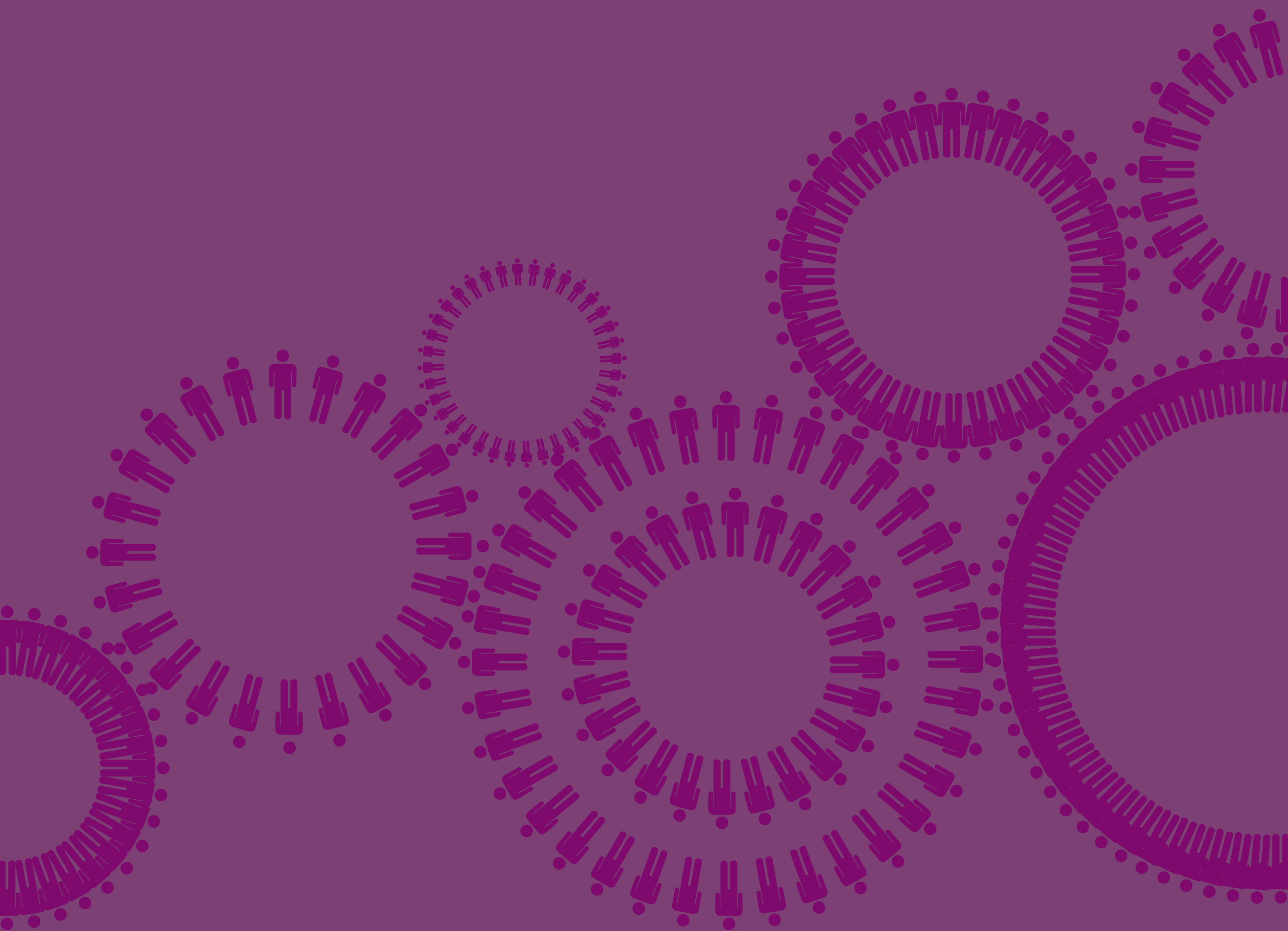
Annual Report 2010–2011

SPSO Scottish Public Services Ombudsman



contents

Ombudsman's Introduction 4

Casework Performance 7

Making a Difference 12

Complaints Standards Authority 14

Local Government 18

Health 26

Housing 36

Scottish Government and Devolved Administration 40

Further and Higher Education 46

Equality and Diversity 50

Governance and Accountability 54

Independent Service Delivery Review 55

Financial Performance 57

Vision, Values and Business Plan 2011 – 2012 58

Appendix – Statistics 60

SPSO Scottish Public Services Ombudsman

Ombudsman's Introduction

Touching lives

In last year's annual report, I described the SPSO as a tight ship, with a lean management structure and efficient business systems in place. Over the past year we have continued to streamline our processes to further improve our performance and we have made good progress towards increasing our impact.

This progress is demonstrated in this report and it is proper that we give account of it. I want to do more, though, than provide evidence of better management, more effective processes and sound financial management, important though these are. I want to provide evidence of the difference we are making to people's lives and to do this by telling the human stories that are at the heart of what we do. Telling these stories allows people who don't use our service to hear from those who do, and helps to demonstrate how a single complaint can have positive effects far and beyond the individual circumstances of the case.

So this report is a little different from our previous annual reports. All the usual information is there – performance indicators, case statistics, outcomes, financial reporting, trends, issues and analysis – but we have added quotes and stories to this that show some of the ways in which we have put things right for individuals and brought about change by drawing attention to wider problems.

Complaints standards — failing the public

Earlier this year, when I issued our annual statistics for 2010–11, I gave a clear signal to service providers that they must improve their procedures for dealing with complaints. As I said then, I am very concerned about the high number of cases that we upheld last year. Of all the complaints that were valid for SPSO in 2010–11, we upheld or partly upheld 34%. To put this another way, in over a third of cases that had already been investigated by the local service provider, through multiple, often lengthy, stages of review and appeal, that provider had got something wrong. This level of upheld complaints is unacceptable and demonstrates that public bodies need to have better processes and policies and a better culture of valuing complaints to support staff in making the right decision first time round.

I am also very concerned at the high level of premature complaints, those that come to this office before they have completed the complaints procedure of the service provider. There continue to be stark differences in rates of prematurity between the sectors – the rate for the NHS, the Scottish Government and devolved administration and the Further and Higher Education sector is around 30%, but it rises to 55% for the local authority sector and 64% for housing associations, figures that are simply unacceptable.

The disparity in rates of prematurity can largely be explained by the difference in sectors' complaints processes. There is confusion and frustration for service users confronted by systems that have cumbersome stages of review or appeal and this leads to premature complaints to the SPSO. The NHS, with its standardised two stage process with clear timescales scores much better than councils and housing associations whose procedures frequently involve differing stages and timescales, with layers of delay-inducing review.

Since becoming Ombudsman in 2009, I have detected in a range of public bodies an unhealthy culture around ownership and a lack of customer focus in public services. What I mean by this is that some, by no means all, organisations appear to have lost sight of the basic fact that public services are the people's services and that providers exist to deliver these on behalf of the public. The public are more than just customers of public authorities – they are owners, shareholders and stakeholders rolled into one. The processes that are put in place when members of the public are dissatisfied should reflect this. Public service providers in all areas should strive to deliver services which meet the gold standard of provision.

This is just as important when handling complaints. The first priorities of any complaints process striving to be the best it can be are that the public know how to access a fair hearing and that they know that the outcomes will be people-centred and fair. In too many cases, particularly in local authorities and housing associations, complaints systems are confusing, difficult to access, slow, cumbersome and overly bureaucratic. The NHS, which has a good system in place, still has room for improvement but has at least grasped that a simple system is in everyone's best interest.

All this underlines the importance of the Complaints Standards Authority (CSA) we are developing. The CSA's role is to simplify and standardise complaints handling procedures and promote good complaints handling. The CSA principles and guidance aim to move service providers towards quicker, simpler and more streamlined complaints handling procedures with a focus on local, early resolution by empowered and well-trained staff. The public deserve nothing less.

Simplifying the landscape and saving money

User-focus and efficiency underpin the Government and Parliament's drive towards decluttering the complaints handling landscape. Under legislation passed in 2010, the SPSO was asked to further expand its remit. In addition to our CSA role, we took on complaints about Scottish prisons in October 2010 when the Scottish Prisons Complaints Commission was abolished. This new area of responsibility (entailing 500 or so complaints each year and a whole new set of communications and stakeholder needs) passed smoothly to us and required no increase in our headcount. According to the accompanying Financial Memorandum, this transfer saved the public purse £37K in 2010–11 and will save £163K in 2011–12 and £174K in future years.

In 2010 we were also asked to prepare for the closure of Waterwatch Scotland and the subsequent transfer of complaints about water and sewerage to us. Like the transfer of prison complaints, this change was achieved without any reduction in service to the user. 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.

(continued overleaf)

As well as these wider savings, we are managing a reduction in our own budget. In 2010–11 the Scottish Government began an efficiency drive to bring about a 15% saving over a three-year period throughout the public sector. We have worked closely with the Scottish Parliamentary Corporate Body to plan for these savings.

Improving complaints procedures

I am particularly pleased to report that the progress of the CSA over 2010–11 has been excellent. After running a successful consultation in summer 2010, we published principles and guidance on complaints handling in early 2011. These form the basis of the model complaints handling procedures that the CSA is developing in partnership with key stakeholders in each sector.

Much more detail about the CSA is contained in a dedicated chapter in this report. I want to underline my personal support for this aspect of our work. In my view, improving the standard of complaints handling is as core a function of SPSO as our complaints handling role. There are multiple benefits to both users and service providers in simplified, standardised complaints processes and I have every confidence that in future we will look back on the CSA as having brought about a sea change in the culture of complaints handling in the public sector.

Sharing good practice

Over the course of the past year, I have been gratified to see a growing number of individuals and organisations visit us to find out how we do things. Several ombudsman and other offices have sent high-level delegations to Scotland to learn about our business processes, how we report our findings and about our development strategy for the work of the CSA. It would appear that the SPSO is now seen as a centre of excellence by many in the UK and further afield. It is my and my senior managers' task to continue to make the SPSO worthy of that regard and I look forward to doing so in the years ahead.

Jim Martin
Ombudsman

Casework Performance

Niki Maclean, Director of Corporate Services

Improving our service

We implemented our new business process for handling complaints in May 2010 with a number of aims in mind – to increase focus on customer service and build in greater proportionality in our casework as well as ensure transparency in our processes and clarity in our decision making. This required a restructuring of the complaints and investigations arm of the business in addition to a review of when and how we reached decisions to ensure they were timely, proportionate, well reasoned and that there was an appropriate mechanism for reviewing them.

The new process has led to improvements in the time we take to resolve cases. By 31 March 2011 no case had been with us longer than 307 days, compared with 368 days at the end of 2010 and 844 at the end of 2009. The number of cases open at the end of 2010 –11 was only 306, despite the fact that half way through the year we started handling complaints about Scottish prisons (amounting to an additional 295 complaints during the year).

One of the first things we now do when we receive a complaint is check whether it is ‘fit for SPSO’.

Fit for SPSO criteria

- that the complaint is about an organisation and a subject that the law allows us to consider
- that it has completed that organisation’s complaint process

We also check whether it meets other criteria, such as how long the complainant has known about the matter about which they are complaining, or whether there is another way in which the complaint may be resolved (for example through an appeal or a legal process).

We also ensure proportionality in our approach, by using revised criteria for public reporting – this has reduced the number of public reports laid before the Parliament (our figures of reported complaints and reporting criteria are discussed later in this section). At the same time we have worked towards new ways of sharing lessons from our other casework with service providers and appropriate scrutiny bodies as well as with the public, by publishing in the Ombudsman's monthly Commentary the main recommendations from our decision letters to complainants. Due to a change in our Act, from April 2011 onwards we have been able to extend this to publish a report of our decision letters (these are technically 'discontinued investigations').

Casework Performance

To support the new business process, we also reviewed our quality assurance system, as well as our procedures for handling complaints about our service, and requests for reviews of our decisions. We worked to improve our written explanations by making them clear and easy to understand and revised our internal performance targets.

We have made these business process changes without increasing staff numbers at a time when we were also required to take on a new area of jurisdiction, absorbing prison complaints. As a result of our drive for cost savings and efficiency, we cut our non-staff costs by 6.6% for the year.

Critically, to support this initiative we have reviewed the way in which we work with public bodies and made a few changes to ensure that we are working effectively together to deliver the best possible outcome to members of the public. We have introduced clearer guidelines on what evidence and information we wish to receive through our enquiries and when and how it should be provided. When we issue decision letters or draft recommendations we now ask only for comments on factual accuracy or significant new information. In 2011, we reminded public bodies of their obligation to notify complainants of their right to come to this office within 12 months of receiving a final decision on their complaint. These steps are helping us to deliver in a timely manner clear, informed decisions that accurately reflect and take into consideration the work that bodies have done to try to resolve complaints before they reach this office.

Public reporting

To be the subject of a public report, a complaint must satisfy our public interest test. The public interest refers to the ‘common well-being’ or ‘general welfare’. The public interest is central to policy debates, politics, democracy and the nature of government itself. A matter that is in the public interest is one that is important and has the potential to adversely affect other people were it not put in the public arena when it became known. Taking these principles as a foundation, we developed the following framework for decision making on reporting to Parliament.

SPSO reporting criteria

- **Significant personal injustice** – an explicit administrative or service failure by a public body resulting in personal detriment of a severity and nature that requires wider acknowledgement and recognition
- **Systemic failure** – a failure of more than one element or component in a whole system designed to deliver a service or particular outcome to members of the public
- **Precedent and test cases** – where a decision on the part of the SPSO will establish a reference point for future case handling and potentially impact upon matters of wider public policy.
- **Local complaints procedure failures** – significant failing of any element or component in a local complaints or representations procedure resulting in a poor customer experience and/or the loss of explicit rights and entitlements under the procedure
- **Special and exceptions reporting** – where persistent non-cooperation of a public body with SPSO recommendations (either through a decision or report) requires the non-compliance to be highlighted to Parliament

Having impact

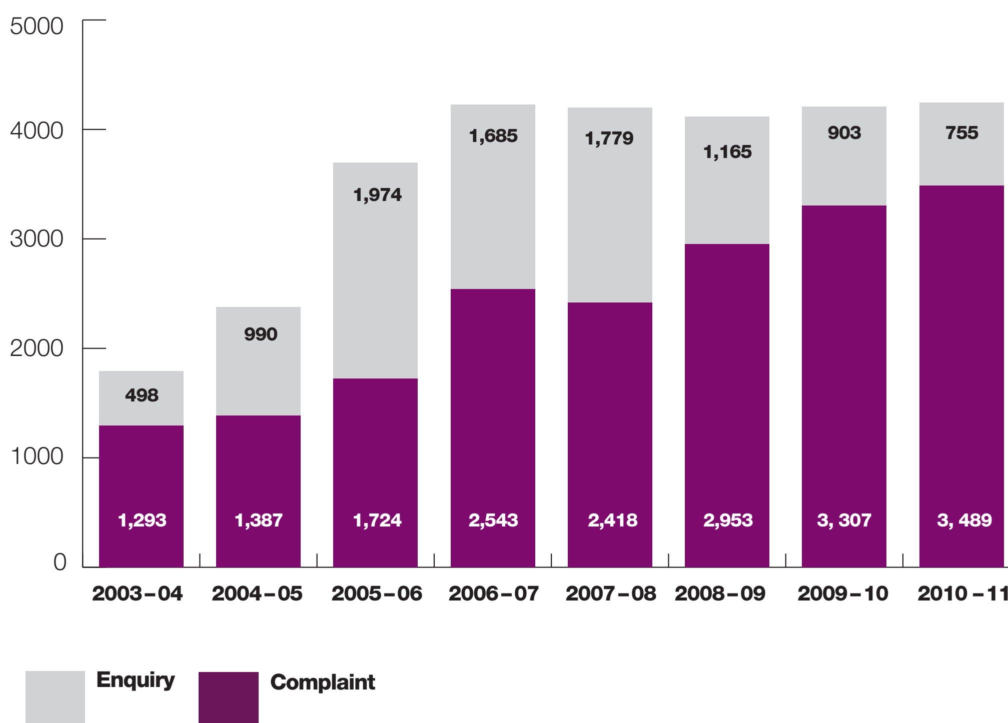
We make recommendations in our letters and public reports to drive improvements in public services. We aim to put things right as far as possible for the person who has complained, and to prevent the same thing happening to someone else. Our letters and reports this year contained 490 recommendations, a selection of which are included in later chapters of this report. The recommendations we make are diverse, from telling a council to review their policy on dealing with school bullying, through to suggesting improvements in how a council handle notices about statutory repairs to buildings, to recommending that a health board ensure that a clinician learns from mistakes made when treating a patient who later died. (Health is the only area where we can look directly at and make recommendations about the professional decisions made by staff.) To make sure that authorities act on our recommendations we ask them to provide evidence that they have been carried out and in April 2011 we introduced a new internal performance standard related to this.

Complaints and enquiries received

In 2010 –11, for the third year in a row we handled fewer enquiries, but received more complaints than in the previous year. The sectoral breakdown of incoming complaints and enquiries again remained roughly the same. We received 4,244 enquiries and complaints, about 1% more than in the previous year.

Total contacts received by year (enquiries and complaints)

Complaints received **3,489**
Enquiries received **755**
Total **4,244**

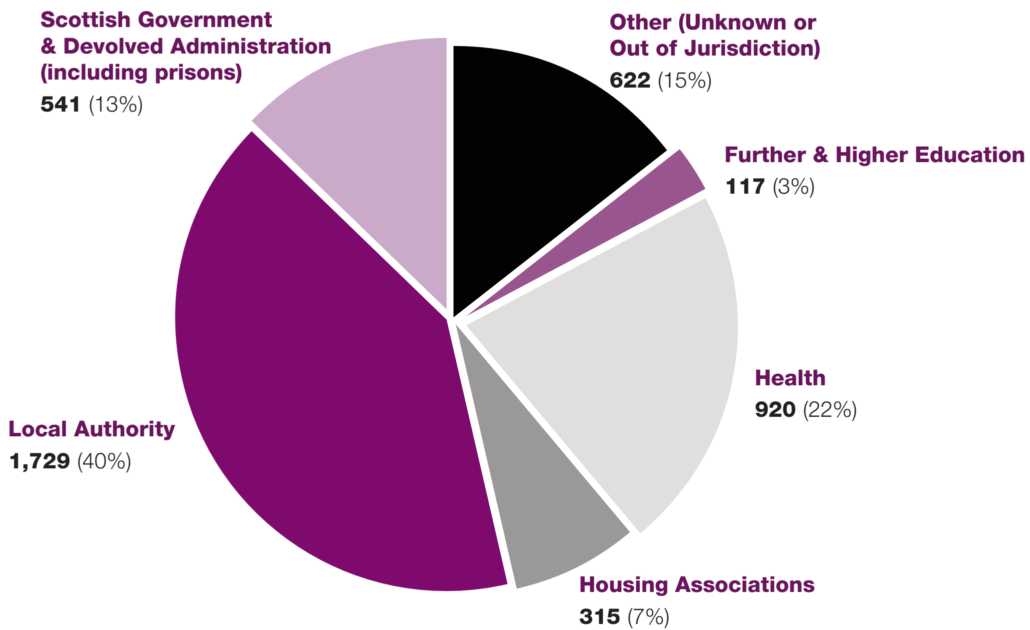


Casework Performance

Who the complaints were about

The chart below shows the proportion of complaints and enquiries we received about different areas of the public sector.

Total contacts received by sector in 2010 – 11



How the complaints break down

Our Advice and Early Resolution team see the complaints first, and check their 'fitness for SPSO'. They deal with the vast majority of the complaints we receive, passing to the Investigations team only those cases that require further in-depth examination.

Most of our decisions on complaints are given in decision letters. These are sent directly to the complainant and the organisation complained about. We take the view that it is proportionate to do this and to report publicly to the Parliament in full only the small proportion of the complaints we receive that meet our revised public reporting criteria. In 2011–12 we started to lay an additional monthly report of decision letters before the Parliament. Legislation that came into force in April 2011 allows us to make the learning from the vast majority of complaints we investigate widely available.

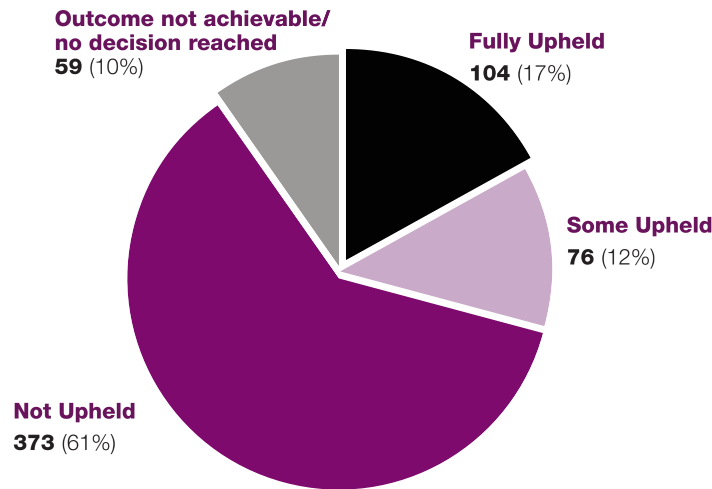
During 2010–11 we determined 755 enquiries and 3,351 complaints. We resolved 2,678 complaints by providing advice or guidance to the complainant or public body concerned. Of those cases, 1,500 reached us prematurely – i.e. they had not completed the complaints process of the organisation concerned.

We investigated 673 complaints in depth. We determined 612 with decision letters, and 59 through issuing 58 public reports. We published information about our recommendations on most of the cases for which we sent decision letters.

Outcomes of our decisions

As described previously, we report to the Parliament only cases that meet the criteria we established as part of our business review. This has resulted in us publishing fewer full investigation reports. In 2010 –11 we issued 612 decision letters and took 61 complaints to the investigation report stage.

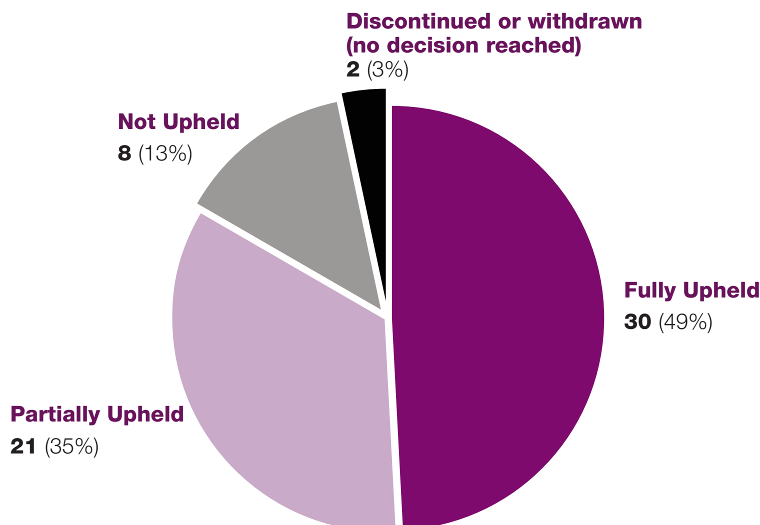
Decision letter outcomes 2010 – 11



Investigation report outcomes

Of the 61 cases that reached this stage, we discontinued two, and published 58 reports about a total of 59 complaints. Of these, we upheld all or some of the complaint in 51 cases (84%) and we made a total of 201 recommendations.

Decision letter outcomes 2010 – 11



Making a difference

Emma Gray, Head of Policy and External Communications

Ombudsman offices have a number of roles. One is to make recommendations for changes in national policy, for example where an investigation reveals that a piece of legislation or guidance lacks clarity. These are the cases that, understandably, make headlines and attract the attention of MSPs or the Government because they involve serious issues like the death of a child or adult, prisons policy on drug testing or the cost of residential care for the elderly. However, Ombudsmen carry out another, more everyday, role – resolving individual issues that affect people's lives in what may appear from the outside to be small ways but which have significance for the person involved.

From the hundreds of complaints we resolved in 2010–11, here are two stories that illustrate the small ways our work can impact on individuals. The first concerns a prisoner who had not seen his three young children for over a year because he had been transferred to a prison they could not easily travel to. The prisoner was trying to get another prison to take him temporarily, so that he could have a few visits from the children before going back to his own prison. Our investigator found that the Scottish Prison Service had not acted wrongly – they had no obligation to allow the prisoner a temporary move. However, by speaking with the prisons involved, our investigator was able to bring about a transfer for up to two weeks. This gave the prisoner the chance he wanted to see his children.

The second case is about a pupil who had missed out on the recognition a council give for perfect attendance at primary school. He had gone to school in plaster following an ankle injury, but was sent home in accordance with the school's health and safety policy. The resulting half-day absence was the only unauthorised absence of his entire time at primary school. His parents felt it was unfair to penalise him when he had made such an effort to attend. After discussion with the school and the council they agreed, given the specific circumstances, to give the pupil the perfect attendance recognition that he had missed out on.

Both the cases described above were dealt with by our Advice and Early Resolution team. They were not matters that required in-depth investigation, since they could be sorted out more speedily and effectively by good communication between us, the complainant and the body concerned. Of course, not all cases lend themselves to this kind of resolution, but many do and outcomes like these are in everyone's interest.

Sharing the learning

We spent much of the final quarter of 2010–11 preparing for a change that would allow us, thanks to legislation which came into force in April 2011, to put more of our decisions into the public domain.

In June 2011 we started to lay before the Parliament a report of complaints that we had resolved by decision letter and we expect to publish 40 – 50 decisions a month. To make them accessible, we publish the decisions on our website, where they can be searched by body, subject and so on. This format is designed to help the public, service providers and other stakeholders in a number of ways including:

- **greater learning providing opportunities for service improvements**
- **sharing good practice among authorities**
- **helping the public understand our role**
- **informing other stakeholders**

Impact through the press

We devote relatively modest sums to raising awareness of our service. The press helps us publicise what we do, indeed sometimes complainants bring a concern to us as a direct result of having heard about a similar case in the media. In 2010, our analysis of press coverage of SPSO showed that we featured in 283 articles, creating 40 million opportunities to see (the advertising value equivalent of the press items was just over £248,600).

As we report in the health section, our health investigations attract the greatest amount of attention, but there is also coverage of complaints about other sectors. In complaints about council services, press interest is more limited but often focused around local campaigns. Overall, coverage in local newspapers in 2010 was three times higher than in national papers (though the latter generate a higher number of opportunities to see the information).

Looking ahead

Water complaints

We took on responsibility for complaints about water and sewerage providers on 15 August 2011. This change resulted from the Public Services Reform (Scotland) Act 2010 which transferred the complaints handling function of Waterwatch Scotland to the SPSO. The customer representation function of Waterwatch Scotland transferred to Consumer Focus Scotland. We worked with Waterwatch Scotland, Consumer Focus Scotland, the Scottish Government, the Scottish Parliamentary Corporate Body (SPCB), the Water Industry Commissioner for Scotland and Scottish Water to ensure a smooth transfer.

Relative to other sectors we handle, the water caseload is small – last year Waterwatch received 914 contacts of which 105 were complaints that they considered in detail. On the day of the transfer we took on 38 cases. The legislation allows licensed providers to opt into the SPSO scheme. Licensed providers who do so become, in effect, listed authorities. Providers that have opted into the SPSO scheme are Business Stream, Aimera and Wessex Water.

Prison health complaints

The NHS takes over direct responsibility for healthcare in Scottish prisons in November 2011. This means that the SPSO will become the final stage for complaints about prisoner healthcare. We have been preparing for this change through discussion with the Government, the Scottish Prison Service and the nine health boards that are affected. The SPCB is also involved in the preparations for the change, given the potentially significant resource implications for the SPSO.

Police complaints

In December 2010, the Cabinet Secretary for Justice issued a letter to stakeholders about his proposal to transfer the functions of the Police Complaints Commissioner for Scotland (PCCS) to the SPSO, in accordance with the recommendation set out in the Sinclair Report. In March 2011, we were invited to participate in the Government's short life working group 'to identify and consider all the practical issues involved in a transfer, so that initial advice can be given to the next administration in early June'. The group was made up of officials from the Government, the SPCB, the SPSO and the PCCS. We look forward to contributing further to the debate in the context of the Government's *Keeping Scotland Safe and Strong: A Consultation on Reforming Police and Fire and Rescue Services in Scotland* which was published in September 2011.

> The benefits of introducing standardised complaints handling systems are considerable and should not be underestimated. Better systems will lead to better outcomes for the public – both through having easier access to processes and then having to spend less time in the system. However, the most important benefit will be that services will improve with the more effective learning of the lessons from complaints, and this will benefit all consumers of a service, not only those who raise complaints.

DOUGLAS SINCLAIR, CHAIR
FIT-FOR-PURPOSE COMPLAINTS SYSTEM ACTION GROUP
JULY 2008

Complaints Standards Authority

Paul McFadden, CSA Manager

Background

The Public Services Reform (Scotland) Act 2010, building on the work of the Crerar and Sinclair Reports, gave the SPSO the authority to lead the development of simplified and standardised complaints handling procedures (CHPs) across the public sector. The Act also provided the SPSO with a duty to monitor and promote best practice in complaints handling for relevant public service delivery staff.

Benefits

The Sinclair Report concluded that existing complaints procedures were not fit for purpose. It recommended that the SPSO be given what it called a 'design authority' role in leading improvements that would put the service user at the heart of complaints processes. Simplification and standardisation would provide the public with a faster and more effective means of getting issues resolved, and it would also bring about benefits to service providers, supporting them to deal with complaints more efficiently and consistently and to deliver service improvements.

Principles and guidance on model CHPs

As required by the legislation we developed a *Statement of Complaints Handling Principles* on which all public sector complaints handling procedures are to be based. We also developed *Guidance on a Model Complaints Handling Procedure,* which is based on those principles. Together these documents provide the framework for developing, in partnership with public service providers, model CHPs for the areas of public services that they deliver.

The emphasis of this framework is firmly on timely, simple and streamlined complaints handling. This involves a two-stage internal process with local, early resolution by empowered and well trained frontline staff followed by a one-off investigation within consistent timescales. The removal of the 'safety net' of subsequent tiers of review or appeal will encourage complaints handlers to get it right first time.

Our guidance states:

'Complaints resolved at the frontline of service provision are an effective tool in terms of minimising costs as well as resolving customer dissatisfaction. The fewer people that are involved in responding to a complaint, and the quicker a response is given, the lower the cost of that complaint to the service provider in terms of resources and potential redress.'

Published February 2011

Complaints Standards Authority

As provided for by the legislation, we consulted stakeholders on the design of a model CHP to be implemented across the public sector in Scotland. Our three month consultation generated 92 responses. Most were supportive of the guidance and recognised the benefits of a simplified, standardised approach to complaints handling. Many respondents acknowledged that the guidance would deliver improvements in their area of public service, but some had concerns about the detail of our proposals and how they might work in practice. Many responses centred on a wish for greater flexibility in our approach to standardisation. In responding to these concerns we decided to adopt as flexible and non-prescriptive an approach as possible in each sector, while maintaining focus on delivering a consistent and standardised approach to complaints handling across the public sector. We also held a number of events with stakeholders, including focus groups run by Consumer Focus Scotland to obtain the views of consumers. The consumer responses were overwhelmingly supportive of the move towards a streamlined model focused on early resolution by frontline staff.

Following the consultation, we revised our *Statement of Complaints Handling Principles*. These principles were approved by the Parliament and were published in January 2011. In February 2011 we published our analysis of the responses to the consultation on the proposals for standardised CHPs. We also revised and published the SPSO's *Guidance on a Model Complaints Handling Procedure* based on these responses.

SPSO Statement of Complaints Handling Principles

An effective complaints handling procedure is:

User-focused: it puts the complainant at the heart of the process.

Accessible: it is appropriately and clearly communicated, easily understood and available to all.

Simple and timely: it has as few steps as necessary within an agreed and transparent timeframe.

Thorough, proportionate and consistent: it should provide quality outcomes in all complaints through robust but proportionate investigation and the use of clear quality standards.

Objective, impartial and fair: it should be objective, evidence-based and driven by the facts and established circumstances, not assumptions, and this should be clearly demonstrated.

…and should:

Seek early resolution: it aims to resolve complaints at the earliest opportunity, to the service user's satisfaction wherever possible and appropriate.

Deliver improvement: it is driven by the search for improvement, using analysis of outcomes to support service delivery and drive service quality improvements.

Published January 2011

Culture change

The single greatest challenge to improving complaints procedures lies in creating a positive culture towards dealing with complaints. In launching the consultation the Ombudsman acknowledged this when he said *'the right complaints culture can pay dividends: restoring trust between the service user and provider, improving public services, and cutting costs to the public purse'*. There needs, therefore, to be clear direction from senior management on the extent and limits of discretion and responsibilities in resolving complaints, including the ability to identify failings, take effective remedial action and apologise. There also needs to be recognition of the skills involved in dealing with complaints well at the investigation stage, and an investment in frontline staff.

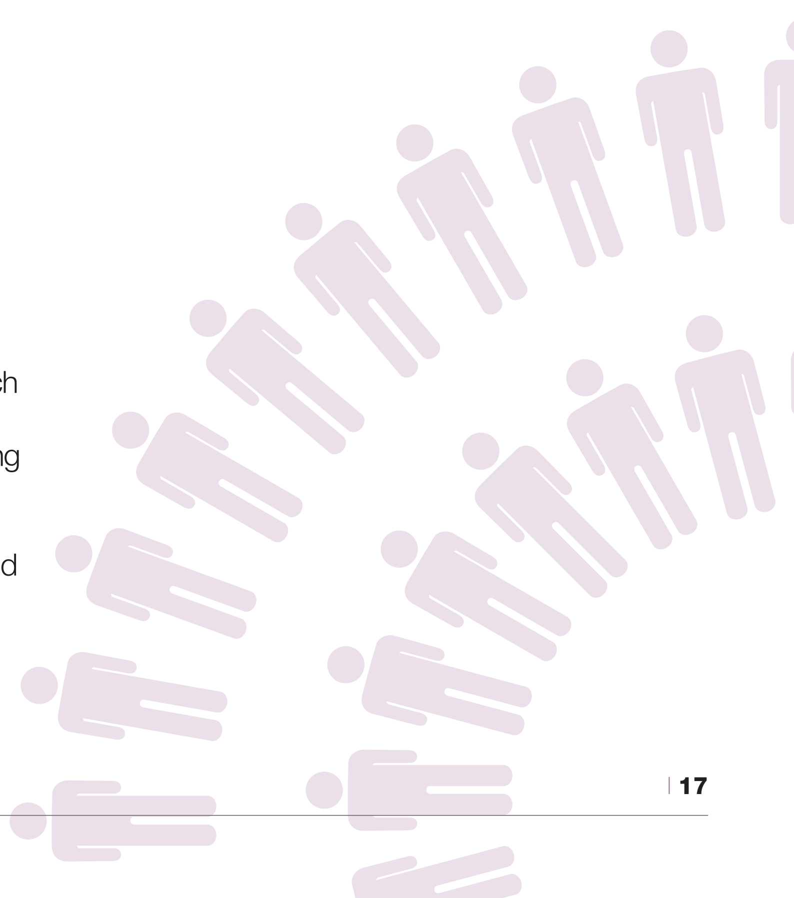
We recognise that training investigative staff in complaints handling and empowering frontline staff means providing them with appropriate skills and resources. The SPSO's training unit, which offers courses in frontline complaint handling as well as investigative skills training, is developing materials to support organisations.

Supporting bodies and developing the model CHPs

We set up our new internal unit, the Complaints Standards Authority (CSA), to provide support in standardising and improving complaints handling procedures. The CSA is working in partnership with individual public sector areas to oversee the process of developing a model CHP for each sector in line with the framework of the principles and the guidance. It is also working in partnership with the sectors to agree the timescales for introduction of the model CHPs, to build monitoring of compliance and performance into existing regulation and to provide support through the sharing of best practice guidance.

In 2010–11, we focussed on two sectors in particular, local government and housing (there is more detail about our CSA work in each area in the sectoral chapters later in this report). We adopted different approaches in each, but with a common aim of introducing a model CHP in March 2012. There are a number of other elements to this work including developing a baseline on complaints volumes and costs, standardising recording and monitoring, creating networks of complaints handlers and developing training. We have had tremendous backing from stakeholders and are very grateful to the many members of the public and many organisations that have supported and are supporting our work. We look forward to working with all public service providers in Scotland as, together, we seek to develop procedures that comply with the principles and to build a culture across the public sector that values complaints as a driver of improvement in the delivery of public services.

For further information about our CSA work, see our complaints standards website www.valuingcomplaints.org.uk



We trust that your findings will ensure that those in a similar situation to us in future may benefit, especially those unable to speak up for themselves. We are really grateful that you have listened to us and have upheld much of our grievances. I don't know if SPSO will ever realise just what this means to us. On behalf of my family and I, thank you

COMPLAINANT

Local Government

Overview

In 2010 –11 we received 1,604 complaints about local government service provision, representing 40% of all the complaints we received. We had 125 local authority enquiries, exactly the same number as the previous year. Some of the enquiries and complaints are about organisations delivering services on behalf of local government. Given the vast number and range of services delivered by councils, it is understandable that this sector represents the greatest proportion of our casework.

The issues complained about have changed little this year, with complaints about housing, planning and social work remaining at the top of the list. Housing complaints are discussed in detail in a separate section of this report, but the figures in this chapter do include housing complaints.

Standardising complaints procedures

Although this year saw a slight decrease in the rate of premature complaints about local authorities (from 57% of all local authority complaints received in 2009 –10 to 55% in 2010 –11), the rate remains high compared with other sectors. As the Ombudsman says in his introduction to this report, this is due in large part to the complexity and variety of complaints procedures within this sector, which is confusing for many service users. This confusion, combined with the frustration of dealing with multiple layers of review and appeal, accounts in large part for the high level of premature complaints we see in local government complaints (compared with a rate of only 31% in health complaints, where the sector operates a standardised, simplified complaints procedure).

The priority, then, for the work of our Complaints Standards Authority (CSA), is on delivering, in partnership with the local government sector, a consistent and standardised approach to complaints handling. With the Society of Local Authority Chief Executives (SOLACE) and the Convention of Scottish Local Authorities (COSLA) we have established a working group of local authority representatives to develop a model complaints handling procedure (CHP) for the sector in line with the framework of our principles and guidance. The group has agreed a broad approach to taking this work forward, and is developing a number of supporting products in parallel with the new CHP. We plan to introduce the new CHP in March 2012 and we are working with Audit Scotland to build the monitoring of compliance with this model CHP into their regulation arrangements.

Parliamentary Committee evidence

The Ombudsman gave evidence to the Local Government and Communities Committee twice in the course of 2010 –11. In May 2010, he gave an account of our 2008 – 09 annual report and in November 2010 he spoke to the 2009 – 10 annual report. These appearances were opportunities for Committee members to discuss the SPSO's performance and priorities, and to ask a range of questions about complaint numbers and trends, and the transfer of prisons and water complaints to the SPSO. The Ombudsman also presented his first *Statement of Complaints Handling Principles* to the Committee and received Parliament's approval of these shortly after. Within this context the Ombudsman discussed the preliminary work and aims of the CSA.

Local Government

There was almost no change in the top ten subjects of local government complaints received this year compared with last. Complaints about recreation and leisure disappeared from the top ten, and were replaced by complaints about land and property. Many of these complaints were about matters we cannot consider such as boundary disputes and in these cases we would refer the complainant to other avenues such as the Lands Tribunal.

Top areas of local government complaints received 2010-11

Area	Complaints
Housing	343
Planning	241
Social work	226
Finance	122
Education	102
Roads and transport	98
Legal and admin	60
Environmental health and cleansing	54
Building control	50
Land and property	33

The headings above show the top areas of local government complaints. We also record information about the main issues involved in the complaints. When we looked into these, we again found planning and housing-related issues near the top of the list. Notably, we received more than 70 complaints about complaints handling or appeal procedures.

Top subjects of local government complaints received 2010-11

Subject	Complaints
Policy/administration	342
Handling of planning application (complaints by opponents)	124
Council tax (including community charge)	111
Repairs and maintenance of housing stock (including dampness and infestations)	89
Complaints handling (including appeal procedures and social work complaints procedures)	71
Neighbour disputes and anti-social behaviour	52
Applications, allocations, transfers & exchanges	49
Parking	40
Finance – local housing allowance (previously housing benefit) and council tax benefit	39
Children in care/ taken into care/child abuse/ custody of children	35

What happened to these complaints?

During 2010–11 we determined 1,562 complaints about local authorities. This included some cases carried forward from 2009–10.

We published 16 reports about local authority complaints. Of these we fully upheld six, partly upheld five and did not uphold a further five. The reports were about a variety of subjects. Four were about planning, and of those, three were about the quality of the advice provided before a planning application was submitted. Four reports were about social work processes – specifically, about the complaints review committee procedures relating to decisions made about notional capital and financial assistance. We explain this in more detail over the page under the heading *Issues in local authority complaints.* In six of the published reports, complaints handling issues were a subject of concern. The issues included problems such as delays, failure to manage processes during staff absence and failure to ensure that meetings and calls were properly recorded.

We have provided more information about some of these reports in the case studies at the end of this chapter.

Recommendations in council complaints

We made 138 recommendations to 24 councils, including that they:

Planning

- remind staff to scrutinise plans adequately, seek clarity where there is any doubt regarding an applicant's intentions; and re-notify neighbours where required
- introduce a requirement that the applicant for planning permission provides details of dimensions, the footprint of existing structures and a calculation of useable garden area
- explore allegations of unauthorised vehicle and domestic appliance repair activity in a premises

Council tax

- apologise and reimburse a complainant for the amount charged by his solicitors for a consultation about his council tax dispute
- include in their guidance that where there is unpaid council tax because of a council error, they consider the circumstances of the case and are flexible with their normal practice
- make an ex-gratia payment to recognise the time, effort and trouble to which a complainant was put in getting problems with a council tax account addressed

Housing, building and repairs

- pay a landlord the amount of local housing allowance wrongly paid to his tenant instead of to him
- review instructions to building standards officers about defining the enforcement powers and limits of the council's role
- deduct 25% from a complainant's share of repair work to a chimney and meet additional costs

Education and schools

- review their policy about those applying for school places from outside a school catchment area and then, if there is a vacancy at the school in question, the complainant's application to be reconsidered with all others waiting
- ensure that school staff are fully aware of options for ensuring that pupils with disabilities are included in extra-curricular activities; and that the council meet all reasonable costs associated with ensuring that a particular pupil can complete such activity

Other

- put in place clear directives about consistency in communication and engagement with the community where it is proposed to close a council facility or centre
- give priority to arranging a Social Work Complaints Review Committee

Local Government

Issues in local authority complaints

Notional income in relation to residential care costs

A particular area of social work that featured in our reported cases was that of financial assistance for, and financial assessments of, older people in residential care. Last year we reported on four cases about this, where the matter had gone through the statutory Social Work complaints process. In a number of cases[1] we upheld the complaints, mainly because of the way Complaints Review Committees (CRCs) had gone about their decision-making and/or how they had communicated it to the complainant. This is an important area for members of the public, often at a very difficult time in their lives, and we found room for improvement in all the cases.

When reporting on these, the Ombudsman drew the attention of the Government and Parliament, the Convention of Scottish Local Authorities and local authorities themselves to the need to ensure consistency in decision-making, based on the national guidance – the 'Charging for Residential Accommodation Guidance' (CRAG) on financial eligibility for public funding for residential care.

'Neither the legislation nor the guidance prescribes a period beyond which it would not be reasonable to assume that an asset has been transferred to avoid it being taken into account in the financial assessment of an individual at the time they enter care. A local authority has discretion in the way in which it decides the matter and, therefore, each case requires to be decided on its own merits. It is not the role of this office to stipulate conditions or terms beyond those contained in national guidance; our role is to examine the administrative process followed. For those looking for equity of treatment in the decisions, I believe we must consider the wider issues. On the one hand, public bodies have a duty to safeguard the public purse, and in doing so must be alert to individuals purposefully depriving themselves of capital in order to ensure that, if they at a point in the future require residential care, their assets at the time of assessment will be reduced to such an extent that the costs of care will be a burden picked up by the taxpayer. On the other hand, where an asset was disposed of many years ago the council are required to establish whether avoidance of residential care charges was a significant part of the motivation, and to justify their decision. CRCs appear to me to be being used as a venue to challenge decisions of officers and I consider that it is important that, in dealing with appeals, the CRC provide an adequate and reasoned explanation of their decisions and any associated recommendations to their social work authority.

On the basis of the two investigations published today, and others that are currently under consideration by my office, I am concerned that there may be a perceived unfairness by the public about the differing interpretations of the CRAG by local authorities. It would be difficult for the ordinary citizen to understand why there is a marked difference in the amount of time taken into consideration by different local authorities when considering these disposals. To use a cliché, there would seem to be a 'post-code lottery' in operation. I urge the relevant authorities to read these reports and consider whether further guidance might be appropriate.'

Ombudsman's Overview, SPSO Commentary, December 2010

1 These can be read on our website – references 200904647, 200905049, 200905042, 201000684

Through our Complaints Standards Authority, we are also in close discussion with the Scottish Government on their consultation on reform of social work complaints. Social work complaints procedures are specified in Directions made by Scottish Ministers and the consultation will seek views on any changes needed to the Directions to ensure that social work complaints procedures comply with the principles underpinning the reform of public service complaints and meet the needs of service users.

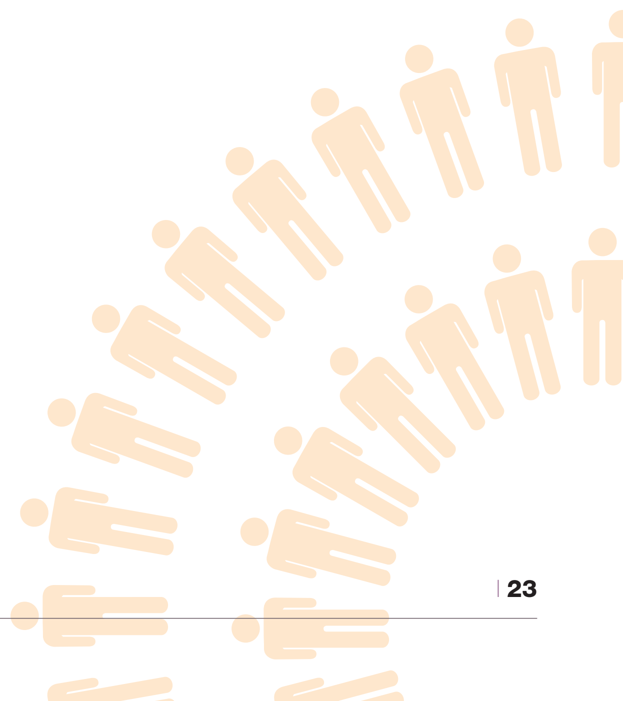
Planning

We received 124 complaints from people or groups opposed to particular planning applications and 20 from people who were unhappy about the way in which their own planning application had been handled. In planning cases we often find it necessary to explain to complainants that our powers in this area are limited and we cannot overturn decisions reached by planning authorities. We cannot look at what are called 'discretionary decisions', i.e. decisions that a council were entitled to make, unless something has gone wrong in the process. What we can look at is the procedures that led up to a decision. We often find that service providers have correctly followed the procedure. In such cases, the complainant is likely to remain unhappy with the body's decision, but if there is no evidence of anything having gone wrong in the way a decision is reached, we cannot question its merits.

Last year we suggested that changes to the Planning etc. (Scotland) Act 1996 might affect the number of planning cases we received. The number of planning complaints we received did drop by 9% to 241 (we received 265 in 2009–10) but the types of complaint remained relatively steady, and planning remained the second top subject of complaint. We will continue to monitor the trend on this in coming years.

Complaints handling

From our investigation reports and from other cases closed by decision letter we identified that complaints handling problems frequently happen in cases where the authority concerned has not found it possible to meet the standard timeframe for dealing with the complaint and responding to the complainant. In the cases we saw, this seemed to trigger confusion and further delay, and a process which should have been clear became muddled. Our complaints handling guidance emphasises that authorities should meet their published timescales wherever possible. However we recognise that in some cases, for example where the subject is complex or there are many individuals involved, it may not be possible to do this. In these cases, authorities should clearly explain the reasons for the delay to the complainant and keep them informed about how long they expect the process to take.



Local Government

Case Studies

Enforcement of planning conditions
> Case: 200900221

Mr C had a house, which had fallen into disrepair, on his croft. He applied for planning permission to build a new house. The council granted this on condition that the croft house reverted to use as a byre. Mr C later decided to apply for permission to convert the byre back to a house. The council gave outline planning permission, but with significant conditions about access. As Mr C felt these conditions were too onerous, he sold the building with its planning consent. When the new owners then carried out work on the property – without complying with the planning conditions – Mr C complained to the council. We found that there were significant administrative errors in processing Mr C's application and in the council's failure to enforce planning conditions on the property when the new owners began work on it. We upheld Mr C's complaint that the council's handling of the planning situation was inadequate. We recommended that they apologise to him for this and consider how best to meet any remaining requirements of the planning conditions.

Pre-planning advice
> Case: 200903131

Mr C complained that the council did not deal adequately with his pre-planning enquiry. He was unhappy that as a direct result of the advice he got, he spent time and money preparing and submitting applications that the planning committee rejected. We upheld the complaint as the council did not tell Mr C that any advice provided was 'without prejudice' and so could not be relied on to indicate what the committee's decision would be. We noted that the council have since taken steps to ensure suitable wording about this is put on all relevant documents, and to remind staff of the need to ensure that applicants are made aware of it. In light of this, we only recommended that the council tell us when the new wording is introduced and published on their website.

Social Work: complaints handling
> Case: 200905042

Mr C complained on behalf of his client, Mrs A, about the council's financial assessment of her mother and the way their CRC dealt with his complaints. We upheld his complaint that the council gave Mrs A insufficient information at the time of the assessment. This was because there was no evidence that the council told her about the specific implications of property transfer. We also upheld the complaint that the CRC did not fully explain the reasoning behind their decision not to uphold the complaint. We recommended that, in consultation with the Chair and other members of the CRC, they revisit this decision with a view to providing a full and adequate explanation based on the merits of Mr C's case. We did not uphold complaints that the council failed to consider the case on its own merits, or acted unreasonably in not agreeing to convene a new CRC hearing to consider a document submitted after the CRC took place. We did, however, recommend that they assess the significance of that document.

Social work: notional capital; complaints handling

> Case: 200904647

When Mrs A entered residential care the council assessed her income and assets to calculate residential costs. They took the value of her former home into account even though she had not received the sale proceeds. (Mrs A had entered into a legal agreement with her son and daughter-in-law, Mr and Mrs C, which meant they were entitled to the proceeds.) Mr and Mrs C disputed the council's decision. Their solicitors complained that the decision was administratively flawed and that their complaint was poorly handled. We upheld both complaints, as we found that although the council reached their decision by considering relevant factors, they made assumptions that were not entirely based on the evidence provided. A CRC had recommended that the value of Mrs A's property should not be taken into account, but the executive committee of the council dismissed this, based on internal legal advice. We concluded that the CRC hearing process was not conducted entirely fairly. We recommended that the council obtain independent legal advice and convene another CRC to reconsider the matter in the light of that advice. We also found that the complaints process took over a year to complete, partly because a member of staff was unavailable. We recommended that the council provide evidence that they now record, track and respond to correspondence in good time. We recommended that they review their handling of the initial correspondence and formal complaint. We also said that they should review their staff absence procedures and take measures to ensure that future staff absences do not unduly impact upon the delivery of service standards.

Closure of leisure facilities: policy/administration; communication

> Case: 200803019

A number of local residents were unhappy that the council decided to close various municipal facilities, including a swimming pool, without consulting the public. The residents believed that this was not in accordance with the council's practice and statutory procedures. We did not uphold the complaint as we found no specific duty or requirement on the council to consult the public about a decision to close a facility or centre. We did, however, find that the council's approach to engaging with the public after the closures were announced was piecemeal, and communication was inconsistent. We, therefore, recommended that in the interests of good practice the council should ensure that their strategy to communicate and engage with the community includes clear directives in relation to consistency in communication and engagement where the council proposes to close a facility or centre.

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

I would like to take this opportunity to thank you. From the well written report you sent me it was obvious that your investigations were very thorough, and that was very much appreciated. It highlighted some issues that we had not been aware of and gave a proper explanation of what had happened to my dad. It is very reassuring to know that you and your colleagues are there to help when things go wrong within the NHS.

COMPLAINANT

Health

Overview

Concerns about the NHS made up 22% of the total contacts we received during the year, a very slight increase on 2009–10 (21.5%). This number is line with our expectations. Health complaints form the second largest part of our caseload and the highest proportion of our investigation reports. In 2010–11, 38 (66%) of the 58 reports that we laid before the Parliament were about health. These reports are in the public domain and by their very nature are 'human interest' stories. This means that health generates a much higher level of press attention than any other sector we deal with. We try to ensure that complainants, health boards, the Scottish Government and organisations such as professional regulatory bodies are aware in advance of the likelihood of publicity.

There are two main reasons that a high proportion of health cases reach the investigation stage. The first is that, unlike in other sectors, the law allows us to look at the **clinical decisions** that led to a complaint. In other sectors our powers do not extend to judging decisions because we are barred from examining the merits of 'a discretionary decision taken without maladministration'.

The second reason lies in the effectiveness of the NHS complaints system itself. From our perspective, as a sector, health service providers are well supported by the Government's coordinated approach to sharing the learning from complaints. The public also benefit from the NHS's standardised procedures – unlike other sectors, the health service provides a single procedure for all its users. The procedure involves a very simple process (attempts at resolution by frontline staff followed by a one-off in-depth investigation with senior management sign-off) with clear timescales. The Complaints Standards Authority (CSA) has taken the NHS procedure as the model for its guidance on complaints handling and is proposing a similar two stage model procedure for other sectors.

The simplicity and transparency of the NHS procedure is one of the reasons for the relatively low level of premature complaints we receive. In 2010–11, the premature rate for health complaints was 31%, compared with 55% in the local government sector and 64% for housing associations.

2010–11 brought in the Patients Rights Act. It contains several measures that will impact on our examination of health complaints and also on the way the NHS deals with feedback including complaints. We were pleased to be asked to contribute in a number of ways to the Parliamentary Committee, Government teams and individuals charged with putting the legislation in place.

We were on the No Fault Compensation Working Group and look forward to supporting the recommendations that the Group arrived at. We also became members of the NHS Complaints Personnel Scotland group, which we find a very useful forum for discussion of ideas and good practice.

Patients Rights (Scotland) Act 2011

There are a number of measures in the Act that will impact on our work in investigating unresolved complaints about the NHS, including a 12-week treatment time guarantee, provision for a patient advice and support service, a legal right to complain and a duty on Scottish Ministers to publish a Charter of Patient Rights and Responsibilities.

The Act has a strong focus on complaints. It makes provision for a new Patient Advice and Support Service (PASS), whose goal is to help and support patients to make complaints, provide information about health services and direct patients to other types of support such as advocacy. The Act puts a duty on health boards to publicise the details of PASS to patients with complaints and to ensure an adequate complaints process is in place. It also places a duty on NHS bodies to encourage patients to give feedback or comments, or raise complaints about the care they have received. We welcomed the emphasis on, and ensuing debate about, the value of complaints, and noted the comments made by the Health Secretary when the Bill was passed:

Ms Sturgeon said: *'Patients' rights are of paramount importance and it is absolutely right they have now been given the prominence and priority that primary legislation affords. The bill ensures that patients know what their rights are and have access to independent support and advice to assist them in their dealings with the NHS.'*

Different sections of the Act will come into force at different times. We are responding to the consultation on the associated Directions and regulations and we look forward to playing our part in improving the quality of feedback and complaints procedures in future.

No Fault Compensation Group

In February 2011, the Government's No Fault Compensation Review group, on which we were represented, published their report. The group supported reform of the current system of NHS compensation claims in cases involving clinical error. They said that the system is failing to meet patient needs and creates potential tensions between patients and healthcare providers. Their research showed that patients are more interested in a meaningful apology, an explanation and assurances about future practice. They recommended that the Government consider establishing a 'no fault' scheme for medical injury, along the lines of the system in operation in Sweden. This is an aim that SPSO has supported since the very early days of its operation. The Government are now looking at how such a scheme would work in practice, as well as the potential costs.

Working with others to improve complaints handling in the NHS

As well as raising awareness of the outcomes of health complaints in a variety of different forums, we shared our experience through workshops and training events. In November 2010, we participated in three regional events organised in Dundee, Glasgow and Edinburgh by the Independent Advice and Support Service (IASS, which currently provides support to the public in making health complaints) and the NHS Complaints Personnel Scotland group. We shared a platform with organisations including the General Medical Council, General Dental Council, the Health Professions Council and the Scottish Government team that was working on the Patients Rights Bill. It was an excellent opportunity to share learning and listen to the views of delegates including IASS workers, mediators and NHS complaints handlers and frontline staff.

It was also a useful forum for discussion about how complaints handling could be improved in the NHS. It was evident that there are common frustrations across IASS and health boards, and equally strongly, there is a wealth of good ideas and good practice that could be shared. One of the roles of the CSA will be to act as a platform for sharing and promoting good practice and we look forward to further developing the ideas generated.

SPSO training in complaints handling

We tendered to provide training for delivering complaints handling training to NHS staff throughout Scotland. We presented two options – the first was to deliver courses throughout the country and second was a 'cascade' approach whereby we would train NHS staff as trainers to deliver the SPSO course. Our bid was successful and the second option was chosen.

We offered training to all the geographic health boards, the National Waiting Times Centre Board, the Scottish Ambulance Service and NHS 24. The training included sessions on encouraging early resolution and getting it right from the start; planning and managing an investigation; writing a meaningful response and apology; and feeding back the learning from complaints to all staff and the general public.

We delivered a total of 27 courses to approximately 400 staff as well as eight 'train the trainer' days to 30 NHS trainers. We have continued to provide support to the NHS trainers as needed.

Professional advisers

The Ombudsman contracts a range of advisers to provide professional expertise to inform his decisions about health complaints. Three advisers provide services directly to the SPSO on a part-time basis, supporting the office in the areas of mental health, GP services and nursing care. They are also involved in liaising with health providers, national bodies such as the Scottish Government, and other scrutiny bodies such as Healthcare Improvement Scotland and the Mental Welfare Commission. They also have good relationships with the regulatory bodies (the General Medical Council and the Nursing and Midwifery Council, for example) to ensure any fitness to practice issues, which are there to protect the public, are acted upon.

Our advisers are often invited to talk to NHS staff about complaints, using complaints as a driver for change and improving the quality of healthcare experiences for patients and their relatives and carers. They use case studies and stories to highlight the key issues in complaints, recognising that most people complain because they want lessons to be learned and to avoid a mistake being made again.

Our advisers are particularly encouraged by the increasing awareness in ensuring the NHS delivers person-centred care, as a significant number of our complaints are about people who want to be actively involved in their care and treatment, properly informed and treated as an individual with respect, dignity and compassion.

Our investigators can also call on a bank of specialist medical advisers (based at the Parliamentary and Health Service Ombudsman office) who provide additional expertise on a wide range of clinical casework issues. The most common specialties for request for this advice are orthopaedics, anaesthetics, dental and surgical.

Health

In 2010–11 we received a total of 920 contacts about the NHS, compared to 904 in 2009–10. Of these contacts, 32 were enquiries and 888 were complaints. This continues the trend of a drop in enquiries and a rise in the number of complaints received, although the rise in complaints was small (just over 3% more than in 2009–10).

There were some changes in the top ten areas of complaint compared with last year: complaints about GPs and GP practices dropped by 17%, from 189 to 157 and complaints about care of the elderly dropped by 15%, from 60 to 51. We saw small increases in complaints about hospital orthopaedics and oncology.

Top areas of health complaints received 2010-11

GP & GP practice	157
NHS boards (including special health boards and NHS 24)	120
Hospitals – general medical	87
Dental & orthodontic services	58
Hospitals – care of the elderly	51
Hospitals – psychiatry	47
Hospitals – gynaecology & obstetrics (maternity)	29
Hospitals – general surgical	24
Hospitals – oncology	24
Hospitals – orthopaedics	24

In terms of specific subjects complained about, the nature of ill health means that complaints about the NHS frequently involve multiple areas of concern. The next table reflects only the main subject complained about – many of the complaints we receive also involve issues such as communications or poor complaints handling. One of the concerns that we may uncover is inadequate record-keeping. This may not be reflected in complaints when they reach us, as often we only see problems when we obtain the medical records as part of our investigation.

As in previous years, the most complained about main subject areas are to do with clinical treatment and diagnosis, policy and administration and issues about staff interaction with patients and their families. Complaints about GP and dentist lists (which, typically, are about patients being removed from a practitioner's list) rose almost threefold (although the figures themselves are not high) from 8 in 2009–10 to 20 in 2010–11. Practitioners are of course permitted to remove a patient from their list provided they follow the rules correctly. Where we find they have not done so, we cannot instruct them to reinstate someone, but we make recommendations to help them improve their practice in future. Last year we commented that we receive few complaints about hygiene and infection control in hospitals. The trend has continued this year and that subject has dropped out of the top ten subjects of complaint altogether.

Top subjects of health complaints received 2010-11

Subject	Complaints
Clinical treatment /diagnosis	402
Policy/administration	143
Communication, staff attitude, dignity, confidentiality	64
Appointments/admissions	35
Complaints handling	27
GP/dentist lists	20
Nurses/nursing care	13
Record keeping	10
Admission, discharge & transfer procedures	9
Other	8

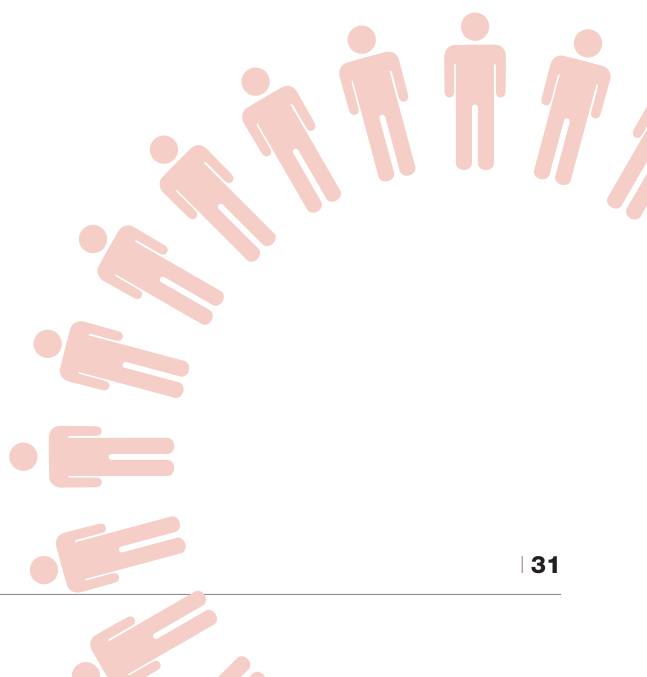
What happened to these complaints?

During the year we determined 872 complaints about health bodies, including some carried forward from 2009–10. During 2010–11, as we have widely reported, we revised our criteria for reporting full investigation reports. This year, therefore, we published fewer reports on health cases – in total we laid 39 reports on health cases before the Parliament, compared to 74 in the previous year. However, during the year we also started to publish the recommendations made in our decision letters, and starting in June 2011 we published a report of the letters themselves. In the cases where we published full investigation reports about the NHS, we fully upheld 21 (54%), partly upheld 15 (39%) and did not uphold three (7%). We discontinued and did not report on two cases that had moved to this stage of our investigation process.

Almost all the cases we reported to Parliament had multiple subjects of complaint. Unsurprisingly, the top area of complaint was clinical treatment, which featured in 25 (64%) of the cases on which we reported. Other significant areas were communication and/or record-keeping (both featuring in 31% of cases); complaints handling or policy and/or administration (26% of cases); diagnosis (23% of cases), care of the elderly (18% of cases) and nursing care (15% of cases). Some cases involved further issues including follow-up care, consent for procedures, delays in treatment, dignity of the patient, staff attitude and pain management.

Issues in health complaints

Our complaints reflect – and should inform – the national work on person-centred care. The complaints brought to our office show very clearly how people become disempowered and may feel helpless when they become a patient. This is particularly acute when it involves incapacity in the elderly and of course places a great responsibility on proactive communication. It is essential that such communication takes place as a matter of course between healthcare staff and incapacitated people's welfare guardians – it makes all the difference to how patients and others perceive their care.



Health

Disjointed services

One of the reports highlighted in the case studies section at the end of this chapter summarises an issue that is present in many of the complaints we see – a lack of joined-up thinking in the delivery of care services. Our report, published in March 2011, about the service, treatment and care provided to a terminally ill man, concludes:

'When patients are in need of care, they do not consciously approach individual agencies for the specific care that such agencies provide – they approach the NHS. How the NHS is structured is, rightly, not their concern. Mr C received very poor service, care and treatment from the NHS… From being collected too early by [the Ambulance Service], enduring a long, painful and uncomfortable wait for his procedure at the hospital, and being returned to the hospice by inappropriate transport, I consider there was a catastrophic failure of the continuum of care that Mr C expected to receive. I believe that both agencies in this report still have lessons to learn about communicating within and between NHS organisations and treating all patients with the dignity and respect they deserve, especially terminally ill patients like Mr C.'

To avoid these failures, the NHS must coordinate its services, and health professionals involved in the care and treatment of patients must ensure that communication and record-keeping are of the highest order.

Dementia

Rightly, national bodies and the media focus a great deal of attention on how people with Alzheimer's are cared for. We continue to see failings both in the clinical aspects of care and in nursing practice, including failures to uphold patients' dignity. There are several examples of findings of poor care and treatment in the case studies section, along with recommendations we made for improvement.

Guidance on adrenaline auto injector prescription

One other area to which we drew the attention of the Scottish Government Health and Social Care Directorate was the lack of national guidance on adrenaline auto injector prescription. We made a number of specific recommendations on a complaint, which was brought by the mother of a nine-year-old girl with a nut allergy who died suddenly from a severe form of allergic reaction. In calling for wider action, our report, which was published in March 2011, stated:

'Faced with the lack of national guidance on adrenaline auto injector prescription, there is a danger of inconsistency in approach, with potentially devastating consequences. Introducing national guidance could be a safeguard against this. A national paediatric allergy network that has been set up could take this forward and build on the work already done by Greater Glasgow and Clyde NHS Board.'

Recommendations in health complaints

As a result of investigating these complaints, we made 272 recommendations to 37 different practices and hospitals and 13 health boards, including that they:

Care and treatment

- create a protocol to ensure that diabetes is diagnosed in line with recognised practices and that newly diagnosed diabetics receive appropriate follow-up care
- undertake an external peer review of a hospital's assessment, treatment and care of people with confusion, delirium or behavioural disturbance, the use of Adults with Incapacity legislation and the use of both physical restraint and restraint by medicines
- review the circumstances of a man's falls in hospital to make sure that falls management and dementia care policies and procedures are robust
- undertake an external review of nursing care, including assessing a patient's ability to consent to administration of medication; and the use of bank and agency staff

Communication

- provide patients with written information about potential complications of surgery when gaining their consent and ensure appropriate consent is obtained
- apologise to a complainant for failing to ensure that she clearly understood the implications of her child having a particular medical condition
- apologise for inappropriately contacting a relative of the complainant and review their procedure to ensure the confidentiality of complainants.

Record Keeping

- review a discrepancy on a death certificate and give a family a definitive answer
- ensure medical notes include a record of discussions between consultants when a patient's care is transferred
- provide evidence that strategies are in place to ensure all nursing records meet the standards of the Nursing and Midwifery Council

Other

- take steps to ensure that the NHS Scotland deadline for treatment of cancers is adhered to
- apologise for not following the regulations for excluding a patient from a GP practice list and review their procedures to ensure they comply with these
- ensure that all mental health staff receive appropriate training relating to their child protection duties and obligations including record-keeping
- use the example of the loss of a vulnerable person's jewellery to revisit their policy on the procedure for the care of patients' property and valuables

Case Studies

Dementia care > Case: 200904074

Mr A, who had Alzheimer's, was resident in a care home which specialises in particularly challenging aspects of dementia. His granddaughter complained that her grandfather was not afforded the care or dignity he deserved. She told us that when admitted to hospital from the care home just before his death, he was severely dehydrated, had a urinary tract infection and bedsores. We upheld her complaints about poor communication and that the board did not provide Mr A with proper nutrition, general personal care or any form of stimulus. This was of particular concern because the home was one that was supposed to specialise in care of this kind. We recommended that the board monitor procedures in the care home for four months and emphasise to staff there the necessity of following procedures and properly completing forms, the importance of appropriate activities for patients, and the benefit to all parties of clear communication. We also recommended that they ensure that, when a patient is admitted, the care home take steps to discuss and record communication methods with families. We asked for evidence of this and of the range of activities now available to residents of the care home.

Health

Lack of joined-up care

> Cases 201001146 and 201001520

This complaint involved a health board and the Scottish Ambulance Service. Mr C was terminally ill with cancer and was living in a hospice. He had to attend an outpatient appointment at a hospital and was to be picked up and returned to the hospice by ambulance. We found that Mr C received very poor service, care and treatment altogether. He was collected by the Ambulance Service some three hours too early and endured a long, painful and uncomfortable wait in the reception area of the hospital for a procedure which was in itself delayed. After the procedure he was returned to the hospice by inappropriate transport in which he could not lie down. Mr C died in the hospice later that night. We upheld complaints by his wife, Mrs C, that the care and treatment provided by the health board and the Ambulance Service were not reasonable. We also found a wider cause for concern in what we described in our report as 'a catastrophic failure in the continuum of care'. We made several recommendations to address the failings identified and to ensure that other patients and their families will not endure the pain and distress caused to Mr and Mrs C.

Fatal allergic reaction; provision of insulin auto injector

> Case: 201000940

Miss C was a nine-year-old girl, who died suddenly from a severe form of allergic reaction. Her mother, Mrs C, complained that the GP's care and treatment of her daughter was inadequate. In particular, she complained that they did not prescribe an EpiPen (an adrenaline auto injector). We found that the GP did not treat Miss C appropriately, as we found that they did not act on a letter from the board's Dermatology Department and did not discuss it with Miss C's parents. The letter said that, although Miss C had not responded to efforts to arrange follow-up, she was considered nut allergic and should be referred on to the Allergy Service if the GP wanted this reviewed. We recommended that the GP apologise to Mrs C for this failing. We also noted that, as there is a lack of national guidance on adrenaline auto injector prescription, there is a danger of inconsistency in approach, with potentially devastating consequences. A national paediatric allergy network has been set up and could take this forward and build on the work already done by Greater Glasgow and Clyde NHS Board. We drew this to the attention of the Scottish Government Health and Social Care Directorate.

Hospital transfer; clinical treatment; nursing care; policy/administration

> Case: 200900775

Mr A, who had mental health problems, was a patient in an Intensive Psychiatric Care Unit (IPCU). He had been transferred there, against his mother's wishes, from a unit in another city, where he was being treated under a compulsory treatment order. His mother, Mrs C, opposed the transfer because she thought he would more easily be able to access illegal drugs and to abscond from the IPCU. Mrs C's fears were realised when Mr A absconded. When he returned that evening he admitted taking drugs and after he was examined, staff were told to monitor him overnight. He was, however, found dead in the early hours of the morning, after a bag of heroin that he had concealed in his body burst. We upheld all of Mrs C's complaints. We found that the board's decision making processes in transferring Mr A were unclear and that his physical care and treatment was inadequate. Our recommendations included that the board apologise to Mrs C for these failures and urgently improve their transfer procedures and appeal processes. We also made recommendations about supervision of patients and care and treatment. These included that the board provide training to ensure adequate medical examination, nursing observation and assessment of vital signs within the IPCU in similar circumstances. We also recommended that the board remind all staff of their professional responsibilities towards the care and treatment of a patient, and share our report with all the staff involved in Mr A's care on the night he died, so that they can learn from its findings.

Taking medical history; clinical treatment; follow-up care

> Case: 200801946

Mr A, who had Peripheral Vascular Disease (PVD – a narrowing of the arteries) fractured his left ankle, which was treated with surgery. The wound, however, failed to heal and he had to have his leg amputated. His wife raised concerns about the orthopaedic treatment provided. She felt that Mr A's wound was managed inappropriately and so his leg was unnecessarily amputated. We upheld her complaints that doctors did not recognise Mr A's vascular condition, and that both the decision to operate and Mr A's post-operative treatment were inappropriate. In particular we found that the clues to the PVD lay within Mr A's medical history, which medical staff had not explored adequately. Treatment for the fracture would have been managed differently had this been identified although we could not say that this would have led to a different outcome, given the nature of PVD. We recommended that the board highlight this report to the relevant staff, particularly junior doctors, to ensure that they are aware of the deficiencies identified. We also recommended that they apologise to Mr A for failing to identify and take into account his vascular condition, and for the delay in referring him for vascular review when his surgical wound failed to heal.

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

Thank you for your assistance and for the considerate way in which you dealt with me through your letters, telephone calls and personal visit. It was most kind of you and very much appreciated.

COMPLAINANT

Housing

Overview

This section is about social rented housing. Our jurisdiction covers registered social landlords (RSLs) and so includes housing associations and council-provided housing. The housing sector accounted for 681 total contacts received in 2010–11. 638 of these were complaints (just over 18% of our total complaints caseload).

The rate of premature housing complaints (those that come to us before the complainant has completed the organisation's own process) continues to be the highest of all the sectors. The rate in 2010–11 is 63% (63.5% for housing associations and 62.3% for housing complaints determined by local authorities).

As we highlight elsewhere, there appears to be a correlation between the number of stages in a complaints process and the number of premature complaints we see. The greater the number of stages of review and appeal – as in the housing sector – the greater the number of premature complaints to us. We are, therefore, working through our Complaints Standards Authority (CSA) with relevant organisations, including the Scottish Housing Regulator, towards reducing rates of premature complaints and developing the approach to and procedures for complaints handling.

Improving complaints handling

In the summer of 2010 we consulted on our *Guidance on a Model Complaints Handling Procedure* (as discussed in the CSA chapter). We had very useful input from the Chartered Institute of Housing and the Scottish Housing Regulator and, while there was an acknowledgement that some RSLs may be reluctant to move away from appeals to their management committees, there was substantial support for streamlining and standardising procedures. The Tenant Participation Advisory Service provided helpful information on the tenant perspective, following a series of focus groups. Eight RSLs also fed back their perspectives on the guidance, with a mixture of views – all of which have been useful in moving forward with the development of a model complaints handling procedure (CHP) for the sector.

We are working closely with the sector to develop a model CHP that meets the needs of customers and housing providers. We applaud the good progress made by some providers in developing procedures that put the customer at the heart of the process, and bring resolution of complaints to the frontline. For example, the number of complaints reaching us about Glasgow Housing Association has reduced over the years, from nearly 20% of the sector's complaints to the SPSO to just over 10%. We can to a large extent attribute this improvement to their internal focus on customer service and staff training. We look forward to seeing further improvements as their new complaints policy beds in.

It has been encouraging to see the very substantial progress that such organisations have already made in reducing the number of complaints that escalate. This will stand them in good stead for the introduction of the two stage model CHP, planned for March 2012. We hope that other champions of good practice in this area will come to the fore as this work continues.

More recently we have been working closely with the Scottish Government in the development of the Scottish Social Housing Charter. We are keen to ensure that the outcomes in the Charter will provide a robust mechanism for ensuring that complaints are valued and that complaints procedures are used effectively to improve services.

Housing

We received 43 enquiries and 638 complaints about social housing in 2010–11. This continued the sectoral trend of a reduction in total contacts with us. Of the complaints we received in 2010–11, 295 were about housing associations (compared with 323 in 2009–10) and 343 about local authorities (compared with 432 in 2009–10).

The categories most complained about remained similar to previous years, with repairs and maintenance again topping the list. The only areas in the top subjects of complaint where numbers rose were housing related benefits and complaints handling (and these increases were very small).

There was a sharp decrease – just over 28% – in the number of complaints about neighbour problems and anti-social behaviour, although it remained third in the top subjects of complaint. This alters a trend that we had seen in preceding years, where such complaints were on the increase. Another area where complaints fell noticeably was that of issues about homeless persons – down by almost 65% (albeit on relatively small numbers of complaints). We hope this reflects the progress that local authorities are making towards the abolition of priority needs homelessness by 2012.

Top areas of housing complaints received 2010-11

Repairs and maintenance	170
Policy/administration	106
Neighbour problems and anti-social behaviour	89
Applications, allocations, transfers, exchanges	71
Local housing allowance (previously housing benefit) and council tax benefit (local authorities only)	39
Capital works, renovations, improvements, alterations, and modifications	30
Complaints handling	22
Estate management, open space & environment work	11
Homeless person issues	11
Rents and tenancy charges	10

What happened to these complaints?

We determined a total of 631 complaints across the sector, including some carried forward from the previous year. As we explain in the casework performance section of this report, most of the complaints we determine do not result in a public report. In 2010–11 we did not lay any public reports about housing before the Scottish Parliament, although we did investigate 61 complaints. Of these, we upheld sixteen, partly upheld eight and did not uphold 37. Some of the recommendations made as a result of the complaints investigated are outlined below.

Issues in housing complaints

Complaints handling

Complaints handling continues to be an issue, particularly for housing associations – we found that the proportion of complaints to us about complaints handling in housing associations was twice as high as for similar complaints relating to local authority housing matters.

Anti-social behaviour and neighbour complaints

Although we saw a decrease in the number of complaints about anti-social behaviour, this should not deflect attention from the misery that such behaviour creates.
In a case that we concluded by decision letter, rather than in a public report, we said that we would *'...draw [a council's] attention to the Ombudsman's view that as a public body, they should ensure that allegations of antisocial behaviour are properly investigated and that action is taken in line with their policies and procedures, where appropriate, in an effort to ensure the situation does not escalate.'* While such issues can be seen as simply minor or trivial disputes between neighbours, we have seen evidence that these can escalate into difficult and sometimes dangerous disputes, if not properly managed by the relevant authority. We have also seen evidence of authorities, apparently with the intention of resolving the matter, unsuccessfully trying to arrange mediation over a period of time, thus prolonging an outcome to a complaint.
It is important that organisations with responsibility for social housing respond appropriately and promptly to such allegations, and that they do not prolong matters by continuing to try to establish mediation where it has become clear that it is unwelcome or unlikely to be consented to.

Factoring

Complaints about factoring reduced by almost half during the year. Numbers may have been affected by the progress through the Scottish Parliament of a Bill which resulted in the Property Factors (Scotland) Act 2011. This received royal assent in April 2011. We are generally unable to look at issues about factoring, which is a contractual matter between the home-owner(s) and the factor concerned. This is the case whether or not the factor is a body under the Ombudsman's jurisdiction. This legislation is a welcome development, giving people with concerns about their property factor another avenue through which to air their concerns.

Recommendations to housing providers

As a result of investigating these complaints, we made 22 recommendations to eight housing providers, including that they:

- apologise for the delay in taking eviction proceedings against a neighbour; review the process for recording breaches of an ASBO, to ensure that decisions about whether to proceed to formal enforcement action are recorded; and consider making an ex gratia payment to a complainant for the distress caused by these failings
- put procedures in place for staff to follow when considering whether there may have been a breach of tenancy
- take steps to ensure that following any preliminary meeting of maintenance officers to discuss proposed works and decant arrangements with a tenant, all the arrangements and responsibilities are confirmed in writing
- apologise for their failure to address the poor staff attitude that was complained about and, in future, ensure a comprehensive approach is made when considering complaints

> Thank you for the extremely thorough and painstaking approach which you undertook when investigating my complaint. I have never had an investigation referred to SPSO before and am deeply impressed. The manner in which you conducted the inquiry was as helpful as possible without prejudicing impartiality.

COMPLAINANT

Scottish Government and Devolved Administration

Overview

This sector includes all of the departments and directorates in the devolved Scottish Government, handling a very broad range of policy issues. It also includes Scottish non-departmental public bodies, other devolved Scottish public bodies and cross-border authorities, when acting in a Scottish capacity. Traditionally, numbers of complaints across this diverse area of activity have been low. This is because, although the administrative activity of these organisations is within our jurisdiction, their direct contact with members of the public tend to be more limited than that of other sectors that we deal with. This changed, however, in October 2010 when the office of the Scottish Prisons Complaints Commission (SPCC) closed, and direct responsibility for prisoner complaints transferred to the SPSO.

Across this area, apart from complaints about prisons, the complaints we receive often relate to activities that are outwith our jurisdiction. Restrictions to our jurisdiction are set out in the Scottish Public Services Ombudsman Act 2002 and mean that we generally cannot investigate anything involving court cases, legal matters or where there is an alternative appeal route. Examples of areas where our ability to consider matters is restricted include the Scottish Courts Service, the Crown Office and Procurator Fiscal and the Accountant in Bankruptcy. These organisations are within our jurisdiction but because of the nature of the work they do, we are limited in the areas we can look at. Most often the issues that members of the public ask us to look at are inextricably linked to the legal process.

2010 –11 saw various bodies within the sector working towards major changes. These included the formation on 1 April 2011 of Social Care and Social Work Improvement Scotland, a new body taking on the roles of the Care Commission and the Social Work Inspection Agency. It also saw the setting up of the Commission for Ethical Standards in Public Life in Scotland (where the Public Standards Commissioner replaced the Chief Investigating Officer).

We have been reviewing our Memoranda of Understanding with some of the bodies in the sector and in March 2011 we signed a new Memorandum with the Scottish Social Services Council. As a result of the changing complaints landscape in Scotland we also reviewed and updated a number of our advisory leaflets for members of the public. We make these leaflets available online and in print (on request) with the aim of letting people know what we can and cannot do about complaints in various sectors under our jurisdiction. These leaflets explain the restrictions on our jurisdiction, and where we are not the most appropriate body for an individual's complaint, provide information to help signpost them to the right place.

Scottish Government and devolved administration

Complaint numbers for this sector more than doubled during 2010–11. The increase is entirely accounted for by our taking on prisoner complaints. In 2010–11 we received 22 enquiries and 519 complaints about bodies in this sector compared with 22 enquiries and 241 complaints in 2009–10. Complaints about the Scottish Prison Service topped the list of those we received.

We received 17 enquiries and 415 complaints about departments or directorates of the Scottish Government. 300 of these related to prison complaints. Of the remainder, 73 were about courts administration, justice or financial matters. As explained earlier in this section, these are areas where we can rarely investigate. We received five enquiries and 99 complaints about other Scottish public authorities and five complaints about cross-border authorities acting in Scotland on Scottish matters.

Of the non-prison complaints we received across this sector, financial matters, care and health, courts administration and justice remained the four most complained about subjects (although in most of these, the subject matter of the complaint turned out to be outwith our jurisdiction). We saw a fall in the total number of complaints about courts administration and justice (from 60 complaints in 2009–10 to 38 in 2010–11). This may be in part because we have produced more information and leaflets about subjects within our jurisdiction, including a leaflet about what we can and cannot do in cases involving court and judicial matters. There was also a reduction in the number of complaints about other Ombudsmen (from 30 to 13). The latter will have been affected by the SPCC changes, as we could previously consider complaints about how that office had handled a complaint from a prisoner.

We inherited 42 cases from the SPCC. From October to the end of March, we received five enquiries and 253 complaints about the Scottish Prison Service, a total intake of 300.

Top subjects of Scottish Government and devolved administration complaints received 2010-11

Subject	Number
Prisons	295
Financial matters	50
Care and health	32
Courts administration	20
Justice	18
Education	12
Agriculture, environment, fishing and rural affairs	10
Records	7
Roads and transport	7
Arts, culture, heritage, leisure, sport & culture	6

What happened to these complaints?

Most complaints were closed without intervention on our part. We determined a total of 464 complaints, of which only 114 were ‘fit for SPSO’. The great majority of complaints we received were either premature or out of jurisdiction. Of the 114 that we could look at, we upheld part or some of 22 of them, did not uphold 86 and were unable to reach a decision in six. There is more detailed information on the next page about the complaints we handled about prisons.

Prisons

Under the Scottish Parliamentary Commissions and Commissioners etc Act 2010, the functions of the Scottish Prisons Complaints Commission (SPCC) transferred to us on 1 October 2010.

We set up a small, dedicated team of SPSO complaints reviewers to handle the complaints. They visited a number of prisons in the lead-up to the transfer, and continue to do so, to help understand the prison environment and to let them hear from Scottish Prison Service (SPS) staff about the nature and challenges of prison work.

As part of this engagement, significant changes are being made to prison rules to bring the prisoner complaints process into line with best practice as outlined by our Complaints Standards Authority. In particular a multi-layered prisoner complaints system is being shortened, and timescales cut, with a focus on early resolution of the complaint. In a further development, we expect prisoner healthcare complaints to come under our jurisdiction on 1 November 2011, when responsibility for healthcare in prisons moves from SPS to the NHS. Such complaints will be managed through the NHS complaint system in the first instance, with SPSO the next step if the complainant remains dissatisfied.

We laid our first report about the SPS in January 2011. It involved the process that a prison used to test a container they believed to contain drugs, and we upheld the complaint that the prison failed to adapt that process properly. There is a summary of the complaint at the end of this section. A point that we wish to make clear, and which has been misunderstood by certain sections of the press, is that in doing so we do not in any way condone substance misuse. We recognise that keeping prisons drug-free is an ongoing challenge for the SPS. Our role is to review how they administer the matter and to ensure that suitable administrative policy and practice is in place and applied consistently.

One of the areas that we have found refreshing when working with the SPS is their positive response to our findings and recommendations. They have been a model of good practice in quickly acting on our recommendations and sharing the learning from complaints across the prison estate. We have worked closely with them on these lessons; for example we meet regularly with SPS representatives to review complaints that have been complex or difficult, to see if things could have been done differently. We look forward to building on this cooperation and continuing to contribute to improving how prisons carry out their administrative duties.

Issues in Prisons

Top subjects of complaints received about prisons

Subject	Number
Security, control and progression	83
Privileges and prisoner property	33
Communication and records	32
Health, welfare and religion	21
Leave from prison (including home detention leave)	17
Admission, transfers and discharge	17
Discipline	17
Physical and personal environment	15
Work, education, earnings and recreation	13
Supervision levels	2

Although the subjects above were the most complained about, we upheld very few prison complaints. This is because the matters complained about were mainly discretionary decisions that the SPS were entitled to make, and there was no evidence that they had not followed the appropriate procedures. Unless something has gone wrong in the administrative process of making a decision, we will not uphold a complaint about it. For example, our intervention enabled a prisoner to access a particular education programme. He had been on a waiting list, but was overlooked because of a clerical error. When we became involved, the mistake was spotted and he was given a place. We upheld the complaint because of this administrative error.

Scottish Government and devolved administration

Some of the issues raised in prison complaints are common across the complaints spectrum, such as poor communication or complaints handling but others are peculiar to the prison system. For example, 'progression' relates to the ability of a prisoner to progress through the prison system with a view to a move to less restrictive conditions and eventual release. Prisoners are understandably concerned that this is properly handled and that they are moving through the system appropriately.

We found that due to unavailability of accommodation in some areas, there have been progression problems (and the decision letters that we started publishing in 2011–12 bear this out). However, where the prison have taken appropriate action to manage the situation we are unlikely to uphold a complaint. Complaints about access to behaviour-related programmes were mainly about inability to access these programmes due to high demand. Again, although prisoners were unhappy about not being able to access programmes as quickly as they might wish, in the majority of cases we did not find any administrative errors.

In fact, during the year we upheld very few prison complaints. Of the 86 complaints that we found to be 'fit for SPSO' we upheld some or all of the complaint in only 15 cases (17.5%). Most often we found that, although the prisoner was unhappy about something that had happened, the SPS had taken appropriate steps to manage the situation and had acted within their policies. We have, however, been able to make a difference in some cases, particularly through early resolution of the complaint. Again, helpful responses and action from the SPS contributed to this.

Recommendations in Scottish Government and devolved administration complaints

As a result of investigating these complaints, we made 49 recommendations to four organisations, including that they:

- allow a complainant to resubmit his complaints through the prison complaint system and convene a hearing to review those complaints.
- re-open and investigate a complaint about their organisation
- review their complaints process to ensure that a formal process is in place to allow for complaints made against the Chief Executive to be considered
- revisit a decision to place a prisoner on an anti-bullying strategy and inform him of the outcome; and remind all staff of the importance of ensuring that the reasons for placing a prisoner on this strategy are based on full and accurate information
- tell individual prisoners when they can expect to access identified offending behaviour programmes
- action a review and issue guidance to staff on the process for receiving and opening prisoner mail from external medical facilities
- apologise for not providing a satisfactory explanation about why a prisoner was not allowed unescorted day release
- update the Ombudsman on the outcome of a consultation about proposed changes to the assessment process for offender related programmes

Case Studies

Policy/administration; communication; complaint handling

> Case: 200801907

Mr C complained that the Scottish Prisons Complaints Commission (SPCC) did not properly investigate his complaint that the Scottish Prison Service (SPS) were keeping him in segregation unnecessarily. A new Commissioner was appointed, who decided to firstly suspend, then to re-investigate the complaint. Mr C said that these decisions were unreasonable. He also complained of delays and poor service by the SPCC. He said that, having decided to re-investigate the complaint, the SPCC misinterpreted it and later dropped it because Mr C was moved to another prison. We upheld all Mr C's complaints and recommended that the SPCC urgently find out whether the SPS had a long-term management plan for Mr C. We also recommended that the SPCC review their internal procedures, including timescales and communication, and apologise to Mr C for the failings identified.

Policy/administration; communication; complaint handling

> Cases 201001146 and 201001520

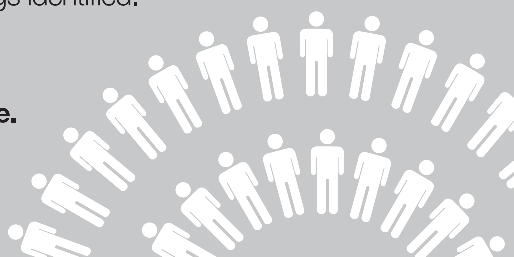
Mr C complained that the SPCC did not deal with his complaint in a reasonable time, did not communicate adequately with him or with the SPS, and did not deal with the substance of his complaint against the SPS or pursue it appropriately. We upheld his complaints as we found that the SPCC had not kept him updated about progress or dealt with his complaint adequately. We made a number of detailed recommendations including process and timescale changes and that the SPCC should apologise to Mr C for these failings. We also asked them to provide redress to Mr C by referring his complaints to the SPS again and setting a deadline for response.

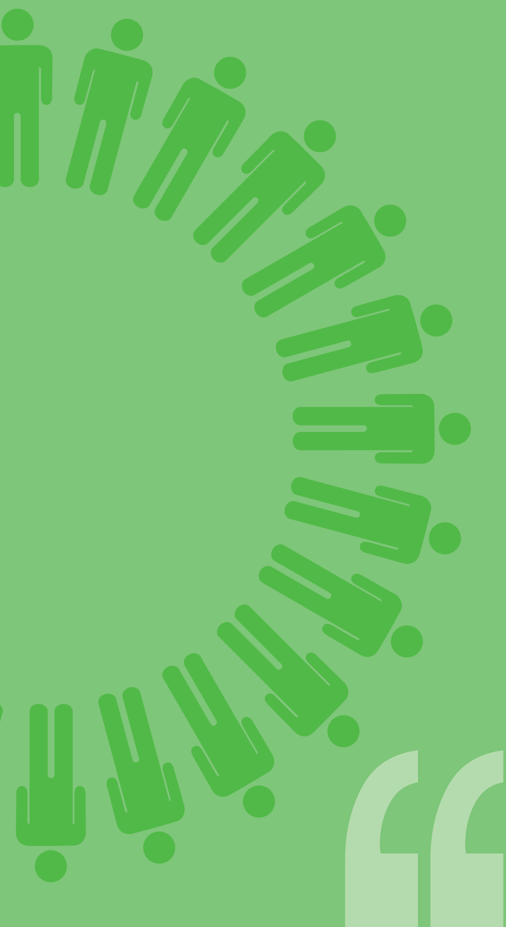
Policy/administration; record-keeping

> Case: 201002487

When staff searched Mr C's prison cell they found a container, which they suspected contained drugs. When tested, it was found to contain methadone. To carry out the test, the prison adapted their mandatory drugs testing policy (normally used for testing prisoners' urine samples). Mr C claimed that they failed to apply the adapted process properly. We upheld the complaint, as we found that the process normally required the prisoner to be present to witness the test, which did not happen in this case. We recommended that the SPS put in place a policy for staff to follow when testing liquids or substances for the presence of drugs and take steps to make prisoners aware of this process. We also recommended that they remind prison staff to accurately record the timings of cell searches and drug testing confirmation results and that the SPS apologise to Mr C for the failings identified.

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





It takes a special person who can digest all the facts of a case, especially a complex one like mine which was accompanied by vast paperwork. To remain objective is a great talent and your integrity throughout has been marvellous. Your kindness meant a lot to me and I was aware that you understood the stress I suffered. Thank you for your patience.

COMPLAINANT

Further and Higher Education

Overview

We received a total of seven enquiries and 110 complaints about authorities in this sector. The number of complaints received rose by 19 (21%) compared to only a very small rise in the previous year. However, as we have said before, this is an area with relatively low levels of complaint and it is difficult to identify specific trends or themes.

In looking at complaints about further and higher education, we cannot look at the exercise of academic judgement, the quality of teaching or assessment, or the awarding of grades or degrees. We can, however, look at the process that the organisation went through when considering the student's concerns. An issue that we see in the sector is that the number of stages that a student may have to go through in order to progress their appeal or complaint can cause confusion about the point at which they may approach us with their complaint. Our Complaints Standards Authority is at an early stage of working with representatives from some of the authorities to develop a model complaints handling procedure that can be used across the sector.

Further Education

We received a total of 26 contacts about further education in 2010–11, a slight drop on the previous year. We determined a total of 27 complaints during the year, including some from the previous year. The main matters raised with us were issues of policy and administration, most usually about the processing of an academic appeal or complaint. Of the complaints overall, out of those that were 'fit for SPSO' we upheld all or some of four complaints and did not uphold one.

Top areas of further education complaints received 2010-11

Policy and administration	12
Academic appeal/exam results, degree classification	2
Student discipline	2
Admissions	1
Complaints handling	1
Facilities	1
Grants/allowances, bursaries	1
Personnel matters	1

Further and higher education

Higher Education

We received a total of 91 contacts about higher education in 2010–11. We determined 88 complaints – 32 more than in 2009–10. This was mainly due to an increase in the number of complaints about academic appeals and degree classifications, and issues of policy and administration. These were the top two subjects of complaint for this area. 25 of the complaints reached us prematurely, and ten were out of our jurisdiction. As we say above, issues of academic judgment are not for us to consider. Of the complaints overall, out of 24 that were 'fit for SPSO' we partly upheld nine complaints and did not uphold twelve. We reported to the Parliament on one complaint. It was about student discipline, and a summary of it is at the end of this section. As we commented last year, in this sector where a complaint is upheld it tends to be where an appeal or complaint process has gone wrong. This displays a different trend to other sectors, where it is more often the substance of the complaint that is upheld.

Top subjects of higher education complaints received 2010-11

Subject	Number
Academic appeal/exam results, degree classification	28
Policy and administration	24
Teaching and supervision	8
Complaints handling	4
Admissions	3
Plagiarism and intellectual property	3
Grants/allowances, bursaries	1
Personnel matters	1
Property	1
Special needs – assessment and provision	1
Welfare	1

Recommendations in further and higher education complaints

As a result of investigating these complaints, we made 27 recommendations to seven educational organisations, including that they:

- ensure that future investigations consider all available and relevant forms of evidence, and that adequate records of the evidence and how it was considered are kept
- ensure that letters to students giving the outcome of an investigation provide full information, setting out what the complaint was, what evidence was considered, including relevant dates, and what conclusion was reached
- remind staff of the need to exercise care to accurately report the result of plagiarism testing
- apologise that facilities and technical support available were not in keeping with expectations in promotional materials, and review the materials to ensure that they accurately reflect both this and the availability of access

Case Study

Student discipline

> Case: 200801977

Mr A, a student who has dyslexia, was disciplined after allegations of misconduct were made against him by the university. Mr A's parents were unhappy with the university's investigation and felt the punishment was excessive. We upheld their complaint that the university did not properly follow their own process in reaching a decision. We made several recommendations, including apologising to Mr A and his parents, reviewing what happened in his case to improve the transparency of procedures in future, and providing more information to the student in such situations. We did not uphold complaints that the university did not take Mr A's special needs into account or that the punishment was not appropriately decided.

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

> The report means so much to me as it contains the truth. The recommendations are excellent and should prevent something similar happening to others. This is all I ever wanted.

COMPLAINANT

Equalities and diversity

As a public body, the SPSO is fully committed to the fair and equal treatment of everyone we deal with. We have met our obligations in a number of ways as we outline below. We will continue to so under the new Equalities Act 2010, which came into force in Scotland in April 2011, under both the general duties and the specific duties as they are agreed by the Scottish Parliament.

Accessibility

We are committed to making our service as accessible as possible. We have an accessibility section on our website, which explains our approach and includes our equalities statement. We work hard to identify as early as possible any individual requirements that may need to be met so that a member of the public can fully access our services and our staff are trained to be responsive to changing needs and requirements. We will always try to make reasonable adjustments where these will help members of the public to make and explain their complaint to us. These adjustments can include anything from producing all correspondence in large font for someone with a visual impairment to using our interpretation service to ensure that complainants for whom English is not a first language are well supported in taking their case through the complaints process.

Some of the ways in which we try to ensure people can access our service are:

- our website has Crystal Mark status and many of our public leaflets, including the 'easy read' version of our complaints leaflet, carry the Plain English symbol
- we produced Plain English-approved leaflets, complaints forms and an information poster for groups of complainants where literacy had been identified as an issue
- we produced audio and large font versions of several of our leaflets and made them available on our website
- we continued to use Language Line services effectively to provide written translations of documents and in live telephone conversations, on which we have had positive feedback
- we continued to provide the on-line 'Browsealoud' facility, which allows our website to 'talk' to the user and enables them to highlight information on their screen. During the year, the Browsealoud software was downloaded 314 times from our site, in addition to those people who already had the software and used it to access our site.

In the course of revising our complaints handling service in 2010–11, we built in explicit points in the process to allow our complaints handling staff to identify as early as possible any individual requirements that may need to be met and to allow them to check and be as responsive as possible to changing needs and requirements.

Equality analysis

SPSO uses equality impact assessments (EIAs) to make sure that our policies and the ways that we carry out our functions do what they are intended to do for all those interacting with the organisation, including complainants, staff and other stakeholders. We look for ways in which we can promote equality as well as identifying potential negative or adverse impacts of our policies and processes which we look to remove or mitigate.

In 2010–11 we reviewed and adjusted changes to our policies and processes using our equalities impact assessment tool. These included our new service standards and our policies on unacceptable actions and complaints about our service. We assessed these to ensure that the changes took the needs of all our service users into account.

Equalities and diversity

Training

We annually review staff diversity requirements, both as part of the annual training needs analysis and as we undergo changes in policy and practices.

In 2010–11 all our advice, early resolution and investigations staff received Clear English training from the Plain Language Commission. The training aimed to help staff produce clear, well presented and well structured writing that fulfils its purpose. This is very important as we always confirm our decisions in writing, and we want to make sure that the reader can understand what we have said. Staff were encouraged to review their own work as well as SPSO standard letters.

In addition, as part of the quality assurance process, we regularly feed back to staff through training and update sessions on best practice around handling equalities issues within casework.

Monitoring and profiling

Each year we monitor and analyse data in relation to service users against census data. During 2010 a total of 818 people returned our monitoring forms. This represents just over 23% of the total complaints we received, the same number as last year. It is not possible, however, to say exactly what the return rate is because many people do not ask for or send us a form at all – many send their complaint straight in to us by letter.

Of those who responded, we found that:

- 52% were male and 43 % female (5% did not tell us their gender)
- 66% fell in to the age groups 35 – 49 (35%) and 50 – 64 (31%)
- very few young people complained to us themselves – less than 5% of respondents said they were aged under 24
- 28% of people described themselves as having a disability; 58% of these were identified as problems with physical mobility

Reporting on the 2010 figures, we cannot make direct comparisons with previous years in all areas, as the information we sought has changed over time. We are planning to review this again in 2011–12 after discussing best practice with the relevant equality bodies.

Employer profiling

As an employer we also gather statistics on the staff and applicant profiles for SPSO and these are published as part of our publication scheme.

Managing equality and diversity at the SPSO

In 2010–11 our Equalities Strategy Group held responsibility for overseeing this area of work and was made up of representatives from each area of the business. This group will be responsible for ensuring all obligations are met under the new requirements of the Equalities 2010 Act.

One area that the Group will explore is around the issue of people with mental health issues wishing to access our service. We want to be sure that we have staff trained and equipped to ensure that people who suffer from difficulties associated with mental health have equal access to SPSO. Equally, we want to make sure that the bodies under our jurisdiction, who are delivering services to people who may have special needs, are mindful of their obligations.

In September 2010, the Ombudsman commented on a case about the treatment of a vulnerable person, saying:

'It is important that this case and my conclusions on it are correctly understood. There is no dispute about the facts of the case. In a nutshell, a distressed woman was injected with antipsychotic drugs by hospital staff against her will. There is no documentation to show that this action was properly assessed in advance, or properly recorded after the event.

In upholding the complaint, however, I wish to make clear that the complaint was not about restraint, but about consent. I accept that there are times when restraint is justified. What is unacceptable is for health practitioners not to show proper understanding of the legislation and policies that exist to ensure that patients' human rights are not breached. I believe that in this case they were. Staff must also be made aware of the vital importance of recording the reasons for taking action to restrain or inject despite a patient's clear protestations.

As well as patients' rights, I am concerned about the rights of health practitioners. The legislation and policies should act as a safeguard for them. Health boards have a duty to provide staff with the right information and training that will enable staff, when difficult situations arise, to make the right split second decisions. Health professionals working in stressful situations need to be well equipped and supported. My recommendations are intended to ensure that in future staff will have the right information and training. For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the board concerned but across the NHS in Scotland.'

Case Study

Care of the elderly; record-keeping; consent

> Case: 200902396

Mrs C collapsed and was admitted to hospital. The next day, she was very agitated and confused. She refused intravenous antibiotics, and was injected with two doses of haloperidol (an antipsychotic drug). Mrs C's representative complained that this was done against her will. We found that, given her confused state, it seemed that medical staff were concerned about Mrs C's ability to make decisions about her treatment. However, there was no documentary evidence to show how they decided what to do, or that they reached a decision that she was not competent to refuse treatment, as documentation required by the Adults with Incapacity legislation was not completed. We found no evidence that they considered trying to obtain consent for the treatment, or that they took recent guidance from the board into account. The board also failed to provide Mrs C with a satisfactory explanation when she complained. We upheld her complaint and made a number of significant recommendations, including peer review of the hospital's practices in managing assessment, treatment and care of people with confusion; the use of Adults with Incapacity legislation and of restraint; how the board train staff about such matters; and that they tell us the outcome of the review. We also recommended that they apologise to Mrs C and remind staff of the need to properly and accurately complete written records, and share these findings with the staff involved.

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

Governance and Accountability

Sir Neil McIntosh, Chair of the SPSO Audit and Advisory Committee

The Ombudsman, as Accountable Officer for the SPSO, is responsible for ensuring that resources are used economically, efficiently and effectively. The SPSO is subject to scrutiny by external auditors (provided by Grant Thornton UK who were appointed by Audit Scotland in 2006), internal auditors (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 and Advisory Committee (A&AC) was established in June 2007 by Professor Alice Brown, who was Ombudsman until she demitted office in March 2009. 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 Mr John Vine (Deputy Chair) and Mr David Thomas. John Vine is Chief Inspector of the UK Border Agency. David Thomas is Corporate Director and Principal Ombudsman for the Financial Ombudsman Service. I am grateful to them for the quality of their contribution. Baroness Rennie Fritchie stood down from the Committee in October 2010. Her contribution to the Committee was greatly valued and had assisted the SPSO in taking great strides towards a position of good governance.

The Committee met four times in 2010–11. 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 A&AC in 2010–11 including reviewing the organisation's case handling process, making changes to the organisational structure and preparing for the two new Acts of Parliament that would impact on the SPSO's daily operations.

The past year has been one of continuing progress in relation to the operational and financial management of the service. The Committee has benefited from the constructive engagement of our external auditors and the input and contribution from the internal audit service. In his role as Ombudsman, Jim Martin has provided drive and leadership of a very high order and this, coupled with the commitment of senior management and staff, has resulted in the achievement of further advances in governance and performance.

We recognise that the significant programme of service changes being pursued by the Scottish Parliament will bring further challenges, workload demands and pressures in the coming year. This will again require determined leadership, structural flexibility and staff commitment to meet these expectations. The Committee looks forward to playing its part in this process.

Independent Service Delivery Review

Service delivery complaints to the SPSO

In 2010 –11 we received 12 formal service delivery complaints on 11 cases. Of these, 4 were fully or partly upheld, 7 were not upheld and no details were provided on one case. The complainant appealed the decision on one of these cases and was referred to the Independent Reviewer. A further five cases were referred directly to the Independent Reviewer for investigation. An additional four complaints were referred in the previous year.

The role of the Independent Reviewer

The Independent Reviewer's role is purely to look at complaints about service delivery within the SPSO. The Independent Reviewer has no powers to review decisions made by the Ombudsman. These can only be challenged by judicial review. The role of the Independent Reviewer was introduced at the SPSO's initiative, and is not a statutory requirement. It is part of our commitment to service delivery, allowing us to provide the Parliament with further assurance about our accountability.

The role is a three-year contract, currently carried out by an individual who has a similar role across a number of organisations. She can require evidence and explanations from the SPSO and she reports her findings directly to us. We can comment only on factual accuracy, or by providing her with material new evidence, but we cannot influence or change her findings and recommendations.

We post the outcomes of all the complaints we receive about our service on our website on a quarterly basis. Whilst it is difficult to identify systemic issues on the basis of the small numbers received, 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 to the Audit and Advisory Committee and action planning at Senior Management Team level. The Reviewer's report below is her account of the nine cases she closed in 2010 –11.

Reviewer's Report

by Ros Gardner, Independent Service Delivery Reviewer

This report covers my second year working as Reviewer for the SPSO, a role I began in January 2009. The cases I review relate to claims of maladministration and poor service delivery by the Ombudsman or his staff. The number of cases reviewed this year has reduced, although most of them were more complex (containing multiple elements) and more time-consuming than previously.

In my first full year as Reviewer, some of the cases referred to me were about historic issues. They came from complainants who had had decisions provided by the former Ombudsman in the previous two to three years and remained dissatisfied. These individuals viewed the appointment of a Reviewer as a new opportunity to express their ongoing dissatisfaction with the system. There were no complaints of this type this year.

All nine cases that were referred to me in 2010 –11 related to issues that had occurred during that year. In two instances the complaints were referred prematurely and had to be returned to the Ombudsman's office for completion of the second stage of their internal process before being returned to me.

Independent Service Delivery Review

This year, I have reviewed two complaints relating directly to the Ombudsman himself. In order to ensure that there was no conflict of interest during the internal review of the complaint these were referred to and overseen by me at an earlier stage than would normally have occurred. This approach was at the suggestion of the SPSO itself and aimed to ensure that complaints regarding the Ombudsman personally were handled transparently, objectively and independently.

Findings

As I have noted, most complaints contained multiple elements, each of which required independent consideration and decision. In total, 25 separate elements of complaint were raised in the nine cases. The issues that I investigated included:

- lack of clarity over the Ombudsman's remit and delay in explaining why a matter did or did not fall within its remit
- the SPSO had not followed its internal processes correctly
- the SPSO's internal investigation into its service delivery was inadequate, including excessive delays
- the quality of SPSO correspondence (poor grammar, punctuation and layout)
- failure by the SPSO to explain its decision and refusal to provide further clarification on the matter
- refusal by the Ombudsman to answer a letter
- SPSO personnel ignored complaints and the delay resulted in the complaints becoming time-barred
- confusion regarding decisions to reopen or to re-investigate complaints

Recommendations

Following my investigation, I made a number of recommendations which I discussed with the Ombudsman and his Senior Management Team. The key recommendations that I made for the office were:

- the role and remit of the Ombudsman still requires greater clarity
- the remit of the Independent Reviewer requires clear explanation at the time of referral
- once a decision has been taken not to progress a complaint, this decision should be adhered to unless new material has been identified
- greater clarification as to what is being investigated during the complaint process
- when delays arise, complainants should be kept informed on a regular basis

The SPSO Senior Management Team accepted and acted on all of the recommendations.

Conclusion

It is clear that much good work has been done in the Ombudsman's office in the current year, both in terms of streamlining internal processes and in improving the quality of its service delivery decisions. The instances where there were significant delays in the handling of complaints and replies to complainants have reduced. The quality of the replies and the clarity of the reasons behind decisions given to complainants have improved.

There will always be some individuals who remain dissatisfied with the outcome of their complaint and the process by which that outcome was arrived at. Inevitably, some complainants will try to use the Independent Review process to reopen their case and have 'another bite of the cherry'. These attempts must be resisted.

I am pleased to note the improvements I have identified in the processes within the Ombudsman's office. In my view, the benefits of the work undertaken in the restructure and reorganisation of the SPSO's processes are now coming to fruition.

As the Ombudsman's remit is extended, and the number of cases under review is likely to be increased, it is important that these improvements are maintained. I look forward to working with the Ombudsman and his team in the year ahead to ensure this is achieved.

Financial performance

The 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 2010 –11 we operated on a budget of £3.26 million with a total of 46 staff (full time equivalent). This equated to 78% 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 shown in our statutory accounts over the past three years. In cash terms, the Scottish Parliament awarded the Ombudsman a budget of £3,260,000 for the financial year 2010–11, excluding depreciation. The Ombudsman's actual funding of £3,168 million was below budget.

In 2010–11 the Scottish Government began an efficiency drive to bring about a 15% saving per year for a three-year period throughout the public sector. The Ombudsman worked closely with the Scottish Parliamentary Corporate Body to plan for these savings in the SPSO.

The Public Services Reform (Scotland) Act 2010 required bodies including the SPSO to provide information on certain expenditure. This information is available, along with our full audited accounts, on the SPSO website www.spso.org.uk.

Summary analysis of expenditure	**2011 £000s**	2010 £000s	2009 £000s
Staffing costs	**2,385**	2,610	2,419
Other operating costs			
Property costs*	**301**	296	287
Professional fees**	**94**	149	148
Office running costs***†	**310**	248†	250†
Total operating expenditure	**3,090**	3,055	2,854
Capital expenditure	**48**	2	160
Less other income	**(90)**	(15)	(11)
Net expenditure in 2010 –11	**3,048**	3,042	3,003
Staff FTE	**46**	47	47

* Including rent, rates, utilities, cleaning and maintenance

** Including professional adviser fees

*** Including ICT, Annual Report and publications

† Office costs for earlier years adjusted to exclude notional cost of capital which is no longer charged.

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

Vision and Values

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

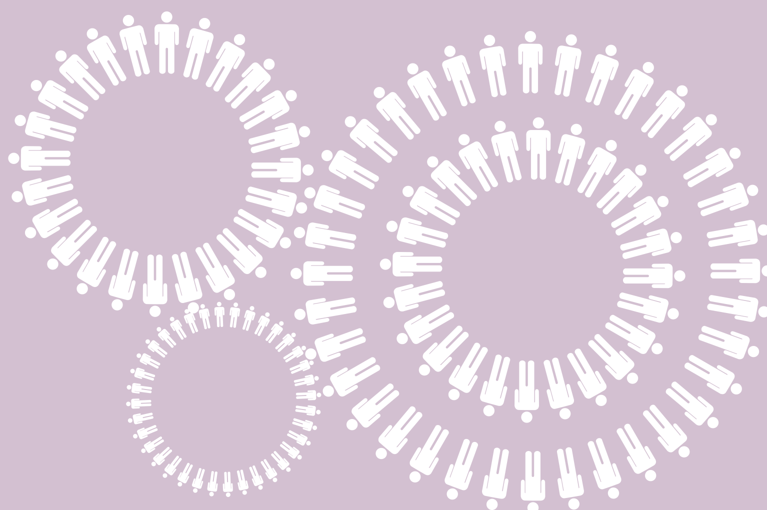
We aim to be:

- 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.

Business Plan 2011-12

Our key priorities are to:

1. deliver an efficient and effective complaints handling service, working to stretching but achievable targets, continuously building quality and accessibility;
2. share strategic lessons from our casework with service providers and appropriate scrutiny bodies; ensure service providers implement SPSO recommendations; and use communications tools effectively to promote understanding of the SPSO;
3. through the Complaints Standards Authority and training and outreach activities, build and coordinate sectoral complaints handling networks and facilitate the sharing of good practice in complaints handling;
4. lead the simplification and standardisation of complaints handling by working in partnership to develop and implement model Complaints Handling Procedures, based upon the SPSO *Statement of Complaints Handling Principles* and *Guidance on a Model Complaints Handling Procedure*, prioritising the local authority sector; and
5. deliver operational efficiency, effectiveness and accountability through clearly defined priorities, performance measures and resources that meet business needs, while supporting development of new areas of business.



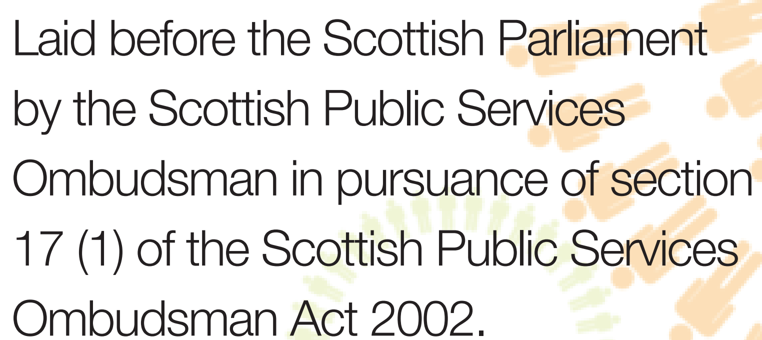
Statistics

Cases determined in 2010 – 11 by sector, stage and outcome

Report Case Type	Stage	Closure Category	Further & Higher Education	Health
Enquiries	Advice & Signposting	General Enquiry	2	4
		Premature	1	14
		Out of Jurisdiction	1	2
		Outcome Not Achievable	0	2
		No Decision Reached	3	8
		Other	0	2
	Total Enquiries		**7**	**32**
Complaints	Advice	Premature	34	218
		Body Out of Jurisdiction	0	0
		Out of Jurisdiction (Discretionary)	0	5
		Out of Jurisdiction (Non-Discretionary)	5	8
		Outcome Not Achievable	0	3
		No Decision Reached	24	216
		Other	0	0
		Total	**63**	**450**
	Early Resolution 1	Premature	2	37
		Body Out of jurisdiction	0	0
		Out of Jurisdiction (Discretionary)	1	28
		Out of Jurisdiction (Non-Discretionary)	6	9
		Outcome Not Achievable	8	18
		No Decision Reached	4	28
		Total	**21**	**120**
	Early Resolution 2	Premature	0	5
		Out of Jurisdiction (Discretionary)	1	8
		Out of Jurisdiction (Non-Discretionary)	1	1
		Outcome Not Achievable	0	2
		No Decision Reached	1	12
		Fully Upheld	0	10
		Partly Upheld	2	14
		Not Upheld	6	46
		Total	**11**	**98**
	Investigation 1	Outcome Not Achievable	1	2
		No Decision Reached	1	10
		Fully Upheld	2	34
		Partly Upheld	8	21
		Not Upheld	7	64
		Total	**19**	**131**
	Investigation 2	No Decision Reached	0	2
		Fully Upheld	0	21
		Partly Upheld	1	15
		Not Upheld	0	3
		Total	**1**	**41**
	Total Complaints		**115**	**840**
Total Contacts			**122**	**872**

Authority Sector

Housing Associations	Local Authority	Scottish Government and Devolved Administration	Other and Out of Jurisdiction	Total
4	26	3	18	57
8	57	8	1	89
4	21	4	523	555
1	4	1	1	9
3	16	5	6	41
0	1	1	0	4
20	**125**	**22**	**549**	**755**
170	768	109	20	1319
0	0	0	18	18
3	8	0	0	16
2	28	37	5	85
3	13	1	0	20
51	249	113	25	678
0	0	0	1	1
229	**1066**	**260**	**69**	**2137**
18	78	25	0	160
0	0	0	3	3
5	41	15	0	90
8	44	12	0	79
6	24	18	0	74
1	41	16	1	91
38	**228**	**86**	**4**	**497**
0	13	3	0	21
0	9	1	0	19
1	1	0	0	4
0	1	0	0	3
3	11	4	0	31
2	10	10	0	32
0	8	4	0	28
8	60	66	0	186
14	**113**	**88**	**0**	**324**
0	0	0	0	3
1	7	2	1	22
6	27	3	0	72
1	16	2	0	48
7	89	20	0	187
15	**139**	**27**	**1**	**332**
0	0	0	0	2
0	6	3	0	30
0	5	0	0	21
0	5	0	0	8
0	**16**	**3**	**0**	**61**
296	**1562**	**464**	**74**	**3351**
316	**1687**	**486**	**623**	**4106**



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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