2	2		2		6
	194	724	63	12		1,238
	219	**911**	**96**	**34**	**19**	**1,665**
	6	13	5			51
	6	56	22		4	121
	2	15	2			26
	59	289	44	1		482
	73	**373**	**73**	**1**	**4**	**680**
			1	1		2
		6				15
						1
	1	31	5			59
	5	21	8			48
		21	1			41
	2	9	5			20
	8	**88**	**20**	**1**	**0**	**186**
	4	11	4			36
	25	398	53			814
	29	**409**	**57**	**0**	**0**	**850**
		6	1			9
		12	1			46
		6				9
		7	1			14
	2	25	1			65
	2	**56**	**4**	**0**	**0**	**143**
	331	**1,837**	**250**	**36**	**23**	**3,524**
	345	**1,964**	**272**	**74**	**670**	**4,430**

Vision, Values and Corporate Strategic Plan 2008–11

VISION

Our vision is of enhanced public confidence in high quality, continually improving public services in Scotland which consistently meet the highest standards of public administration. We aim to bring this about by providing a trusted, effective and efficient complaint handling service which remedies injustice for individuals resulting from maladministration or service failure.

VALUES

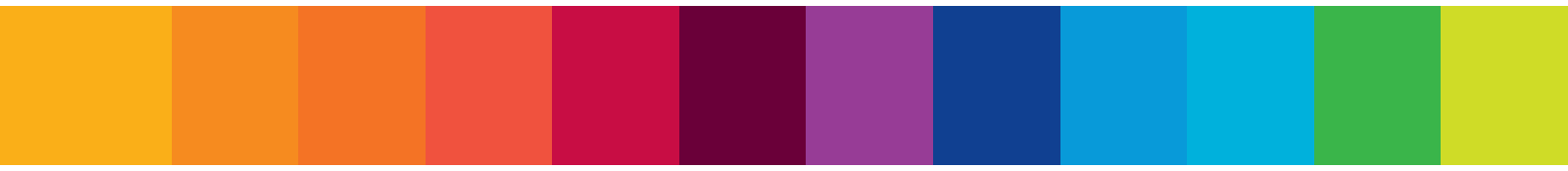
We aim to be:

- courteous, considerate and respectful of people's rights;
- independent, impartial, fair and expert in responding to complaints;
- accessible to all, and responsive to the needs of our users: complainants and service providers;
- collaborative in our work with service providers, policy makers and other stakeholders;
- open, accountable and proportionate about our work and governance, ensuring stakeholders understand our role and have confidence in our work;
- a best value organisation which is efficient, effective, flexible, and makes good use of resources; and
- best practice employers with well trained and highly motivated staff.

STRATEGIC OBJECTIVES

Over the period 2008–11 our five objectives are:

1. To provide a high quality, independent complaint handling service – by being accessible and dealing with all enquiries and complaints impartially, consistently, effectively, proportionately and speedily; and producing clear, accurate and influential investigation reports.
2. To improve complaint handling by public service providers – by working in partnership with others to promote early local resolution of disputes and complaints and to promote best practice.
3. To support public service improvement in Scotland – by working in partnership with public service deliverers, policy makers, scrutiny bodies and regulators to feed back and capitalise on the learning from our consideration of enquiries and complaints and to promote good administrative practice.
4. To simplify the design and operation of the complaint handling system in Scottish public services – by working in partnership with others to promote an integrated, effective, standardised and user-friendly system as an integral part of the wider administrative justice system in Scotland; and to promote informed awareness of the role and activities of the SPSO.
5. To be an accountable, best value organisation – by making best use of our resources and demonstrating continuous improvement in our operational efficiency and supporting the professional development of our staff.



Laid before the Scottish Parliament by the Scottish Public Services Ombudsman in pursuance of section 17 (1) of the Scottish Public Services Ombudsman Act 2002.

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