SPSO Scottish Public Services Ombudsman

# Annual Report

2011>2012

# Contents



# Ombudsman's introduction

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### A Scottish solution

As Scotland and the UK move to test new constitutional waters, it is worth reminding ourselves of the distinct character of Scotland's Ombudsman. In setting up the SPSO after devolution, Parliament decided that new arrangements should provide for much more than a simple transfer of the functions of the existing Scottish offices of UK ombudsman services. The then Scottish Executive and the new Parliament took an altogether more radical step in considering, consulting on and debating what a modern complaints system in Scotland would look like.

The result was legislation that aimed to provide a simpler and more accessible way for people to make complaints about public bodies. The need for members of the public to complain through their elected member of Parliament was replaced with direct access. Today, citizens of Scotland can and do bring their complaints directly to the SPSO, either themselves or with the help of an advocate, using a wide range of means of communication. Many of these cases are covered in the media, increasing our visibility to the public.

The SPSO Act 2002 brought together the four previous Ombudsman services (the Scottish Parliamentary Commissioner for Administration, the Health Service Commissioner for Scotland, the Commissioner for Local Administration in Scotland and the Housing Association Ombudsman for Scotland) under the leadership of Scotland's first SPSO, Professor Alice Brown. The offices were merged and the Act also included provision for the new office to take over the Mental Welfare Commission's function of investigating complaints relating to mental health, and to consider complaints about the Enterprise bodies in Scotland. In 2005, the SPSO's jurisdiction was further expanded to cover colleges and universities and, in the past two years, complaints about prisons, water and sewerage providers and, most recently, the canal network, were added to our remit.

### One-stop shop

The 'one door' solution was considered increasingly relevant in 2002, when the delivery of public services was becoming more coordinated through programmes such as joint partnership and Community Planning arrangements. Today, joint delivery of services is an approach that is still very much alive, with integration of health and social care services underway. This raises complexities as these are areas with overlapping procedures and a variety of legislative routes for complainants. I see our role as working effectively with policy makers to ensure that complaints procedures are simple and clearly signposted, and highlighting that the needs of service users should be paramount.

### Flexibility, efficiency and effectiveness

Since the SPSO opened its doors on 23 October 2002, the office has endeavoured to live up to the aspirations of our founding legislation and to be a modern complaints service. I believe that over the past decade the SPSO has moved with the times, demonstrating flexibility and a can-do approach on each occasion it has been asked to expand its remit. To do this successfully, we have developed expertise in an increasing number of jurisdictions, and now have a proven track record in taking on new areas with no loss of service to users.

We have also demonstrated efficiency in managing our resources to deal with an ever increasing number of complaints. Since 2002,

the SPSO has handled approximately 35,000 enquiries and complaints. Each year has seen a continuing increase in contacts, and in 2011–12 we dealt with a record number of complaints, with a 12% increase in receipts. We achieved this against a background of reduced funding. Over the three year period between 2010–11 and 2013–14 we committed to achieving, as a minimum, a 15% real term decrease in our budget and we remain on target to do so.

We are also expanding the amount of learning we share from our consideration of complaints. Since April 2011, we have been able to report on many more of our decisions, and we now post approximately 50 decisions a month on our website. These reports help the public and service providers understand what kinds of subjects we can, and cannot, look at, and the outcomes we are able to achieve. To maximise the accessibility and relevance of the material, the decisions are searchable on our website by categories such as service provider, subject and outcome. We are continuing to publish reports of full investigations that meet our public interest criteria. Many of these cases are covered in the media, increasing our visibility to the public.

## Improving complaints procedures

As well as our role as the final stage in handling complaints about an increasing number of public services, we have been given a significant additional statutory role. The Public Services Reform (Scotland) Act 2010 gave us the authority to lead the development of simplified and standardised complaints handling procedures (CHPs) across the public sector. Our internal unit, the Complaints Standards Authority (CSA) developed a *Statement of Complaints Handling Principles*, which was approved by the Scottish Parliament in 2011. The complaints handling procedures of all public service providers under our jurisdiction must now be based on these principles. The CSA also developed *Guidance on a model complaints handling procedure*, and is in the process of developing, in partnership with public service providers, model CHPs for the different areas of public services that they deliver. Much of the groundwork for the model CHPs, and how compliance and performance against these will be monitored, was laid in 2011–12 through extensive work and consultation with key partners, including service providers, users and regulators. Model procedures have now been developed for two sectors – local government and registered social landlords. There is much more about the CSA in a dedicated chapter later in this report.

## Complaints trends

In last year's annual report I said that the level of partly and fully upheld complaints of those that were valid for SPSO, was, at 34%, unacceptable. In 2011–12 that figure has risen to 39%. This means that I am finding fault in well over a third of cases that have already been investigated by service providers and I find this worrying.

To reduce this, public bodies must adopt better processes and policies and, crucially, they must develop a culture of good complaints handling. They must equip staff to make the right decision the first time round and deliver that decision in a reasonable manner and within an appropriate period of time. The model CHPs should act as a sound framework, and the CSA has developed a range of training tools to help empower and skill up staff.

More encouragingly, there is a continuing downwards trend in the level of premature complaints (complaints that come to our office before they have completed the complaints procedure of the service provider). The overall level of premature complaints has fallen from 51% in 2009–10 to 45% in 2010–11 and 43% in 2011–12. This trend is welcome for a number of reasons. Firstly, it reduces the frustration of people who bring their complaint to us too early, only to be guided back to the service provider. Secondly, it allows the provider to respond to the complaint more quickly after the incident that gave rise to it. Thirdly, it means that SPSO resources are used for the purpose for which they are provided – as a final tier complaints resolver.

## Looking to the future

Ten years after its founding, the SPSO is now woven into the fabric of the Scottish administrative justice framework. It is handling more complaints about more areas than ever. It is more efficient than ever and is feeding back more lessons from its decisions. Importantly, it is playing a vital role in improving the procedures and culture of complaints handling by public service providers in Scotland.

Delivering our objectives in the current economic climate will require creativity and collaboration. There are serious financial challenges ahead for all of us in the public sector. At the SPSO, we have already taken steps to do more with less, and by working in partnership with others to improve complaints handling in the public sector we have an opportunity to make overall savings to the public purse.

I look forward to continuing to work to strengthen our role, to leading further improvements to our service, and to increasing our impact in the years ahead.

**Jim Martin**
**Ombudsman**

# The ten year journey

## 2002
## Open for business

SPSO Act 2002 came into effect on 23 October, creating a one-stop shop for complaints about public bodies in Scotland. It merged the offices of the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland.

**Remit:**

- Scottish Executive and other devolved agencies
- NHS services
- Local authorities
- Registered Social Landlords
- Enterprise bodies
- Mental welfare

"... the development of a modern complaints system should be seen as integral to plans to improve public services in Scotland."

**Alice Brown**
**2002–03 Annual Report**

## 2003
## An accessible Ombudsman

Focus on the SPSO's drive to reduce barriers for people with complaints, and to encourage more simplicity and greater consistency in complaints processes in the public sector.

"We see our role as being part of a wider process of good governance and the delivery of good public services."

**Alice Brown**
**2003–04 Annual Report**

## 2004
## Ensuring accountability

Worked to enhance own accountability and to increase accountability of bodies under SPSO jurisdiction. Advocated for an Apology Bill and for reform of public sector complaints handling procedures.

"We recommend that Scotland should consider legislation to allow for providing an apology without admission of liability."

**Alice Brown**
**2004–05 Annual Report**

## 2005
## Improving public services

Remit widened to include complaints about further and higher education. Simplified complaints process introduced in the NHS, making it easier for the public to bring complaints to the Ombudsman. Stepped up SPSO publication of investigation reports, which aimed to share learning for improvement.

"... a single complaint from an individual can challenge our most powerful institutions and bring about changes that improve the lives of many."

**Alice Brown**
**2005–06 Annual Report**

## 2006
## Promoting proportionality

Significantly increased caseload brought challenges and highlighted the need for proportionality in handling complaints. SPSO strengthened links with bodies such as regulators, inspectors and auditors, continued to campaign for apology legislation and launched Valuing Complaints initiative to support bodies in handling complaints.

"Our priority is to deliver the best service we can to the public, and our challenge is always how to achieve that aim through the most efficient use of our resources."

**Alice Brown**
**2006–07 Annual Report**

## 2007
### Restoring trust

Emphasised how handling complaints well is an important part of restoring people's trust in public services. Ombudsman played a significant role in the Sinclair group on complaints handling, which recommended that SPSO build on Valuing Complaints work and be the 'design authority' to lead the standardising and simplifying of complaints handing procedures across Scotland. Ombudsman also involved in commissioning research on tribunals and administrative justice.

> My aim has been to ensure the integrity of the role of ombudsman, in order to maintain the faith that people have in us as an independent and impartial final stage complaints resolution service.

**Alice Brown, 2007–08 Annual Report**

## 2008
### Right first time

Focus on getting things right first time and sharing the learning from complaint outcomes to improve services. Scoping and partnership work to take forward the Sinclair report recommendations got underway.

> I would like us to work together to ensure that people have an accessible and fair process for airing grievances, and that legitimate complaints are heard and lead to changes for the better.

**Jim Martin, 2008–09 Annual Report**

## 2009
### Changing times

New Ombudsman in place from May 2009. Overhaul of SPSO's complaints handling processes with a focus on reducing case handling times while maintaining the quality and impact of decisions. Began specific reporting on equalities matters and asked Parliament to look at closer links with a committee to enhance accountability and share learning more fully. Further progress on implementing the Sinclair recommendations, and SPSO training unit opened for business.

> Better complaints processes will strengthen the public's voice about how services are delivered and will support providers in responding more effectively to complaints and using the learning from them to improve services.

**Jim Martin, 2009–10 Annual Report**

## 2010
### Changing the culture

Remit widened to include complaints about Scottish prisons. SPSO set up an internal unit, the Complaints Standards Authority, to consult on and progress, in partnership with key stakeholders, the development of principles of good complaints handling and guidance on model complaints handling procedures. Legislative changes enabled SPSO to publicise many more decisions.

> 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.

**Jim Martin, 2010–11 Annual Report**

## 2011
### Simplifying the complaints landscape

One-stop shop's remit further expanded to include complaints about most water and sewerage providers and about prisoner health care. SPSO published hundreds of decisions on its website, to further public understanding of what it can and cannot look at and the outcomes it can achieve, and to share the learning from complaints to improve services. Standardised complaints handling procedures published for local authority and registered social landlord sectors.

> Ten years after its founding, the SPSO is now woven into the fabric of the Scottish administrative justice framework. It is handling more complaints about more areas than ever. It is more efficient than ever and is feeding back more lessons from its decisions. Importantly, it is playing a vital role in improving the procedures and culture of complaints handling by public service providers in Scotland.

**Jim Martin, 2011–12 Annual Report**

## 2012 >

# The SPSO's role and remit continue to widen

# Casework performance
## Niki Maclean, Director of Corporate Services

Ensuring robustness, quality, timeliness, empathy and proportionality in our consideration and investigation of complaints is not an easy challenge

### Measuring our performance

This section deals with casework performance and focuses on our first strategic objective – *'to provide a high quality, user-focussed independent complaints handling service'*. Other areas of our business are covered elsewhere in this report, for example in the chapters dealing with governance and accountability and financial performance.

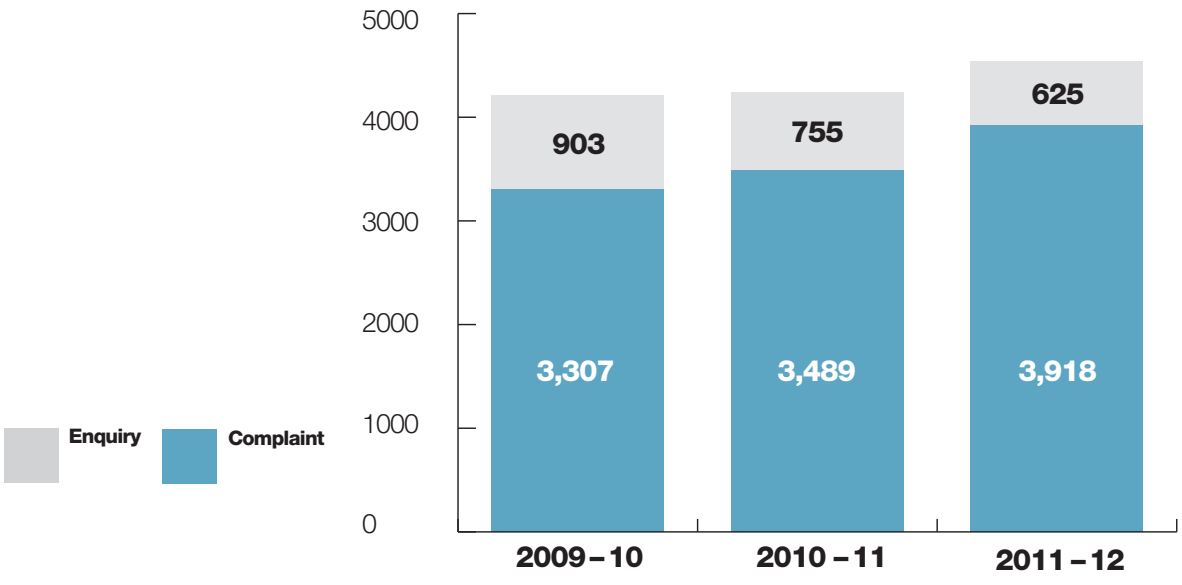
The three drivers of strong performance in casework handling are process efficiency, quality of decisions and customer satisfaction, and this is reflected in our performance measures. Ensuring robustness, quality, timeliness, empathy and proportionality in our consideration and investigation of complaints is not an easy challenge. We work extensively with our staff, to provide them with the knowledge and skills they need to carry out their work. We have an ongoing commitment to developing our people through, for example, our work to maintain our Investors in People status. We were recognised as achieving the IIP standard in March 2011 and are committed to continuous improvement in the areas identified through the IIP process.

We review and develop our business performance measures on an annual basis and focus on outcomes rather than activities. Performance against these measures is reported on a quarterly basis to the senior management team, and to the Audit and Advisory Committee at least three times a year.

### Enquiries and complaints received

We received 625 enquiries, compared with 755 in the previous year. As well as receiving a record number of complaints in 2011–12 (3,918), we dealt with a record number (3,748). Productivity kept pace with demand, despite the additional resources commited to taking on new areas of responsibility.

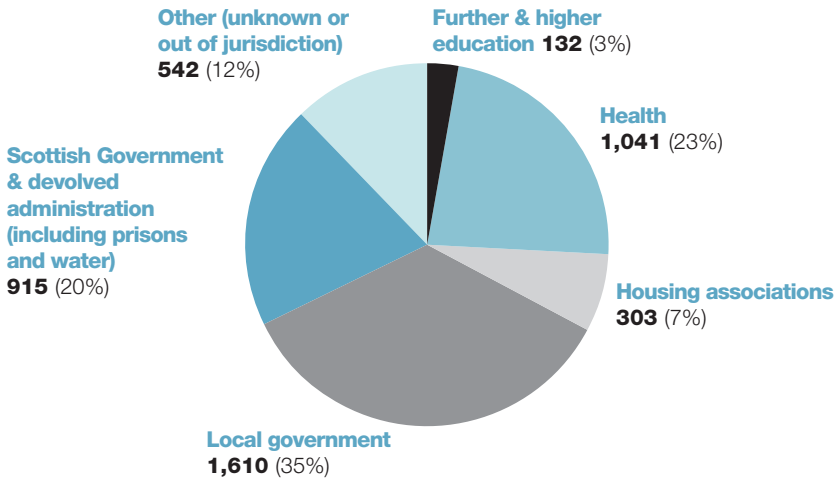
### Total enquiries and complaints received by year



## Who the complaints were about

There was little change in the number of complaints we received about those sectors where we had not seen a change in our remit, such as health and local government. There was a significant increase in the number of complaints classed as Scottish Government and devolved administration, because prisons and water bodies fall into this category[1]. Complaints about these new areas accounted for 703 (78%) of the 903 complaints received about the sector.

## Total enquiries and complaints received by sector in 2011 – 12




## Being proportionate and having impact

Under the new process we put in place in May 2010, our Advice and Early Resolution teams 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 before reaching a decision.

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 in full to the Parliament only the small proportion of the complaints we receive that meet our public reporting criteria.

Under legislation that came into force in April 2011, we were able to publish the learning from decision letters as well as investigation reports. We lay a decisions report before the Parliament each month, and, like investigation reports, make these available on our website. Feedback from authorities on this wider publication is positive and we are pleased that bodies read the reports and share learning from them internally to identify possible issues and prevent similar problems from arising in their own organisations. We have also had positive feedback from members of the public, who find that the reports help them understand our process and what we may be able to achieve for them.

Another way we make sure that our consideration of complaints makes a difference is by following up on the recommendations we make. We set a deadline for each recommendation, and ask bodies to provide evidence that the recommendation has been complied with. In 2011–12, 88% of recommendations were complied with by the deadline we had set. In total we made 619 recommendations, many of which are detailed in the sectoral chapters later in this report.

## How the complaints break down

During 2011–12 we responded to 626 enquiries and determined 3,748 complaints. We resolved 2,985 of the complaints by providing advice or guidance to the complainant or public body concerned. Of those complaints, 1,612 reached us prematurely – i.e. they had not completed the complaints process of the organisation concerned.

This is an improvement in the overall rate of premature complaints reaching SPSO, from 51% in 2009–10 to 45% in 2010–11 to 43% last year. There were, however, sectoral differences. We saw no change in the number of premature complaints about the health sector (where they totalled 31% of all health complaints received). The rate for local authorities fell from 55% to 52% and in further and higher education it rose from 31% to 33%. Premature complaints about housing associations (which year-on-year are the highest of all sectors) saw a further rise from 64% to 67%, and those about the Scottish Government and devolved administration went up from 30% to 36%.

We investigated 763 complaints in depth, determining 707 with decision letters and 56 by investigation report. We made 420 recommendations in decision letters and 199 in investigation reports.

**1** Some water complaints are about private sector providers but have been classified here for ease of reference.

# Casework performance

### Outcomes of our decisions

There are sectoral differences in the rate of complaints we uphold in decision letters and investigation reports. These are explained in the chapters about the different sectors later in this report.

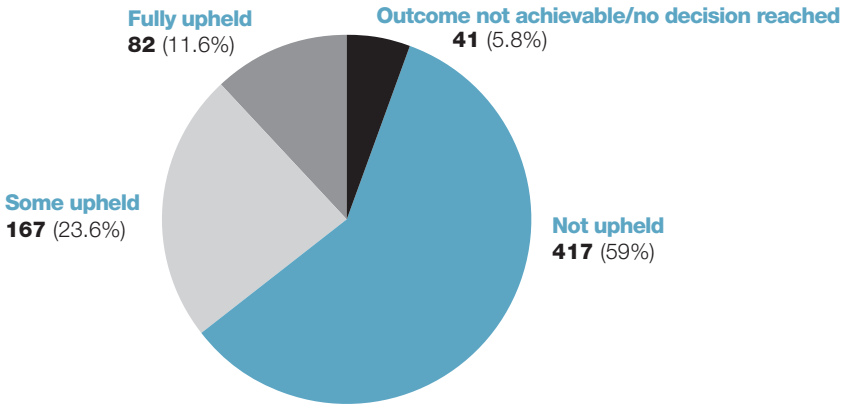
### Investigation report outcomes

Of the 56 cases that reached this stage, we discontinued three and published 52 reports about a total of 53 complaints.

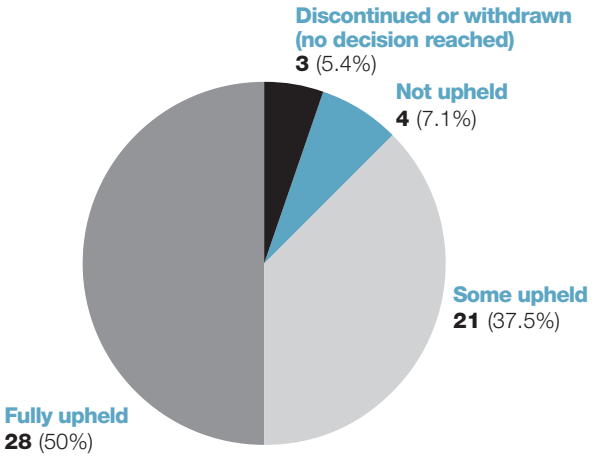
### Quality assurance

In 2011–12, we continued to develop and improve our quality assurance process. Following a pilot scheme, we implemented a revised process in April 2011, which was reviewed by our internal auditors, the Scottish Legal Aid Board.

## Decision letter outcomes 2011–12




## Investigation report outcomes 2011–12




## Customer satisfaction

### Background

There is no statutory requirement for the SPSO to gather service users' views. However, as a body providing a public service, we recognise the value of listening to complainants' views about us. Only people using our service can tell us what they expected from us, how they felt about their interaction with our staff and whether they thought their needs were met. Over the past six years, we have regularly sought user feedback as a means of measuring our performance and informing improvements.

### How we have gathered feedback

Since 2006, we have used a number of different methods to ask complainants for their views. From 2007–2010, we gathered feedback through paper postal surveys, carried out by independent researchers.

The last survey gathered responses in the first 3 months of 2009 and 2010, and compared the results from those periods. At the end of that survey, the researchers' advice was that we had maximised the benefit of measuring satisfaction in that way. They recommended that we use focus groups for future survey work, which they said would give us more qualitative information about what people liked and did not like about our service. We pointed to this in the 'future action' section of our response to the December 2010 survey where we also noted that we had put a new complaints handling process in place in May 2010.

We said that we wanted the new process to have had an opportunity to settle into place before qualitative survey work about our service was carried out. In December 2011, we decided that the time was right to progress this work. The researchers' report *Listening to Complainants* was published in August 2012.

**Satisfaction link to outcome**

As is the case with all ombudsman's offices, complainant satisfaction levels tend to reflect satisfaction with the outcome of a complaint and, given the legislative constraints within which ombudsmen work, levels of satisfaction are generally low. This was recognised in previous SPSO complainant surveys and in *Listening to Complainants* where the report says:

*'Unsurprisingly, people's views were largely coloured by the final outcome in their case. Those that did not achieve the outcome they had hoped for – either because the SPSO was not able to take on their complaint or because their complaint was not upheld – tended to be dissatisfied. Very understandably, their strength of feeling was often linked to the nature of their complaint, with those that had made a complaint relating to very difficult and personal events often left very disappointed by their contact with the SPSO.*

*Those that had reached the latter stages of the SPSO's processes, and who had their complaint entirely or mostly upheld, were almost all fulsome in their praise for the organisation. For these people, it was clear that having achieved their original goal of holding the complained about organisation to account, and, crucially, of feeling they had done all they could to prevent mistakes being repeated, was of immeasurable value.'*

All the report's key messages and recommendations for possible actions or changes were considered by our senior management team and the majority of them were accepted. Many of the recommendations echo conclusions drawn from our quality assurance process and along with those findings, the survey results have been a key source of feedback informing our 2012–13 service improvement plan. The report, our response and the actions are available on our website.

# Making a difference

## Emma Gray, Head of Policy and External Communications

Our policy team is responsible for ensuring that expansions to our remit take place seamlessly, without disruption to existing service users and other stakeholders

Ten years ago, in her introduction to the SPSO's first annual report, the then Ombudsman, Professor Alice Brown, wrote: *'In the spirit of our founding legislation, the new office aims to raise public awareness of its existence, to improve access to the service for members of the public, to provide an informal resolution to complaints where appropriate, and to promote good administrative practices in public services.'*

Ten years later, those same principles of raising awareness, improving access and promoting good administrative practice guide our second, third and fourth strategic objectives. These can be summarised as 'supporting public service improvement in Scotland', 'improving complaints handling by public service providers' and 'simplifying the design and operation of the complaints handling system in Scottish public services'.

These areas lend themselves less easily to performance measures, but to support our work we have developed annual outputs and targets. In relation to the second strategic objective, we measure areas such as the amount of self-initiated material we place in the public domain, the volume of visitors to our website and the press coverage we receive. The output of our Complaints Standards Authority (CSA) contributes in particular to the third and fourth strategic objectives and is covered in more detail in the next chapter. Strategic objective four also covers our engagement with relevant bodies on proposed changes to complaints handling legislation and regulations, which is covered in this chapter.

We begin by outlining the key improvements we made in 2011–12 towards achieving our second strategic objective and how our work can be seen in relation to national policy initiatives such as the Christie Commission and the Scottish National Performance Framework. In the final section, we describe how we have managed the challenges of our widening remit in 2011–12.

### Raising awareness

As we outline earlier in this report, a significant change in 2011–12 was that, due to legislative changes, we were able to exercise greater flexibility in how we publish our decisions. From June 2011 (when we began to publish the outcome of decision letters) to March 2012, we reported 482 decisions. We plan to publish two thematic reports in 2012–13, based on themes emerging from this greater volume of information.

We have also continued to share strategic lessons from complaints through our monthly Ombudsman's Commentary. We issue this as an e-newsletter to over 1,200 subscribers and use it to communicate specific points of good and bad practice in complaints handling, as well as general messages and updates from the Ombudsman. We also provide information and analysis when we issue our annual statistics and in the annual letters to individual bodies under jurisdiction.

We also publish information for specific audiences. For example, in May 2011 we issued our guide for MSPs and parliamentary staff. It explains our role as the last stage in considering complaints about a vast array of public services and describes what we can and cannot achieve for complainants.

While members of the public can bring a complaint to the SPSO directly and do not (as is the case in England, for example) have to ask an elected representative to do it for them, we know that some people ask their MSP for support in making a complaint. When this is the case, it is in everyone's interest that our powers, including their limitations, are understood.

We share the learning from our consideration of complaints in other ways as well. For example, it is the basis of the evidence we provide in responses to Parliamentary Committee inquiries, Scottish Government consultations and the work of other key stakeholders. We also share learning from complaints with professional and regulatory bodies and likewise they share information with us. These relationships are outlined in memoranda of understanding and other protocols, which also detail how we share responsibilities for complaints handling.

### Improving access

We regularly review the communications tools we use to help different groups know about and access our services. As well as leaflets about our process, we publish fact sheets about common subjects of complaint, such as planning, housing allocations and hospital care. From August 2011, when we took on complaints about water and sewerage providers, we were frequently asked about compensation and we decided to issue a new leaflet to explain the legal position on such claims.

In the course of the year, we also produced material to help raise awareness of our service among prisoners. We have visited a number of prisons since complaints moved to us in October 2010 and have used innovative means of gathering feedback about our materials for prisoners, such as a discussion forum amongst young offenders. There is more about this aspect of our work in the Equality and Diversity chapter of this report.

Given the increasing use of the internet, we measure the amount of traffic to our website. In 2011–12, 42,947 unique visitors accessed the SPSO website. This marked a 25% rise in unique visitors compared with the previous year. In 2011–12 we also recorded an overall increase of 20% in visits, compared with the previous year.

One of the ways people hear about the SPSO is through the media. The vast majority of the coverage we receive is case-related – in 2011 our investigation reports generated 234 of the total of 314 mentions of SPSO. Stories about the health sector accounted for 51% of coverage, with the local authority sector second highest at 20%. Total coverage rose last year by 11% compared with the previous year, generating almost 40 million opportunities to see information about the SPSO and producing an advertising value equivalent of nearly £310,000.

### Promoting good administrative practice

In the Ombudsman's Commentary and on our website, we highlight cases where authorities have responded well to complaints and taken action to remedy an injustice before a complaint reached us. We aim to support improvement by focussing public bodies on embedding good complaints procedures and on learning from complaints to identify and prevent future problems. This emphasis on prevention is one of the cornerstones of the Christie Commission report, published in June 2011.

Our strategic objectives can also be seen in relation to the Scottish National Performance Framework (NPF), in particular the national outcome of ensuring that public services are high quality, continually improving, efficient and responsive to local people's needs. Our objectives can also be related to other outcomes, including the additional outcome announced in December 2011 relating to older people *'Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it'.* There are several NPF indicators to which our work is directly relevant – for example, our CSA aims to 'improve the responsiveness of public services' and 'improve people's perceptions of the quality of public services' by ensuring that complaints processes are accessible, timely, robust and transparent.

In health complaints the recommendations that we make for redress and improvement can be related to indicators such as 'improve end of life care', 'improve the quality of healthcare experience' and 'improve support for people with care needs'.

# Making a difference

### Smooth transitions

Our policy team is responsible for ensuring that expansions to our remit take place seamlessly, without disruption to existing service users and other stakeholders. In 2011–12, we were asked to consider widening our jurisdiction to include complaints about the police, water and sewerage providers and prison healthcare. As well as adding to our complaints handling caseload (in 2011–12 we received 385 prison complaints and 318 water complaints) each expansion means that we have to expend our resources on areas including:

- Policy – where appropriate, providing our knowledge and expertise to the teams drafting legislation ahead of the changes, including for the financial memoranda to accompany the bills
- Knowledge management – building our knowledge base and our complaints reviewers' understanding and expertise in the new areas, including, for example, discussions with those already handling such complaints, and site visits to relevant facilities
- Professional advice – identifying sources of technical advice we can call on when necessary
- Communication – telling people who have complaints with the body that is to be transferred to us about the changes; informing the wider public and other stakeholders; closing old websites and updating our own; adding to our suite of leaflets; managing press interest in the changes
- Legacy issues – dealing with financial, administrative, personnel etc issues that result from the changes

### *Police complaints*

We participated in the Scottish Government's two short life working groups that examined scrutiny and complaints handling in the context of the proposals on reforming policing services. The first was set up in March 2011 in response to the Cabinet Secretary for Justice's proposal to review how complaints about the police would be handled. The second group met in October 2011 to look at complaints, scrutiny, governance and accountability under the single police force model.

Following the conclusions of the working groups and the Government's consultation, the Cabinet Secretary decided that a new body would handle complaints about the police. The Police and Fire Reform (Scotland) Bill that was introduced in Parliament in January 2012 provides for powers for the body, which will look at both non-criminal and criminal complaints from 1 April 2013.

### *Water complaints*

When Waterwatch Scotland was abolished, complaints transferred to us on 15 August 2011. In the preceding months, we engaged with key stakeholders including the Scottish Government, Scottish Water, the Water Industry Commission for Scotland and Consumer Focus Scotland (which took on the customer representation function of Waterwatch). The numbers and type of complaints that we received are detailed in the Scottish Government and devolved administration chapter.

### *Prison health complaints*

As we outline in more detail in the health chapter, we began to take complaints about healthcare in prisons in November 2011 when responsibility for this transferred from the Scottish Prison Service to local NHS boards. As we are the final stage in complaints about the NHS, unresolved complaints about prison healthcare are now brought to us rather than to Scottish Ministers. We prepared for the change through detailed discussions with the Scottish Government and the health boards involved. We also visited a number of prison health centres to better understand the environment and the issues that would be coming to us. We had already taken on responsibility for complaints about Scottish prisons in October 2010, following the abolition of the Scottish Prisons Complaints Commission.

# Complaints Standards Authority
## Paul McFadden, Head of Complaints Standards

We decided to adopt a sector based approach that would allow us, in partnership with key stakeholders, to develop model CHPs that would be specific to the needs of each sector

### Background

As we have already outlined, the most significant addition to our role in the past two years is the authority given to us to lead the development of simplified, standardised complaints handling procedures (CHPs) across the public sector. The Public Services Reform (Scotland) Act 2010 also provided us with a duty to monitor and promote best practice in complaints handling for relevant public service delivery staff. Our third and fourth strategic objectives are designed to take these statutory functions forward through the work of our Complaints Standards Authority (CSA).

### Purpose, approach and benefits

In line with the recommendations of the Sinclair Report, the purpose of the CSA is to support continuous improvement in complaints handling by guiding all public service providers under our remit towards a simplified, standardised complaints procedure, which puts the service user at the heart of the process, focuses on early resolution, and values complaints as tools for feedback, learning and improvement.

There were a number of approaches that we could have adopted to bring about simplification and standardisation. Wales, for example, took a 'one-size-fits-all' approach, requiring all public service providers to adopt the same complaints procedure and policy. We decided to adopt a sector based approach that would allow us, in partnership with key stakeholders, to develop model CHPs that would be specific to the needs of each sector, with some critical elements remaining standard across all the CHPs. One key element is the two-stage process, with an emphasis on early resolution, as recommended in the Sinclair Report. We saw the significant benefits of the development of model CHPs as follows:

- standardisation
- customer focus
- focus on early resolution with empowered, well-trained staff
- improved complaints performance
- efficiency (achieved by reducing costs involved in unnecessary stages and resolving more complaints at the point of service delivery)
- benchmarking through standardised recording and reporting
- increased customer satisfaction
- consistency

### Simplifying complaints handling

In 2011–12, we achieved a number of significant milestones towards our aim of introducing a standardised, simplified approach to complaints handling for all public bodies, building on the January 2011 approval by the Parliament of our *Statement of Complaints Handling Principles*, and the publication in February 2011 of our *Guidance on a model complaints handling procedure*.

We took a phased approach to developing model CHPs for each sector, with local government and registered social landlords (RSLs) our immediate priorities in 2011–12. From the outset, we adopted a partnership, collaborative approach in developing these which will undoubtedly prove to be of great value as we move towards implementation. We communicated the various stages of development through the monthly Ombudsman's Commentaries, the SPSO website and the CSA's dedicated Valuing Complaints website, and in emails and letters from the Ombudsman.

# Complaints Standards Authority

We published the model CHP for local authorities in March 2012 and for RSLs in April 2012. We also made significant progress on developing CHPs in other sectors.

A key part of our strategy was to work with regulatory bodies to build compliance and performance monitoring mechanisms into existing structures and processes, avoiding any additional regulatory burden, and doing this through self-assessment wherever possible. We also developed support for complaints handlers through setting up a network for sharing information, good practice guidance and training activities.

### *Local authority model CHP*

Our approach was to establish a working group of local authority representatives, including support from SOLACE (the Society of Local Authority Chief Executives) and COSLA (the Convention of Scottish Local Authorities). Although the primary focus of the working group was to develop the model CHP, sub-groups of the main working group were also set up to support the implementation and monitoring of the CHP and to help further improve other aspects of complaints handling. The sub-groups considered:

- a model for monitoring compliance and performance
- a standardised approach to recording and reporting complaints data
- a training needs gap analysis to help support the implementation of the new model
- a baseline analysis of costs and volumes
- developing a network of professional complaints handlers for the sector

We worked closely with local authorities and a range of other relevant bodies throughout the year and this work is detailed in the local government chapter of this report.

### *RSL model CHP*

Our approach in the social housing sector involved working with high level stakeholders including the Scottish Housing Regulator, the Scottish Federation of Housing Associations, the Chartered Institute for Housing, the Scottish Housing Best Value Network and tenants groups. Representatives of these organisations formed our key stakeholder group.

We also issued a survey to RSL staff, committee members and tenants and coordinated an advisory panel of RSLs to help develop and provide detailed feedback on the model CHP. There is more about this engagement in the housing chapter.

### *Other sectors*

We also engaged with other sectors to provide advice and guidance on developing model CHPs. We made progress in both the higher and further education sectors. Universities Scotland set up a working group with representatives from several universities and student groups, which met several times during the year. Scotland's Colleges also provided valuable feedback as we worked with the further education sector to develop their model CHP. We also engaged with the Scottish Government and will continue to work with them to develop a model CHP, and we worked on an ad-hoc basis with a number of agencies and non-departmental public bodies, providing advice and guidance as they revised their complaints procedures.

### Providing support and promoting good practice

A crucial second strand of our CSA role is to support providers and provide a centre of good practice in complaints handling to help improve overall standards of complaints handling. This is particularly important as public service providers move to adopt the streamlined two-stage approach. The Sinclair Report recommended the introduction of a network of professional complaints handlers. This was one of a number of strands that the CSA progressed throughout the year supported in part through improving our Valuing Complaints website and developing the SPSO's training unit.

### *Valuing Complaints website*

www.valuingcomplaints.org.uk was designed as the platform for providing SPSO best practice guidance and training resources. The site was re-launched in June 2012 and now plays host to our online training centre, a discussion forum for complaints handlers, a blog written by the CSA and guest bloggers, and a best practice resource centre. The online forum provides a platform for discussion among public sector complaints handling professionals to share expertise and best practice across all sectors.

***Training***

We recognise that the key to good complaints handling is staff who are empowered and trained to deal with complaints early and robustly. We set up the SPSO training unit in 2009 to support service providers in this area. It continues to deliver tailored courses in frontline complaints handling and investigative skills to a wide range of organisations. In 2011–12, the training unit completed its programme of delivering 'buddy' courses to all the NHS boards (these courses involve our team training the boards' staff, who then cascade the training to their colleagues).

The SPSO team also trained staff at organisations including:

- Scottish Ambulance Service
- Scottish Prison Service
- Mental Welfare Commission
- City of Edinburgh Council
- Highland and Islands Enterprise
- Jewel and Esk College
- University of the West of Scotland
- East Ayrshire Council
- Care Inspectorate
- Scottish Environment Protection Agency
- Scottish Water
- East Lothian Council
- Housing associations

The redesigned Valuing Complaints website incorporates an online training facility focussed on providing training for frontline staff on the key skills required for frontline resolution in line with the new complaints handling procedures. Although this training is aimed at supporting local authority and RSL staff, much of it is also suitable for staff in other sectors under our jurisdiction. We aim to expand the training to these other sectors during 2012–13 and beyond.

# Local Government

Local government has consistently been the sector about which we receive most complaints each year. In 2011–12 we received 1,527 complaints about services provided by local authorities. Although this represents a drop in the number of complaints received for the sector, it still represents 39% of all the complaints we received, just under the percentage received in the previous year. We also received 83 enquiries, 42 less than last year. As local government touches the lives of all Scottish citizens in one way or another, it is not surprising that this remains the sector about which we receive most complaints.

The figures in this chapter include complaints about the housing functions of councils. There is more detail about social housing complaints in the dedicated housing chapter later in this report.

### Areas complained about

There was little change in respect of the areas complained about, although the numbers of complaints about each dropped compared to last year and there was a slight change in the order in which they appear on the list. Housing, planning and social work remained at the top of the list.

**Top areas of local government complaints received 2011–12**

| | |
|---|---|
| Housing | **341** |
| Planning | **210** |
| Social work | **182** |
| Roads and transport | **96** |
| Education | **77** |
| Finance | **73** |
| Legal and administration | **44** |
| Building control | **42** |
| Environmental health and cleansing | **40** |
| Land and property | **30** |

We also record information about the main subjects involved in these complaints, which gives us more detail of the issues complained about. These are shown on the table below. We found that planning, housing and council tax consistently generated the highest number of complaints. We commented last year about the number of complaints we received about complaints handling and appeal processes – these dropped slightly this year from 4.4% of the total received about local government to 3.9%.

**Top subjects of local government complaints received 2011–12**

| | |
|---|---|
| Policy/administration | **293** |
| Handling of planning application (complaints by opponents) | **105** |
| Repairs and maintenance of housing stock (including dampness and infestations) | **97** |
| Council tax | **58** |
| Neighbour disputes and anti-social behaviour | **54** |
| Local housing allowance (previously housing benefit) and council tax benefit | **48** |
| Children in care/taken into care/child abuse/custody of children | **38** |
| Housing applications, allocations, transfers and exchanges | **35** |
| Parking | **34** |

### Issues in local government complaints

As we highlight in the health section of this report, the Ombudsman is particularly concerned about the unacceptably high level of upheld and premature complaints that we see. In 2011–12, the level of upheld complaints for all sectors – those that were valid for SPSO and where we upheld all or part of the complaint – went up to 39% from 34% in 2010–11.

In the local government sector the level of upheld complaints rose from 29% to 32%. The Ombudsman noted that *'These complaints have been looked at in great detail by local authorities prior to our involvement, and yet in around a third of cases, I am still finding fault'.*

During the year we closed 780 complaints as premature (where the individual has not yet completed the service provider's complaints procedure). This meant that the level of premature complaints fell from 55% to 52% in this sector (across all sectors they fell from 45% to 43%). While this reduction is welcome, this is still the sector with the second highest level of complaints to reach us too early. It remains a matter of concern that more than half of the complaints about local government reach us before they have completed the complaints process of the council concerned. In his annual letter, the Ombudsman again urged councils to consider what they can do to reduce the number of premature complaints.

### *Planning*

Each year, without fail, planning ranks as the subject about which we receive the second highest number of complaints about local authorities. We hear from people on opposing sides of the planning process – from individuals who have made an application and are unhappy about how the planning authority has handled it, and from objectors who have concerns about the effect of planning applications made by others. In September 2011, the Ombudsman commented on the number of these complaints that we receive. He said:

*My approach is pragmatic and where I find that planning authorities are acting unfairly I will make robust recommendations to rectify what has gone wrong and to prevent reoccurrence, and I will draw attention to any failings. As Ombudsman, I do not believe that it is enough for planning authorities to simply toe the line and meet the minimum standard to keep on the right side of the law and regulations.*

*… Given their enhanced powers, planning authorities need to provide a level of service that is demonstrably reasonable, transparent and fair. It is the responsibility of planning officers to ensure that they explain their decisions clearly and fully to the public, and I will hold them to account for that.*

### *Statutory repairs*

During 2011–12 we received a number of complaints about issues relating to problems with the City of Edinburgh's statutory repairs notices. This is a scheme unique to that city, giving the council legal powers to carry out repairs to shared buildings and to bill owners for the costs. However, there were significant problems with it, which became the subject of investigations elsewhere. Because of these other investigations, we decided in May 2011 to suspend consideration of complaints about statutory repairs matters. We passed these complaints back to the council to re-examine. We have therefore not so far taken up complaints that are directly about the alleged mishandling of cases under the scheme.

### *What happened to the complaints*

In 2011–12 we gave decisions on 1,497 local authority complaints. This included a small number of cases carried forward from 2010–11.

We published nine full investigation reports about local authorities. We fully upheld six, partly upheld one and did not uphold two. The reports were about a range of subjects including traffic regulation, the right to buy a council house, facilities for parking for those with disabilities and the handling of planning applications.

We know that people come to us in the hope that we can change something that they are unhappy about. However, we sometimes find that complaints, while understandable, are about issues where we can do little. This most often happens where the person is unhappy with a decision that has been taken, but the authority concerned has acted according to the guidelines. The decision being taken in such cases is usually one that the authority was entitled to take (a discretionary decision), and we have no power to look at these if nothing has gone wrong in the taking of the decision.

For example, a man told us that a developer was operating unauthorised businesses next to his home. He thought that the council should take enforcement action to stop this. We found that the businesses were indeed operating without planning consent. We also found, however, that the council were actively working to ensure that the developer applied retrospectively for the appropriate consents, as they were entitled to do. Government guidance says that enforcement action should only be taken proportionately and when it is clear that the matter cannot be resolved through negotiation.

# Local Government

We did not uphold the complaint as we found that, in the circumstances of this case, the council had acted appropriately. In other cases, we may not be able to change what has happened, but we may find that the authority could have done things better. An example of this is where another man was unhappy when a skate park was built opposite his home. We did not uphold most of his complaints as we found the council had not done anything wrong, but we did uphold his complaint that the council had not put planting in place to screen the skate park as intended. Although the council explained why this had not happened, we were concerned that there had been no effective screening to reduce loss of amenity to local residents. We therefore recommended that the council take steps to see if they could resolve this by planting a dense screen compatible with existing trees and shrubs in the park.

In local government, there are other areas, such as social work and education, in which we cannot look directly at the issues involved, but may be able to look at how a complaint about the matter was handled. In cases where we can look at the main issues involved and we find that the authority concerned has not acted appropriately, we make recommendations to address the problems that have arisen. An example of this, which is in contrast to the previous example about planning enforcement, is where a couple contacted us because they were unhappy about a new games area beside their home. They complained about anti-social behaviour and about the amount of light that fell into their garden from the floodlights on the site. They said that the council had not enforced a planning condition, which said there should be no light spillage beyond the boundaries of the site, to the satisfaction of the planning authority. In this case, we found no evidence that the council had taken satisfactory steps to address these problems. We upheld the couple's complaints and made several recommendations.

Further examples of our work can be seen in the selected recommendations and case studies at the end of this chapter, and our reports and decisions are available on the *Our Findings* section of our website.

**Improving complaints procedures**

As we outline in the Complaints Standards Authority (CSA) chapter, a working group of local authority representatives developed a model complaints handling procedure (CHP) for the sector in 2011–12. This was an intense period of engagement with bodies including councils, regulatory bodies, the Society of Local Authority Chief Executives (SOLACE), the Convention of Scottish Local Authorities (COSLA), the Scottish Government, the Association of Directors of Social Work (ADSW), Consumer Focus Scotland, the Care Inspectorate and Citizens Advice Scotland. As well as arranging meetings, visits and presentations, the CSA team wrote newsletters and articles to raise awareness of the changes and to invite collaboration and participation. Much of our August annual council liaison officer meeting was devoted to the model CHP. Delegates from councils across Scotland heard from a variety of speakers including a council which had successfully piloted the two-stage model. They also participated in workshops designed to identify what councils needed and how we could support them and others in three key areas – complaints handling training, guidance materials and helping set up networks of best practice.

In December, we attended SOLACE's meeting of local government chief executives to present and discuss the proposed model CHP. In January and February, we received final comments on the final draft of the CHP and the associated customer and staff-facing documents, and these were published at the end of March.

We would like to place on record our thanks to all the councils and other organisations who provided staff members for the working group of local authority representatives. Their time, commitment, expertise and sheer hard work were invaluable in developing the local authority model CHP.

### Compliance and performance monitoring

All councils now have a duty to comply with the model CHP and to submit compliant CHPs, or detailed plans for implementation. Since publishing the CHP, we have continued to support councils in this process, and to provide further details of our expectations and advice on implementation.
As we outline in the CSA chapter, Audit Scotland will monitor compliance in conjunction with the SPSO and in line with the principles of the Shared Risk Assessment arrangements. Once implementation has been fully rolled out, Audit Scotland will also report compliance through the annual audit process. In future years, we expect each local authority to have appropriate self-assessment arrangements in place to assure itself that its CHP is operating in accordance with the model. From 2013/14 local authorities will also be required to assess and report complaints handling performance around a range of high level performance indicators.

### Social work complaints

We responded to the Scottish Government's consultation on the Review of Social Work Complaints, which closed at the end of March 2012. Our response supported the option which would see local authority internal processes streamlined and aligned with the local authority model CHP and also the option of providing SPSO with the remit to undertake the external review role currently undertaken by complaints review committees. Our response makes it clear that this would require changes to the SPSO Act 2002 and additional resources for the SPSO.

## Examples of recommendations made in local government complaints

**That a council:**

***Planning***

- amend guidance notes on their submission form for formal objection to a planning application and representation of support
- take all reasonable action to enforce a planning condition
- take steps to ensure that an error in publishing information about a planning application is investigated thoroughly and take action to improve their process to ensure that this does not happen again
- feed back our views to the planning staff who deal with complaints about neighbour notification

***Other***

- take measures to ensure that information is provided to customers when direct deductions are made
- consider regularising permission for a landfill site and ensure this covers all ancillary activity with appropriate planning conditions
- remind staff of the importance of adhering to the relevant timescales when arranging complaints review committee hearings through the statutory social work complaints process
- ensure that their staff act in accordance with the council's anti-bullying policy in relation to the use of the appropriate forms for recording and monitoring
- ensure that the revenues department undertake a review of procedures to ensure a clear process is in place and is communicated effectively to all stakeholders when responding to enquiries or disputes about council tax

***Complaints handling***

- apologise for inaccurate information provided when responding to a complaint and take steps to ensure that accurate information is provided when responding to complaints in future
- say by when recommendations made in response to a complaint will be implemented
- review staff absence procedures and introduce measures to ensure that future staff absences do not unduly impact upon the delivery of the service standards set out in the council's complaints handling procedure
- review the procedures for investigation of service complaints to ensure that staff are interviewed as part of the process and that this is recorded
- ensure that senior staff from a school participate in refresher sessions on handling formal complaints

# Local Government

## Case studies

### Planning; communication; changes to application

> Case 201002146

Mrs C's neighbour notified her that he was applying for planning consent for dormer windows. He assured her that no windows would face her property. Mrs C checked the council's online planning portal and found that that was the case, so she did not object. A council planning officer then suggested changes to the plans, including a window facing Mrs C's house. Mrs C only became aware of this after construction started. Among other things, she complained to us that the plans were changed without anyone telling her and that there was a delay in putting the amended applications on the council website.
We upheld Mrs C's complaints about the changes and the placement of the amended application online. We recommended that the council apologise and offer to meet the cost of Mrs C's neighbour installing obscure double glazing on the window.

### Disabled parking: communication; objectivity of report

> Case 201000579

Mr and Mrs C applied for a disabled parking space outside their home at the same time as their neighbour across the road applied for one. The road was not wide enough to accommodate a space directly in front of each property, so a council committee decided to put Mr C's space on the opposite side of the road to his house. Mr C said that his medical condition meant this was unacceptable, and complained that the information presented to the committee was misleading and inaccurate. He was also unhappy with the process leading up to the decision, and with the council's complaints investigation.
We found that the report presented to the committee included some subjective opinions as fact, and to an extent misrepresented the situation, and that Mr and Mrs C were not given enough notice of the deadline by which they should submit documents to the committee. We also found that the council's investigation of the complaint was clouded by personal opinion and did not concentrate solely on the facts. As, however, the council had agreed to refer the matter back to the committee, we made recommendations with this in mind. These included that, before the applications were reconsidered by the committee, the council compile a new report on the options available and set a deadline in advance for submissions from interested parties.

# Case studies

## Building control: building warrant; fire safety

> Case 201003760

Mr C complained that the council did not take action about building warrants issued for his neighbour's property. His and his neighbour's properties were formerly a single house with a shared stairwell. After Mr C's neighbour applied for a building warrant to renovate his property, including work in the old stairwell, Mr C complained that the work was not completed in line with the building warrant or to the required fire and acoustic insulation standard. He felt that the warrant required his neighbour to divide the properties by introducing a new ceiling at the level of Mr C's floor. Because the neighbour did not do so, Mr C was prevented from carrying out work for which he himself had obtained a building warrant. We upheld part of Mr C's complaint. We did not find that the building warrant required his neighbour to divide the properties. We were concerned, however, that the council did not take prompt action to address Mr C's legitimate concerns about fire safety. We recommended that the council review their procedures for ensuring that fire safety risks are resolved in good time and that they consider taking enforcement action against the property.

# Health

Complaints about the NHS have always formed around a quarter of the cases that come to our office. Like local government, it is an area with which most people have contact throughout their lives. In 2011–12 we received 1,002 complaints about the NHS, continuing previous years' trends of rising complaint numbers. We received 39 enquiries, a small rise on the 32 we received last year.

The difference between complaints about healthcare and other areas under our jurisdiction is that in health cases we have a specific power to look into clinical judgment. This means that we can look in detail at the decisions made by medical staff about the treatment and care provided in places such as pharmacies, surgeries, health centres and hospitals. We make recommendations, sometimes very detailed, about changes to practice and procedure. We also often recommend that training is provided or that staff are asked to read and take account of our findings in order to learn from them.

**Top areas of health complaints received 2011–12**

| | |
|---|---|
| GP and GP practices | **179** |
| Hospitals – general medical | **145** |
| Dental and orthodontic services | **67** |
| Hospitals – care of the elderly | **59** |
| Hospitals – gynaecology & obstetrics (maternity) | **42** |
| Hospitals – psychiatry | **42** |
| NHS boards (including special health boards and NHS 24) | **27** |
| Hospitals – oncology | **26** |
| Ambulances | **26** |
| Hospitals – general surgical | **19** |

The area about which we consistently receive most complaints is that of GPs and their practices. This year there was a small increase in the number of such complaints, up from 157 to 179. Complaints about care for the elderly, a subject that saw a drop in 2010–11, returned to the level of 2009–10. Complaints about hospital gynaecological and maternity treatment also rose, by around 40%.

We see certain recurring issues in health complaints, which the Ombudsman has highlighted during the year. Issues include late diagnosis, poor clinical treatment and nursing care, inadequate communication and record-keeping. He has stressed the need for leadership and ownership of complaints at all levels in the NHS.

### Subjects of complaints

We record statistics of the subjects complained about as well as the area of the NHS involved. The next table shows the main issue that the person making the complaint asked us to look at, but there are often other issues involved. For example, the main issue that is brought to us may be about the care and treatment that a patient received in hospital but they may also not have been happy with the way in which staff communicated with them. We often find that some of the issues about which people complain could have been avoided or mitigated by better communication with patients and their relatives at the time.

The issue about which we received most complaints was, as always, clinical treatment and diagnosis. We received 436 complaints about this – an increase of about seven per cent on last year's complaint numbers, although the percentage of these complaints in comparison to all health complaints received remained virtually the same at around 43%. We took in 104 complaints about policy and administration, and 93 complaints about the ways in which staff interacted with people while they were in hospital (10% and 9% respectively of the complaints we received).

Complaints about people being removed from the practice list of a doctor or dentist dropped slightly after having risen sharply last year, albeit on only a small number of complaints.

| Top subjects of health complaints received 2011–12 | |
|---|---|
| Clinical treatment/diagnosis | 436 |
| Policy/administration | 104 |
| Communication, staff attitude, dignity, confidentiality | 93 |
| Complaints handling | 34 |
| Appointments/admissions | 32 |
| GP/dentist lists | 16 |
| Admission, discharge and transfer procedures | 13 |
| Nurses/nursing care | 10 |
| Record-keeping | 7 |
| Continuing care | 6 |

### What happened to the complaints?

In 2011–12 we gave decisions on 937 health complaints, including a small number of cases carried forward from 2010–11. As we said in last year's annual report, we now work to new criteria for laying full investigation reports before the Parliament. In 2011–12 we laid 41 public reports (covering 42 complaints) about the NHS, slightly more than in 2010–11. In June 2011, we also started to publish monthly reports of the decisions that we gave by letter.

We investigated a total of 296 complaints. Of the 42 complaints that formed public reports, we fully upheld 22 (52%), partly upheld 18 (43%) and did not uphold two (5%). We discontinued and did not report on one case that had moved to this stage of our process. The reports were about various subjects, including diagnosis and clinical treatment, nursing care, care and treatment of mental health patients and care of the elderly. The issues of record-keeping, communication, and complaints handling also featured.

We issued decision letters about 253 complaints that we had looked at in detail. We published reports of most of these cases on our website. We fully or partly upheld 125 (50%), did not uphold 118 (46%) and could reach no decision on ten (4%). We made recommendations to the bodies concerned in many cases. This included some where we did not uphold the main complaint itself – we will do this where during our investigation we find something else that has gone wrong or could be improved.

All the reports can be read in full on our website along with reports of most of the complaints on which we gave a decision by letter. The case studies and examples at the end of this chapter illustrate some typical cases investigated during the year.

### Issues in health complaints

Last year, the Ombudsman expressed his disappointment at the unacceptably high level of upheld and premature complaints about all sectors. In 2011–12, the overall level of upheld complaints – those that were ready for us to look at, and where we upheld all or part of the complaint – went up from 34% in 2010–11 to 39%. In the health sector, it rose from 43% to 56% this year, another worrying trend. The Ombudsman commented *'These complaints have been looked at in great depth by boards prior to my involvement, and yet in more than half of cases, I am still finding fault'.* The level of premature complaints in the health sector remained constant at 31%, the lowest of all the sectors.

While we recognise that boards often take steps to improve when problems are identified, we are concerned about the issues that continue to come before us even after we have drawn serious failures to the attention of the medical community as a result of previous cases. We highlight two such issues below.

#### *Dementia*

We reported last year about the failings we were seeing in the clinical aspects of care and in nursing practice when it came to caring for patients with dementia. It is disappointing that we continue to report on this and to find significant failings in the care of some individuals. It is especially disturbing as those patients are unlikely to be able to speak up for themselves, and it is usually a member of their family that expresses concern and brings the complaint to us.

# Health

One of the case studies at the end of this chapter is a particularly poor example of care. We drew the attention of health boards to the case, and in particular to a paragraph in our report that contains an important, wider message about treatment of patients with dementia on acute wards. In the report, we noted that our independent advisers (a mental health specialist and a nursing specialist) *'... expressed concerns regarding the board's approach to the treatment of patients with dementia. They considered that scant regard was given to Mrs A's mental health needs or to treating her as an individual. They also considered that there was little evidence of a cohesive care plan being put in place for Mrs A. Both advisers felt that there was a general lack of understanding of how to manage the type of behaviour displayed by some patients on [the ward] and that there was no effective strategy in place to manage those patients' behaviour.'*

We urged boards to reflect on how they can ensure that staff on acute wards are equipped to deal not only with pressing clinical needs, but also to manage the particular challenges of people in their care who also have dementia.

### *Vulnerable individuals*

Three of our published reports this year touched on the lives of particularly vulnerable individuals, all of whom were at risk from self-harm. We commented that *'the failures in each of these cases, whilst unique in their own circumstances, have had a devastating impact on the individuals concerned and their families'*. We noted an absence of assessments of the individual and their risk of self-harm, as well as the fact that families should be included in the care pathway of vulnerable individuals. We also acknowledged that there are considerable challenges for clinical staff providing care and treatment to vulnerable patients, and that it is important that confidentiality is observed for the individual. One of these cases is included as a case study at the end of this chapter.

We remain concerned about the treatment of those who lack capacity to make decisions for themselves. We comment further on this in the Equality and Diversity chapter of this report.

### Improving complaints standards

The NHS's streamlined, standardised process is the model for the complaints handling procedures (CHPs) we are developing for the rest of the public sector. The Patients Rights (Scotland) Act 2011 impacts on how people give feedback and make complaints to the NHS, and our Complaints Standards Authority (CSA) fed directly into the development of the revised NHS *Can I Help You?* guidance, published in April 2012, through the Scottish Government's Complaints Review Group. This guidance continues to provide a good model for NHS complaints handling, with a strong focus on early resolution. The CSA will monitor best practice and complaints performance with a view to possible revisions to the guidance in future years under the SPSO's powers to publish model CHPs. Any changes will, of course, be in line with the terms of the Patient Rights Act and associated secondary legislation and would be undertaken in full consultation with the sector.

We also worked with the NHS on awareness information being provided to patients and with NHS Education for Scotland on guidance and training for staff. We will continue to work collaboratively with the NHS and Scottish Government to develop e-learning modules which will support the Patient Rights Act and the Charter of Patient Rights and Responsibilities. The learning materials will endorse the importance of listening to feedback, empowering staff to be proactive in managing concerns and complaints and to use appropriate tools such as de-escalation techniques and apology.

### Feeding back the learning

Complaints are an important driver for healthcare improvement and therefore we continue to share our findings with many stakeholders throughout Scotland. Our professional advisers delivered presentations and seminars to boards about common themes and issues, lessons learned from complaints and the power of apology. The Ombudsman visited a number of healthcare facilities this year to help him see at first hand the complexities of modern healthcare and the environment that patients, relatives and staff inhabit. We would like to thank boards for their support in such outreach work, which we consider a vital part of our role.

During January and February 2012, the Ombudsman met with nursing directors and the Chief Nursing Officer, chief executives of several NHS boards and the chairs of a number of NHS boards. Our nursing adviser, Dorothy Armstrong, attended the meeting of NHS chief executives with the Ombudsman. The meeting focussed on key themes from our casework, prison healthcare, our professional advisers, and education and training opportunities.

Nationally, we were pleased to be involved in providing our views and expertise in relation to national work streams and policy development at the Scottish Government. We also responded to the Parliament's Health Committee Inquiry into the Regulation of Care for Older People and were involved in the Improving Care for Older People in Hospital Stakeholder Group. In particular, we were able to share the themes identified from complaints about older people in hospitals and people living with dementia.

We were also pleased to attend several meetings of the NHS Complaints Personnel Association Scotland (NCPAS) network. The group provides a wealth of information and experience and is a valuable forum for discussing solutions to issues and challenges in handling complaints about the NHS in Scotland.

### Healthcare in prisons

We began to take complaints about healthcare in prisons during the year when, in November 2011, responsibility for this transferred from the Scottish Prison Service to local NHS boards. We had prepared for this though detailed discussions with the Scottish Government and the health boards involved. We would like to acknowledge the support from healthcare staff of HMP Barlinnie and HMYOI Polmont who facilitated visits to their premises. The visits enabled our staff to appreciate the prison environment and the challenge of providing healthcare in a custodial context. We received ten complaints about prison health centres up to March 2012, most of which were about clinical treatment or diagnosis.

## Examples of recommendations made in health complaints

**We recommended that health boards and GP/dental practices take action including:**

***Care and treatment***

- apologising to a man for the delay he experienced when waiting to undergo an operation for a hernia
- ensuring that a consultant is able to attend a plastic surgery clinic at its scheduled start time
- updating their knowledge of diagnosis and management of persistent upper limb symptoms
- ensuring that patients are appropriately monitored and the outcomes recorded during the administration of diuretics (medication used to remove water from the body)

***Communication***

- reminding consultants of their responsibility to personally inform patients of their test results and likely consequences
- reminding all staff to clarify – at the start of any accompanied consultation – who the accompanying adult is and that the patient is content for them to participate
- providing a complainant with a written transcript of relevant notes

***Record-keeping***

- sharing our decision letter with a consultant and reminding him of his responsibility to maintain a standard of record-keeping in line with General Medical Council guidance
- reminding nursing staff in a hospital of the importance of good record-keeping in relation to the assessment of patients on admission, including risk assessment and obtaining information from relatives and/or carers
- ensuring more detailed information is noted in the patient's clinical records in relation to their symptoms and the treatment given

***Other***

- drafting a protocol for patient transport
- reviewing the procedure for removing patients from the practice list, to ensure that future actions are consistent with the obligations in the NHS Regulations
- reviewing their complaints handling policy to ensure that it meets the timescales set out in the NHS complaints handling procedure and includes guidance on how to offer a meaningful apology

# Health

## Case studies

### Care of the elderly; clinical care; communication; complaints handling

> Case 201003976

Mrs A, who had dementia, was in hospital and her daughter and son-in-law raised a number of concerns about her care and treatment. They said that staff failed to monitor her condition properly or provide her with effective treatment. They were also concerned about staff communication, record-keeping, a lack of dignity for Mrs A and a failure to provide stimulation for her despite her dementia.

After investigation, we upheld all the complaints. We found that there was a failure to provide appropriate care and treatment to Mrs A. She was dehydrated and had suffered a number of falls on the ward. After one of these falls, Mrs A was not x-rayed as she should have been. We also found that the nursing notes contained inaccurate and inconsistent information, and unprofessional language. Communication between ward team members and the family was poor, and we noted that on occasion Mr and Mrs C were not advised that Mrs A had fallen, nor was the severity of her injuries explained to them.

We found that the handling of the complaint itself was poor and not in line with the standards set out in the board's complaints procedure. We made a number of recommendations for redress and improvement.

### Mental health assessment; communication

> Case 201003783

Mr A, who was 20, had attempted suicide. His father, Mr C, complained that Mr A's care and treatment was inadequate, and that staff did not involve his family in his care. Mr C said that over a 13 month period, despite numerous appointments with a nurse and review by a psychiatrist, Mr A made attempts on his own life. Each time he was sent home to his family, with no information or support. After Mr A took a third overdose, he was given information about independent providers of mental health care in the community and discharged from hospital. No other follow-up was arranged. Mr A took his own life two weeks later.

Our medical advisers said that Mr A's initial care and treatment was satisfactory, but more thorough assessments would have helped identify changes in his later behaviour pattern. There was no written plan for his care and treatment. Although it would have been difficult to predict Mr A's suicide, his risk of potential self-harm or suicide was never properly assessed. We took the view that these are serious failings, and are against existing national guidelines. It was also clear that Mr A's family tried hard to be involved in his care, with little success. Our advisers pointed out that the relevant guidance says that involvement of family and carers is good practice in assessing and managing patients. However, this did not happen in Mr A's case, nor did the board involve his family in their reviews after his death.

# Case studies

We were also concerned to discover that the board did not produce all the relevant documents until after we issued a draft of our investigation report. The missing documents were crucial, and related to the reviews that they carried out as a result of Mr A's suicide. As authorities are required by law to provide us with all relevant information on request, we expressed disappointment that the board did not provide this at the beginning of the investigation. We were also concerned about the quality of the reviews. We upheld Mr C's complaints and made several recommendations. These included that the board make significant reviews of their processes and procedures and apologise to Mr and Mrs C for the failings we identified.

## Communication; clinical treatment; complaints handling; record-keeping

> Case 200904350

Mr C had been losing weight and vomiting, and was admitted to hospital three times in three months. During the second admission a consultant found a large tumour which, according to the medical notes, was inoperable. However, Mr C and his family were not clearly told at the time that there was a likely diagnosis of cancer or what that might mean for his life expectancy. They only learned of this some three months later, just a few days before Mr C died. His wife complained that, because the consultant involved did not tell them about the cancer, Mr C was denied the opportunity to make informed choices about his treatment and end of life care. She also raised concerns about the way in which the board handled her complaint.

After consulting one of our medical advisers, we found significant failures by the consultant and the board. These included the failure to tell Mr C or his family about his condition, mismanagement of biopsy samples and failure to reach a definitive diagnosis or to manage his nutrition and weight. We found that in handling the complaint, the board had not completely addressed the failings we identified or acknowledged the extent of the consultant's failures. They also took too long to handle it. We made a number of recommendations including that the board review their complaints procedure and how they use feedback from it. We also said that they should arrange an external peer review of the hospital's biopsy management procedures; of their strategy for implementing *Living and Dying Well* (the national action plan for palliative and end of life care in Scotland), and of staff training in end of life care. As well as apologising for the failings identified, we said that they should raise them directly with the consultant at his next appraisal to ensure that he learns from this.

# Housing

## Overview

This section of the report is about social rented housing. Our jurisdiction covers all registered social landlords (RSLs), and includes houses both in council ownership and those owned by housing associations. The number of houses in council ownership has reduced as a result of stock transfers to housing associations over a number of years, although not all councils have taken this approach.

There are fewer houses in social ownership more generally, as a result of the right to buy scheme, where tenants of social housing could buy their home at a discounted price. There were amendments to the scheme over the years, and in the summer of 2012 the Scottish Government began a consultation process about proposed changes to the right to buy legislation. This provides various options, including the possibility of scrapping it, which may impact on complaint numbers in future.

Despite the reduction in the numbers of houses available, housing was the subject about which we received most complaints in the local government sector, with the number received almost exactly the same as last year. They cover a range of issues, from housing repairs and maintenance to neighbour disputes and anti-social behaviour. Complaints about housing associations totalled seven per cent of all the complaints SPSO received during the year.

The rate of premature complaints reaching us about housing matters is high. Premature complaints are those that come to us before completing the complaints procedure of the body concerned. In 2011–12 the rate for housing stood at 62%, against an average of 43% across all the sectors we deal with. The premature rate for housing associations was 67% and for local authorities 58%. Since our office opened ten years ago, housing has consistently been the sector about which we receive the most premature complaints.

## Factoring

Residents in tenements and other collective residential properties in Scotland may use property managers, known as factors, to manage common and shared areas of the property. Some social housing providers have extended their role to offer factoring services to owner-occupiers. The owner-occupier pays a fee for this as well as their share of bills for maintenance or repairs to the property. Social housing providers do this separately from their role as landlord, where they manage common parts of properties in fulfilling a landlord's obligation to their tenants.

We have not generally been able to take up owner-occupiers' complaints about how a social housing provider has acted in the role of property factor. This is because, although an organisation may be within our jurisdiction, there is usually a contract between them as factor and the owner-occupier. The law says that we cannot look at concluded commercial or contractual issues. People who have tried to bring such complaints to us in the past found it very frustrating when we told them this, as there was nowhere else they could turn with their concerns about these matters.

This changed, however, when the Property Factors (Scotland) Act 2011 received royal assent on 7 April 2011, and its full provisions came into force from 1 October 2012. When the Scottish Government were considering this legislation, we provided information from our experience about the barriers that people faced when they had such complaints. The Act applies to all residential property and land managers whether they are private sector businesses, local authorities or housing associations. It has three provisions:

- A compulsory register of all property factors operating in Scotland
- A code of conduct setting out minimum standards of practice with which all registered factors must comply
- A new route of redress – homeowner housing panels

People who are unhappy with their factor therefore now have a route through which they can take their complaint. Homeowners will be able to apply to the panel if they believe their factor has failed to comply with the code of conduct or otherwise failed to carry out their duties. The administrative actions of the panel, and their complaints handling, may fall within our jurisdiction, but only in a very limited sense. It is not yet clear if or how these changes will affect complaint numbers to SPSO. It is helpful, however, that we can now signpost complainants with concerns about their factor to a body that can look at the issue for them.

## Complaints and enquiries

We received 33 enquiries and 628 complaints about social housing in 2011–12. This represents a slight drop from the 43 enquiries and 638 complaints we received the year before, and continued the trend of reducing numbers in this sector. Of the complaints received, 287 were about housing associations (295 in 2010 –11) and 341 about local authorities (343 in 2010 –11).

For another year the categories most complained about remained the same, with repairs and maintenance at the top of the list again. Complaints about neighbour problems and anti-social behaviour were received in exactly the same numbers as last year (stopping the previous downward trend). This category did, however, move from third to second place in terms of the issues most complained about, replacing policy and administration issues, which dropped by almost 35%. Complaints about housing-related benefits rose by 23%, and those about homelessness issues almost doubled, after having dropped last year (although only on relatively small numbers of complaints).

**Top areas of housing complaints received 2011–12**

| | |
|---|---|
| Repairs and maintenance | **171** |
| Neighbour problems and anti-social behaviour | **89** |
| Policy/administration | **69** |
| Applications, allocations, transfers, exchanges | **57** |
| Local housing allowance (previously housing benefit) and council tax benefit (local authorities only) | **48** |
| Capital works, renovations, improvements, alterations and modifications | **23** |
| Homeless person issues | **18** |
| Complaints handling | **17** |
| Estate management, open space and environment work | **13** |
| Rents and tenancy charges | **13** |

## What happened to the complaints?

We determined a total of 604 complaints across the sector, including some carried forward from the previous year. During the year we laid one public investigation report about housing before the Parliament. This was about poor advice provided when tenants wanted to exercise their right to buy a council house, and the case is summarised below. We investigated a total of 68 cases during the year, seven more than last year. Of these, we upheld 26 (38%) in total or in part. Four of the cases upheld were about housing associations and 22 about local authorities. Where we could not take the complaint we helped the complainant through the process, or signposted them to appropriate places where they could get support.

Of the complaints we upheld, the main areas of complaint were about applications, allocations, transfers and exchanges; neighbour disputes and anti-social behaviour; and repairs and maintenance.

## Issues in housing complaints

### *Repairs and maintenance*

We consistently receive most complaints about repairs and maintenance. This is understandable as when there is a problem in the home it needs to be resolved. However, we often find that these complaints come to us too early, or that they are easily resolved. When we get in touch with the housing provider we find that the matter can often be sorted out quickly, to the satisfaction of both the tenant and the provider.

For example, one man told us that his housing association had told him that he would have to pay the cost of an engineer's call-out as no faults were found in his heating system. When we contacted the association, they said that he had not actually completed their complaints process. They wanted to meet him to try to resolve the matter. We agreed to suspend his complaint on the understanding that he could come back to us if he was still unhappy after that. The association met him, and managed to resolve the matter without the need for the complaint to come back to us. In another case, a man was unhappy that the council had not repaired damage caused by a leaking roof. We found that the leak had been partly repaired but there was still water leaking from a downpipe and the living room ceiling needed to be repaired. When we contacted the council about this, they immediately arranged for a plasterer to repair the ceiling and for their roofing contractor to fix the leak. The man was happy with this and withdrew his complaint.

# Housing

These examples highlight that many complaints can be resolved by frontline staff of housing providers acting swiftly to resolve issues. This approach, focussing on early resolution, underlies the RSL and local authority model complaints handling processes that we have developed with the help of those sectors.

***Anti-social behaviour and neighbour complaints***

These continue to cause misery and contention for people in their homes. Last year we drew attention to the dangers of not managing the situation well and allowing these to escalate. This year we received a number consistent with last year's total, including cases where the matter had still not been handled well. In one case we upheld a complaint that a housing association had failed to take effective action to prevent abuse of one of their tenants – the case is one of those summarised below. We were critical of the association because although it was not possible to say what the outcome would have been had they acted, it was clear that they could not take effective action under their policy. It is crucial that in handling sensitive and difficult issues like this, social housing providers adopt policies and procedures that are fit for purpose and that have the potential to help those who report problems to them.

***Improving complaints handling***

Housing was one of the two sectors that our Complaints Standards Authority (CSA) prioritised for developing a model complaints handling procedure (CHP) in 2011–12.

***Developing the RSL model CHP***

We worked closely with a range of housing associations and representative bodies from the sector throughout the development of the model CHP with a steering group established to provide assurance and challenge on our approach. The steering group included representation from the Scottish Housing Regulator, the Chartered Institute of Housing, the Scottish Federation of Housing Associations, Scottish Housing Best Value Network, the Tenants Participation Advisory Service (TPAS) and the Tenants Information Service. We are very grateful to all the bodies involved for their feedback, advice, time, expertise and hard work.

We also rolled out an intensive programme of engagement, carrying out visits, meetings, workshops and presentations with a range of housing associations and associated bodies. To gain specific input from RSLs, we also distributed surveys to staff, committee members and tenants. We received a healthy response to the surveys and a number of respondents volunteered to act on an advisory panel on the development of a model CHP. Given the customer-focussed nature of this initiative, we were keen to gain further feedback from tenants on our proposals and focus groups with a range of tenants, run by the TPAS, provided some very useful opinions. The advisory panel provided detailed feedback on the model CHP and we issued two drafts of the procedure for comments across the sector ahead of publication.

Alongside the development of the RSL model CHP, we were developing the local authority model CHP. By developing them in tandem, we aimed to deliver procedures that align with each other wherever possible. So, while we have taken account of the key differences between local authorities and housing associations, the expectation is that customers and tenants of both will receive similar levels of service.

**Compliance and performance monitoring**

RSLs are now under a duty to comply with the model CHP and compliance will be monitored by the Scottish Housing Regulator (SHR), in conjunction with the SPSO, through its monitoring of the Scottish Social Housing Charter (the Charter). The Charter, published in March 2012, sets the standards and outcomes that all social landlords must aim to achieve and, following close working with the Scottish Government, we were pleased to see the key high level aims of our CHPs incorporated into the Charter outcomes. We have also worked closely with the SHR to ensure that the model CHP is at the heart of their monitoring of the Charter outcomes.

RSLs will also be encouraged to use complaints as a measure in their self assessment exercises in future. Throughout the development of the CHP we have been visiting housing associations and attending events and network meetings across Scotland to provide further details of what we expect from them and advice on implementation.

## Examples of recommendations made in housing complaints

**That a housing provider:**

***Tenancy issues***

- review their procedures to ensure that a proper process is followed when terminating tenancy agreements and that a distinction is made between a refusal to transfer tenancy and the formal decision that a tenancy is being terminated: and that sufficient information is provided to the tenant
- ensure tenants are advised to contact the private rented housing panel at the earliest appropriate point
- apologise because they did not provide a tenant with adequate information after a request to transfer the tenancy was refused
- put steps in place to ensure that they check, approve and, where appropriate, clarify the charges on invoices before they send them to tenants. Any additional information obtained should then be passed on to tenants

***Anti-social behaviour***

- consider introducing a procedure to deal with incidents where an elderly person lives close to someone who may cause problems that affect their neighbours, and to address the potential needs of elderly neighbours
- review their approach to monitoring and acting upon complaints of dog fouling at their properties
- take action to improve record-keeping with proper recording of phone notes and ensure staff receive appropriate guidance about timescales for the arrangement and conduct of mediation

***Complaints handling***

- apologise for failures in complaints handling and improve their processes and procedures
- review the complaints process to consider making it a requirement that decision letters give details of how the investigation was conducted and the documents that were taken into consideration in the decision-making

***Other***

- consider reviewing how they handle cases where a claimant is unable to provide written evidence of the value of a property that falls outside the remit of District Valuer Services
- deduct their administration fee from the amount due for a share of repairs (in view of the unreasonable delay in billing the cost of the repairs and for an error in calculating the share of the costs due)

# Housing

## Case studies

### Right to buy

> Case 201003976

Mr and Mrs C wanted to buy their council house, the tenancy of which was in Mrs C's name. As a long-standing tenant, she was entitled to buy it from the council at a heavily discounted rate under the original right to buy provisions. Mr C, however, wanted to apply for the mortgage. They contacted the council, discussed the options, then asked that the tenancy be assigned to Mr C. The council approved this, knowing that he wanted to do this so that he could apply for a mortgage to buy the house. When Mr C then applied to buy, the council gave him a price based on the original discount due to Mrs C. Before the sale went through, however, they realised that as a new tenant he could only buy under more recent right to buy provisions, at a far less discounted price. They offered to reimburse the legal fees he had already spent. Mr C then applied to buy the house under the new provisions but did not complete the transaction. He complained that the council wrongly advised him about the impact that transferring the tenancy would have on the discount. We found no clear evidence of what Mr C was told. We took the view that, in these circumstances, the council's failure to provide evidence that Mr C was given advice about the position was a serious omission. We upheld his complaint and made recommendations about the council's procedures. In these particular circumstances, we also recommended that the council offer Mr and Mrs C the chance to either change to a joint tenancy or to re-assign the tenancy to Mrs C. Should Mrs C later apply to purchase the property, either alone or with Mr C, we said that the council should apply to Scottish Ministers for consent to sell her the property based on her original discount entitlement.

### Disability adaptations; communication; housing points

> Case 201003731

Mr A suffers from a degenerative muscular disease. His sister, Ms C, complained on his behalf. She explained that Mr A lived alone in a ground floor flat and moved about with the use of a wheeled zimmer. She told us that Mr A was virtually housebound, as the council had not resolved access problems to his home. We noted that the council had agreed that the ramp to Mr A's home was too steep for him to use with his zimmer and that their architect had said that the safest method of access would be to install a step lift. We found that the council offered this after considering all the facts and after discussion with their professional officers. We did not uphold this complaint, as we found that Mr A had decided not to accept the council's offer of a step lift, which would have provided him with suitable means of access.

# Case studies

Although he was not happy with what was offered, we could not criticise the council for not taking the matter further. We did, however, uphold Ms C's other complaints. We found that they had not carried out adaptation work to allow Mr A access to his front and rear gardens and had provided incorrect information about this. They also failed to discuss the remote entry system with him before installing it, and did not fit an entry system to his front door. All this meant that Mr A was, indeed, virtually housebound. There was also confusion over the housing points to which Mr A was entitled, which we resolved during our investigation. We recommended that the council apologise for these failings and review the communication between the various departments involved.

## Dealing with anti-social behaviour

> Case 201004240

Mr C was a former housing association tenant. During his tenancy he was subjected to racial abuse, intimidation and vandalism. He felt he had been particularly targeted because of his nationality. Because he was afraid for his safety, he abandoned his tenancy and registered as homeless. He complained that the association failed to follow their anti-social behaviour policy, or to take any effective action to prevent the abuse he had suffered. We found that Mr C had clearly experienced a serious degree of anti-social behaviour. However, we did not uphold the first complaint as we found that the association followed their policies appropriately, including classifying Mr C's case as category A due to the racial nature of the behaviour. On the second complaint we found that, although the association had installed CCTV, no-one was ever caught or identified and without this the association could not enforce the remedies in their policy. However, we also found that they had expected Mr C to gather very detailed information himself, which we considered unreasonable. He had provided information on a number of occasions, but the association said that because he could not identify particular people for specific incidents, they could not act on this. We thought this unreasonable, and that they could have made further enquiries on the basis of the information provided, so we upheld this complaint. We recommended that the association apologise to Mr C for not acting on the information provided.

# Scottish Government and devolved administration

## Overview

This sector includes all the departments and directorates of the devolved Scottish Government. In addition to this, it includes a number of other Scottish public bodies. These include non-departmental public bodies, and cross border authorities (when they act in a Scottish capacity). Traditionally we do not receive large numbers of complaints about these areas, as they tend to have less direct contact with the public than organisations such as local authorities and health providers. Over the last two years, however, the numbers received for this sector have increased considerably, as our jurisdiction has expanded to include firstly complaints from prisoners about the Scottish Prison Service in October 2010, then complaints about water and sewerage providers in August 2011.

There have been other significant changes to the authorities in this sector, as the Scottish Government have amalgamated bodies or given them further responsibilities. Examples of this are Education Scotland which has taken on the roles of Her Majesty's Inspectorate of Education and of Learning and Teaching Scotland, and the Care Inspectorate which has taken on the roles of the Care Commission and the Social Work Inspection Agency. We are committed to working with these authorities and developing memoranda of understanding with them.

As we explained last year, we often find that complaints received about the Scottish Government or other such public bodies are outwith our jurisdiction and we cannot take them forward. The SPSO Act outlines our remit in terms of the matters that we can look at. It says that we normally cannot investigate issues related to court or legal cases, or where the individual has an alternative right of appeal. Each year we receive complaints that we simply cannot consider; for example; that someone has (or has not) been prosecuted; that someone has been made bankrupt, or that what happened in court was perceived as unfair. By outlining the restrictions on our jurisdiction, our leaflets for the public explain what we can and cannot do in respect of such areas. Where possible we include information to help people find the right organisation to which to take the issue.

## Complaints received

There was a steep rise in the complaints received about this sector in 2011–12. We received 12 enquiries and 903 complaints, compared to 22 enquiries and 519 complaints the previous year. This meant that 23% of all the complaints we received in 2011–12 were in the Scottish Government sector, compared to only three per cent in 2009 –10, before we received the additional areas of jurisdiction mentioned above. The complaints received included 318 about water bodies and 385 about prisons. There is more information about both these areas below.

In terms of complaints in this sector that were not about water and prisons, we received 116 complaints about the Scottish Government, 79 about Scottish public authorities and five about cross border authorities. Complaints about care and health dropped – these are mainly complaints about Scottish public authorities that deal with health and social care issues. We received 66% fewer cases about financial matters (which tend to relate to complaints about student awards and bankruptcies). The number of cases about courts administration (an area where much of the work carried out is outwith our jurisdiction) fell by 75% to only 5 complaints received.

**Top subjects of Scottish Government and devolved administration complaints received 2011–12**

| | |
|---|---|
| Prisons | **385** |
| Water bodies | **318** |
| Justice | **22** |
| Care and health | **21** |
| Education | **20** |
| Financial matters | **17** |
| Agriculture, environment, fishing and rural affairs | **9** |
| Records | **8** |
| Arts, culture, heritage, leisure, sport and tourism | **7** |
| Ombudsmen/Commissioners | **6** |
| Roads and transport | **6** |

### What happened to the complaints?

During the year we determined 852 complaints across this sector. Many of these either reached us prematurely, or were not matters that we could look at. The overall rate of premature complaints for this sector was 36%, of which a large element related to complaints about water bodies.

Of the 194 complaints that were ready for us to look at, we upheld or partly upheld 46, most of which were about issues related to prisons or water. In terms of complaints that were not about these areas, most of the cases we upheld were about failings in the way that the authority had handled the complaint made to them. As we have noted before, this is also prevalent in other areas of jurisdiction. It is important that authorities look at their procedures and ensure that staff understand them and are empowered to resolve complaints at the frontline wherever possible.

## Water

Under the Public Services Reform (Scotland) Act 2010, we took on responsibility for water and sewerage complaints on 15 August 2011. While this represents a relatively low number of complaints (around 8% of our annual total), the transfer was one of the more complex of the recent extensions of our jurisdiction, both legally and in terms of the nature of the industry and the requirements of stakeholder engagement.

### *Water industry and key stakeholders*

The water industry in Scotland is split in two. Scottish Water provide water and sewerage services to the domestic market and act as a wholesale provider in the market for non-domestic customers. Non-domestic customers have a choice of private licensed providers who are registered by the Water Industry Commission for Scotland. In terms of the legislation, Scottish Water became a body under our jurisdiction, and we could deal with complaints about them by domestic customers. Private licensed providers, however, were given the option to opt in.

This was the first time that our legislation allowed for an opt-in. It was also the first time that we had purely private organisations, although dealing with an essential public resource, brought under our jurisdiction. Three licensed providers chose to opt in. These included Business Stream – a wholly-owned subsidiary of Scottish Water – who currently have the largest market share. This is reflected in our complaint figures as Business Stream was the only one of the three licensed providers who opted in about which we received complaints in 2011–2012. Once they have opted in, licensed providers are treated like any other body under jurisdiction and any of their customers can make complaints to us. This includes some bodies, such as public sector bodies, who would not normally be able to complain to us.

Other public bodies have key roles in this sector. Over the year and in the run-up to the transfer, we worked closely with the key stakeholders. We have ensured we have memoranda of understanding in place with the Water Industry Commission for Scotland, the Drinking Water Quality Regulator and Consumer Focus. These allow for an appropriate flow of information to help them with their important roles in regulation and customer representation and to help us with our complaints work.

### *Complaints handling*

Water complaints were previously dealt with by Waterwatch Scotland, who transferred 57 complaints to us when they closed. A number of these were received in the last few weeks of Waterwatch's work when staff were concentrating on the transfer and we were able to deal with many of these quickly, as a number were premature and had not been made to the body in question. Of the 57 cases transferred, it was quickly clear that detailed work was required on 36 of them. Of these, 16 had been open for more than six months at the date of transfer, with seven older than a year and the oldest dating back to 2008. Only one transferred case remained open at April 2012 and it was closed within the first quarter of 2012–2013.

To provide the best service to complainants, we wanted to build up our knowledge base quickly and a small team of complaints reviewers received training on water complaints both before transition and throughout the year. We are continuing with our training programme and extending this to more complaints reviewers. We have also appointed independent experts with relevant technical and engineering expertise who have been invaluable in assisting us with some of the more complex complaints.

# Scottish Government and devolved administration

### *Complaint numbers*

We received a total of 318 complaints about water and sewerage providers. The top areas of complaint were billing and charging, waste water and water supply. The table below shows the six subjects most complained about when people contacted us.

**Top subject of complaints received about water 2011–12**

| | |
|---|---|
| Billing and charging | **89** |
| Waste water | **45** |
| Water supply | **42** |
| Customer service | **17** |
| Environmental concerns | **6** |
| New connections | **4** |

We determined 271 complaints about water bodies. Of these only 41 were 'fit for SPSO' – i.e. ready for us to look at and about a subject that we could look at. Of these, we upheld or partly upheld eighteen. None of these complaints was the subject of a public report to the Parliament.

As mentioned earlier, of the 271 complaints we determined, 56% were premature as they had not gone through the relevant complaints process. This is despite the fact that the complaints processes are relatively short, and about half of the people who contacted us too early had recently been in contact with their water provider. As these complaints are new to our jurisdiction, it is possible that there are other factors contributing to this relatively high rate of premature complaints. However, we have asked the water bodies to look at how they might improve the way in which they internally progress and signpost their complaints. We will be looking closely at these figures again next year.

### *Subjects of complaint*

We received on average two to three complaints per week that required detailed consideration. We have found that complexity in water complaints tends to be around infrastructure and requires an understanding of engineering. However, most complaints we receive have been straightforward and we are seeing regular themes. Billing is a major driver for complaints in the non-domestic sector. There is still a lack of awareness, particularly amongst small businesses, of the need to inform the water provider when they take over new premises and to keep an eye on consumption if at all possible.

Flooding and the damage this can cause leads to complaints on both sides of the industry and is a particular cause of domestic complaints. Complaints are often about a failure to prevent flooding, or about concerns about the response to a compensation claim made after a flood. Causes of flooding can be complex and it can be particularly frustrating for complainants if the cause has been the irresponsible behaviour of neighbours or extreme weather, as no-one is responsible in such cases, and their only recourse is their own insurance policy.

We have found that claims for compensation are much more common in water complaints than other areas. Our role in handling such complaints is limited as the water and sewerage legislation generally sets out arbitration as the route for resolving such disputes. Where arbitration is not appropriate, the question of legal liability – often the focus of the complaint – would be one for the courts. However, both of these routes involve cost and risk. If asked to do so, we will consider complaints that there have been mistakes in processing compensation claims. We would not be able to reassess the claim ourselves. If, however, we found a significant failing and upheld the complaint this could, in some circumstances, lead to a recommendation that an organisation reassess it themselves. We are very aware of the need to clearly explain our role around compensation. A leaflet we designed during 2011–12 helps complainants understand that we will look at claims if they are unhappy but that we can only do so to a limited extent.

## Prisons

We reported last year on the transfer of the functions of the Scottish Prisons Complaints Commission to us. 2011–12 was the first full year in which we received complaints about prisons. These are investigated by a small team of our complaints reviewers who continually update their knowledge and understanding of prisons and the prison environment. As mentioned in the health section of this report, we are also now the final stage for complaints about healthcare in prisons, although the number of complaints received about this so far has been very small.

During 2011–12, we laid one full investigation report (case 201002521) about prisons before the Parliament. As in the case reported in the previous year, it related to drug testing in a prison. We upheld the complaint as we found that procedures were not properly followed. We also issued a number of decision letters, most often about progression issues (moving through the prison system, usually to less secure conditions).

The cases received were similar to last year, and although we received more of them the subject matters about which we received most complaints mostly remained the same. As we received complaints about prisons for a full year only in 2011–12, our 2012–13 complaints figures will be the first from which a comparison can be made.

**Top subject of complaints received about prisons 2011–12**

| | |
|---|---|
| Security, control and progression | **65** |
| Privileges and prisoner property | **51** |
| Communication and records | **45** |
| Health, welfare and religion | **45** |
| Physical and personal environment | **25** |
| Work, education, earnings and recreation | **23** |
| Leave from prison (including home detention leave) | **22** |
| Admission, transfers and discharge | **18** |
| Discipline | **18** |
| Supervision levels | **2** |

Although we received 385 complaints from prisoners, we upheld only twenty in full or in part. In most cases, we find that the matter that has been complained about is something that the prison was entitled to do, or a decision that staff were entitled to take within the Prison Rules. Unless something has gone wrong in that process, we are unlikely to uphold a complaint about such matters. An example of this is about a man who was transferred from one prison to another. He complained that he was allowed to buy certain items in the first prison, but was not allowed to do so in the second prison. Prisons have lists of what they consider acceptable items for prisoners to be allowed to buy. We could only look at the way in which staff considered his request, as it is not for us to say what they should allow prisoners to buy. When we looked at the response from the prison, we found that they had clearly explained why they did not allow him to buy the items in the second prison. We were satisfied that they had carefully considered the request and given the man reasons why it was not granted.

We also often find that the Scottish Prison Service (SPS) has already taken action to change practices that have caused a problem, and it is not necessary for us to make recommendations for further improvement. For example, one man complained that, after a disciplinary hearing, the person who held the hearing did not tell medical staff that the man had been confined to his cell. We upheld the complaint, but made no recommendations as the prison had already acknowledged that the process did not comply with the Prison Rules and had changed it. We commended the prison for recognising their error, apologising to the man and taking action to prevent a similar situation occurring again by making changes to the relevant paperwork. We have continued to find the SPS particularly receptive to suggestions for improvement and to have taken positive steps to widen the understanding about the learning from complaints throughout the prison estate.

# Scottish Government and devolved administration

***Improving complaints handling***

During the year, we responded to the SPS consultation on revising the Prison Rules. These were discussed with our Complaints Standards Authority (CSA) before the revisions were implemented. The revised rules outline a streamlined process with extra tiers of complaints handling removed and new timescales in line with SPSO guidance.

The CSA aims to develop and publish a model complaints handling procedure for all Scottish Government, Scottish Parliament and associated bodies, in line with our guidance on a model complaints handling procedure, over the course of 2012/2013. Work with the water industry on improving complaints handling will also be taken forward at a future date.

### Examples of recommendations made in Scottish Government and devolved administration complaints

**That an authority:**

***Complaints handling***

- review their complaints handling procedure to ensure complainants receive full responses to complaints
- take steps to ensure that all staff are fully aware of the organisation's complaints procedure, and that staff provide information about escalation to the next step and to SPSO appropriately

***Other***

- consider reviewing the process for accessing a legal laptop (in a prison) to ensure that maximum retention timescales are agreed, clearly set out and communicated to the next prisoner in line
- apologise for failing to explain how a prisoner could access a guidance manual
- remind staff of the documents available for prisoners to access from a prisoner library
- remind line managers that they must countersign any completed child welfare reports
- review a claim for loss of property, in line with the relevant internal guidance circular, and contact the complainant with the outcome
- ensure they put systems in place to track the follow-up of commitments they have chosen to give

## Case studies

### Providing correct information

> Case 201000423

Ms C was unhappy with the Student Awards Agency for Scotland. She complained about the way they handled her request for travel expenses and disagreed with their decision to restrict those expenses. We found that they had assessed her travel expenses in line with their policy. However, we also found that they failed on a number of occasions to correct Ms C's misunderstanding that she was entitled to full travel expenses under a disabled student allowance. When Ms C was told that her travel costs would be restricted, she withdrew from her course. We took the view that because she did not have full information, Ms C could not make an informed choice about whether to start her university studies. Because of this she incurred travel costs that she was unable to afford. We recommended that the agency reimburse Ms C for the further travel costs she incurred as a result of travelling by train to university and offset this against any outstanding student debt.

# Case studies

## Advice from an enterprise company

> Case 201100887

Mr C complained about the procedures adopted by Scottish Enterprise to investigate his complaints about what happened some time ago, when one of their regional offices was involved in advising his companies. Mr C made serious allegations of conflict of interest against former employees of the regional office. Because of the nature of the allegations, a senior officer was appointed to investigate and met with Mr C. Over a year later, Mr C was provided with a copy of the investigator's report. Mr C complained that his written statement to the investigating officer was not reasonably considered during the investigation, that the final report did not acknowledge his views, and that the time taken to investigate and to provide a final response was unreasonable. We did not uphold Mr C's first complaint as we found no evidence that his statement was not reasonably considered. We upheld the other complaints, however, as we found that Mr C was not given the opportunity to comment on issues of fact before the end of the investigation, and that the length of time taken was unreasonable. We recommended that Scottish Enterprise seek to agree with Mr C the points he believes to be outstanding and to answer those within three months.

## Protected species

> Case 201101682

Mr C complained that Scottish Natural Heritage (SNH) inappropriately granted funding and licenses to a moorland development project without requiring a relevant appraisal. The project aimed to increase the numbers of red grouse, allowing grouse shooting whilst conserving the local population of hen harriers (a protected species). We accepted SNH's position that the appraisal was not required for the project as a whole, as the project had no statutory basis. However, certain activities proposed as part of the project required a license to disturb the protected birds. As such, an Appropriate Assessment (formal assessment of the impacts of a plan or project in a protected or conservation area) was required under the process before the license could be approved. SNH told us that consideration was given to the impact that the project would have on the birds before the license was issued. However, they failed to document this in a formal Appropriate Assessment. This was completed after Mr C complained. Although we were satisfied that the decision to issue the license was not unreasonable or contrary to regulations or legislation, we did not consider it enough just to consider the potential impact on a protected species. Given SNH's position as a partner in the project, we took the view that they should have been able to demonstrate that the potential impact was properly considered through completion of the Appropriate Assessment, and we upheld this element of the complaint. Based on the evidence we saw, however, we were satisfied that SNH had a process of monitoring in place to record the impact on the hen harriers. We also found that they reached their conclusion that the integrity of the protected site would be maintained after they had assessed appropriate factors and with reference to existing scientific research.

# Further and higher education

### Overview

We received two enquiries and 130 complaints about this sector during 2011–12. This was an increase of 18% on the previous year, continuing a trend of rising numbers of complaints. This year, the main increase was in the number of complaints received about further education.

### Further Education

We received a total of 37 complaints during the year, an increase of 54% on last year's figure of 24. Of these, the majority were about admissions, policy and administration, and teaching and supervision. Although complaints about policy and administration have been near the top of the list since we started taking complaints about this sector, there was an increase in the number of complaints about both admissions and teaching.

**Top areas of further education complaints received 2011–12**

| | |
|---|---|
| Admissions | **7** |
| Policy/administration | **6** |
| Teaching and supervision | **4** |
| Academic appeal/exam results/ degree classification | **2** |
| Complaints handling | **2** |
| Grants/allowances/bursaries | **2** |

### What happened to the complaints?

We determined a total of 35 complaints during 2011–12. Of these, 14 (40%) were received prematurely (i.e. they had not completed the complaints process of the institution concerned). We fully upheld one complaint, about the information provided by a college in relation to changes to a course. The case is summarised at the end of this chapter.

We found that many of the complaints we received were about subjects that we could not look at, such as where someone complained about a college's decision not to award a bursary, or where someone was unhappy with the fees they had paid.

### Higher Education

We received two enquiries and 93 complaints about higher education. The number of complaints about academic appeals, exam results and degree classifications dropped from 28 last year to 22 this year. This was encouraging, as we cannot have a mark or assessment changed, a message we always aim to convey clearly in our leaflets, on our website and in direct communication with students who contact us. This should mean that those with concerns about their academic achievements are not disappointed by expecting us to be able to do this. What we can look at is the process that was followed when the mark was appealed, and see if that was correctly followed.

Although not a significant rise in terms of numbers, it is interesting to note that we received three complaints about special needs during the year, compared to only one the previous year.

**Top areas of higher education complaints received 2011–12**

| | |
|---|---|
| Policy/administration | **26** |
| Academic appeal/exam results/ degree classification | **22** |
| Teaching and supervision | **11** |
| Complaints handling | **7** |
| Special needs assessment and provision | **3** |
| Admissions | **2** |
| Personnel matters | **2** |
| Plagiarism and intellectual property | **2** |

### What happened to the complaints?

We determined a total of 80 complaints about higher education. Of these, 24 were received prematurely (i.e. they had not completed the complaints process of the institution concerned). We upheld or partly upheld seven complaints during the year. These related mainly to issues around appeals processes and policy and administration, including the handling of complaints.

### Improving complaints handling

We worked throughout the year with stakeholders from the further and higher education sectors, including Scotland's Colleges, Universities Scotland and representatives from a number of colleges and universities, to develop a model complaints handling procedure (CHP) for each sector. We will be discussing training and awareness needs with the aim of developing sector specific e-learning modules on frontline complaints handling. We will publish a model CHP for each sector after we receive comment and feedback from these representatives, with the aim of publishing them during 2012.

We also met with other education bodies in 2011–12 to discuss their own complaints procedures and support them in ensuring compliance with our guidance. These included Education Scotland and the Scottish Qualifications Authority.

### Examples of recommendations made in further and higher education complaints

**That a learning institution:**

- apologise for not telling a student that they had a right to appeal
- provide a student with a full apology for initially failing to follow the examination procedure correctly
- remind staff of the importance of following their stated complaints procedure
- in the event that a student wishes to appeal the decision made about stage 2 complaints to the university, consider the appeal in terms of stage 3 of the university's complaints procedure

# Further and higher education

## Case studies

### Communication about a course; complaints handling

> Case 201100862

Ms C enrolled on a professional development course at a college. She complained that the college did not reasonably tell her about changes in course provision, as a result of which she felt that she was due a refund of some of the fees. She also complained that the college did not tell her when the tutor's contact details changed, and did not respond to correspondence about her complaint. We upheld this complaint, as we found from looking at the evidence that the college did not reasonably inform Ms C about the changes in course provision or the tutor's details. They had acknowledged that they took longer than allowed in their complaints procedure to deal with part of the complaint, and did not respond to a letter. We also found that the college's responses to Ms C's complaints about her course fees were not consistent. We recommended that they apologise to Ms C for all the failings identified, and improve their communication and complaints handling procedures.

### Appeal handling procedures

> Case 201000292

A university awarded Mr C a degree, but he did not get the classification to which he thought he was entitled. He complained that the university failed to follow their procedure for classification of his degree or their appeals process; took too long to handle his academic appeal; and did not answer questions about how the marking scheme was applied. We cannot consider issues about academic judgment, so we could not comment on whether the degree was awarded at the correct level. We can, however, look at whether or not the university followed the proper procedure. Having considered the evidence, we were satisfied that the university properly followed the degree classification procedure and had already taken appropriate steps to improve their explanations to students. We therefore did not uphold this part of the complaint, nor that about the marking scheme. We did, however, uphold Mr C's complaint that the university did not follow the proper procedure when handling his academic appeal. They decided that Mr C's original appeal was not competent, and handled this appropriately. However, when they then invited Mr C to submit another appeal, there was considerable delay in dealing with it, and they did not keep him informed about this at the time. It took the university four months to deal with the appeal, which was well over the timescale suggested in the guidance notes. We recommended that the university apologise to Mr C for this.

# Equality and Diversity

We are committed to ensuring that all people in Scotland have an equal opportunity to access our services, and we recognise our duties under the Equality Act 2010 to promote equality of opportunity for all. We also recognise the changing landscape of Scotland's communities and the diverse communication needs that exist, as well as the range of needs that our disabled customers may have.

The provisions of the Equality Act also support our core values:

- we respect others, regardless of personal differences
- we listen to people to understand their needs and tailor our service accordingly
- we promote equal access to our service for all members of the public

As well as taking responsibility for our own activities, we have a role in ensuring that bodies under our jurisdiction also fulfil their obligations. Our Strategic Plan for 2012–16 contains five equalities commitments:

- to take proactive steps to identify and reduce potential barriers to ensure that our service is accessible to all
- to identify common equality issues (explicit and implicit) within complaints brought to our office and feed back learning from such complaints to all stakeholders
- to ensure that we inform people who are taking forward a complaint of their rights and of any available support, and that we encourage public authorities to do the same
- to ensure that we play our part in ensuring that service providers understand their duties to promote equality within their complaints handling procedures
- to monitor the diversity of our workforce and supply chain and take positive steps where under-representation exists

We published these after consulting with stakeholders, including authorities under our jurisdiction and those working with and advocating on behalf of people with disabilities.

As an organisation we continually strive to ensure our practice and processes reflect our obligations. We have undertaken a number of training initiatives and we are adding a section on accessibility to our complaints handling guidance. This demonstrates our commitment to ensuring that our staff are aware of their obligations and that we put in place reasonable adjustments to make our service accessible to all potential users.

### Accessibility

When we accept a complaint we ask if the person making it has any needs that we can make adjustments to accommodate. We always try to make reasonable adjustments and some we have made include providing letters in large print, sending written confirmation of what was said in a telephone conversation and providing a telephone interpretation service.

We also try to ensure maximum accessibility on our website. During 2012–13 we are carrying out an accessibility review with our website provider, to try to maximise the ease of using our site. Currently, the site has:

- Crystal Mark status
- audio and large font versions of our most used leaflets
- a 'browsealoud' facility, allowing the website to 'talk' to the user and allowing the user to highlight information on-screen

Other action we have taken to make our services accessible are:

- we have a Freephone telephone number, allowing members of the public to call us about their complaint at no cost
- the Plain English Campaign have checked and approved many of our public leaflets
- we have an 'easy read' version of our main complaints leaflet
- we use translation services to provide written information for those for whom English is not a first language
- we use translation services during telephone conversations or interview when required
- our complaints process includes checks to ensure that our staff consider and identify any accessibility requirements at an early stage of handling the complaint
- we continue to use equality impact assessments to test our policies and procedures. We have written the use of these into our procedures to ensure that they are used to check any changes to our process
- we have refreshed our monitoring to ensure we are capturing data on the seven protected characteristics under the new equalities legislation, for both complainants and employees
- we have amended our systems to be able to better capture data on how we adapt our service for people with special needs and on those complaints that have an equalities aspect

# Equality and Diversity

### Managing equality and diversity at SPSO

Our internal equalities and diversity group continued to monitor our activities to ensure that we comply with our legal requirements under the new equalities duties. To continue to improve our service to the public, we trained staff in the responsibilities and rights provided by the Equality Act, and on diversity issues. We also trained relevant staff in how to conduct equality impact assessments. This was done to follow best practice, as the law does not require this in Scotland.

We worked closely with an equality and diversity specialist on various issues during the year, including the above training, and have since appointed her as our equalities and diversity adviser. From 2012–13, she will provide advice on complaints that contain an equalities element and on whether SPSO policies and practice comply with equalities legislation. She will also be working directly with our Complaints Standards Authority team to ensure that model complaints handling procedures and the material on our Valuing Complaints website provide guidance to bodies on how to meet their equalities obligations when handling complaints.

### Monitoring and profiling

We monitor data about our service users. We ask people who come to us with a complaint to complete our monitoring forms, which are handled separately from our complaints forms. Filling out the form is voluntary, and this year a total of 807 people (almost 21% of those who complained to us) returned them. This is a slight drop in the percentage of monitoring forms against complaints received, but as we pointed out last year, many people do not ask for or send us a form at all, especially those who write us a letter about their complaint.

Of those who responded, we found that:

- 42% were female and 53% male, with 5% not telling us their gender
- 65% fell into the age groups 35–49 (34%) and 50–64 (31%)
- only 3% of respondents said that they were under 24
- around 30% said that they had a disability of some kind (11% did not want to say)

Of the disabilities identified, most related to problems with physical mobility, impaired hearing or poor sight/blindness; others identified themselves as having multiple disabilities.

We also gather statistics on the profiles of our staff and of those who apply for jobs with us. We publish these as part of our publication scheme.

### Adults with Incapacity

We are aware that individuals who lack the capacity to act for themselves are particularly vulnerable. As mentioned in the paragraphs about dementia in the health section of this report, such people are not in a position to question their treatment. One of the case studies that follows is about an elderly woman whose senses were impaired by hearing loss. The health board concerned did not assess her capacity to act for herself, and her niece initially complained to us because she thought that her aunt was not being properly treated with the drugs used. This is an example of a case where we did not uphold the main complaint brought to us (because we found that the doctors prescribed appropriately in the circumstances) but where our investigation raised other concerns that we needed to address. In this case we were very concerned about the board's failure to implement the provisions of the Adults with Incapacity (Scotland) Act 2000. We commented on failure to comply with this Act in last year's annual report and said that service providers should ensure that staff understand what they are required to do under this legislation. It is with concern, therefore, that we report that similar cases still come to our attention. For the protection of both patients and staff, it remains vital that authorities across Scotland properly understand and implement this legislation.

### Prisons

We want to ensure that our service is accessible and easy to use for all who contact us. A review of a Scottish Government study in 2011 found that one in three people in Scottish prisons do not have 'functional literacy'. We committed to addressing this at a very early stage in our handling of prison complaints to ensure that the Scottish prison population could access our services, including those who have limited reading and writing ability. SPSO staff engaged with prisoners and staff through a series of visits, to learn from them about the particular issues faced by those in a prison environment. During these visits, we took the opportunity to explain what we do and how to access our services.

As a consequence of this, we made a number of changes to our communication materials, including producing leaflets and posters in accessible formats, using large font, increased white space and plain English. As for all service users, we offer a Freephone advice helpline, and provide communications materials in audio, Braille, easy-to-read and translated alternatives. We have also recorded a presentation aimed at young offenders. The prison play this on their TV loop so that prisoners can learn about complaints and their rights. The key aims are to dispel some of the complexities and anxieties around complaining in a prison setting and to try to give information in the best possible way.

# Case studies

### Capacity to consent to treatment; assessment of patient on admission

> Case 201002867

An elderly woman, Miss A, was admitted to hospital. She had significant hearing impairment, and while in hospital was without her hearing aids for a number of days. She presented some challenging behaviours after admission and was prescribed an antipsychotic drug. Miss A's niece, Mrs C, complained that the board wrongly prescribed this to her aunt. After taking advice from our medical adviser, we found that it was reasonable for the board to prescribe the drug to Miss A on medical grounds. In reaching that decision, however, we noted that the board did not meet Miss A's needs as a patient with sensory impairment and that this impacted on her behaviour. Having read Miss A's medical notes, our medical adviser said he thought it likely that she in fact lacked capacity to provide informed consent to treatment, or to participate in decision-making. The board, however, failed to assess this. Had they done so and found, as the evidence suggested, that Miss A lacked capacity to consent to treatment, then they should have completed a certificate of incapacity and consulted Mrs C about treatment. We, therefore, expressed serious concerns about the board's lack of action in relation to the Adults with Incapacity (Scotland) Act 2000. We made a number of recommendations, including that they carry out an audit of their practice on implementing the Act, with particular reference to consent, and report their findings to us; amend their guidance on managing patients with delirium to include the requirements of the Act; and that they share the report with staff to ensure they understand the issues arising from this case.

# Equality and Diversity

## Case studies

### Disabled parking; decision-making

> Case 201001398

Ms C lives in the centre of a city in a controlled parking zone. As her son has a disability, Ms C has a 'blue badge' for her car. This provides parking concessions for people with disabilities, but does not allow parking in some restricted areas. After getting a parking ticket in a restricted area near her home, Ms C asked the council to provide a disabled parking bay by her house so that her son could easily get to the car. The council, however, said that they had decided not to provide any more disabled bays inside the parking zone, although they were continuing to do so outside it. Ms C complained that the council had not fulfilled their statutory duties about parking provision for disabled residents, under Section 5(2) of the Disabled Persons' Parking Places (Scotland) Act 2009. This says that where a qualifying person asks for a designated parking space, the council must decide whether they can identify a place in the street from where the person can conveniently access their house. If it is not possible to do so, then they must tell the person why. The evidence suggested that blue badge holders in the parking zone may be disadvantaged compared to those living outside it. The council have the right to make policy decisions. However, making a blanket decision that they will provide no further disabled bays in a particular area stops them from deciding this on a case by case basis as they should. We recommended that the council review their policy, to take into account the individual circumstances of residents in the parking zone. We also recommended that they reconsider Ms C's request for a disabled parking bay outside her property.

# Governance & Accountability

## John Vine, Chair of the SPSO Audit & Advisory Committee

The Ombudsman, as accountable officer for the SPSO, is responsible for ensuring that his resources are used economically, efficiently and effectively. The SPSO is subject to external audit, currently provided by Audit Scotland, and internal audit, under a shared services arrangement with the Scottish Legal Aid Board. The Ombudsman gives evidence annually to the Parliament's Local Government and Regeneration Committee following the publication of his annual report. He also holds regular discussions with the Scottish Parliamentary Corporate Body (SPCB) about the SPSO annual budget submission and other governance issues that might arise.

The Audit and Advisory Committee 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 and ensuring high standards of governance and accountability, in accordance with Best Value principles.

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 by monitoring the adequacy of the SPSO's governance and control systems and offering objective advice on issues concerning the risk, control and governance of the SPSO. The committee also provide a source of advice and feedback on SPSO strategic objectives and annual business plans as well as commenting upon the recommendations of internal and external audit.

I was delighted to accept the position as chair of the committee, taking over from Sir Neil McIntosh. who stood down last year. I am the Independent Chief Inspector of Borders and Immigration and I am very pleased to be joined on the committee by Tom Frawley, the Northern Ireland Ombudsman, and Anne Seex who is Local Government Ombudsman for England. I am grateful to Tom and Anne for the quality of their contribution. I would also like to acknowledge the energy, commitment and wisdom that the previous chair and committee members brought to the role, assisting the SPSO in moving forward.

The committee met four times in 2011–12. Representatives from the SPSO's external and internal auditors attend our meetings. They can advise us in private when required, before we discuss with the Ombudsman the key operational priorities and risks.

There were a number of key areas of focus for the committee in 2011–12 including a review of the SPSO's case handling process, and changes to the organisational structure to prepare the SPSO to accept additional responsibilities.

The past year has been one where the committee has carefully examined the operational and financial management of the SPSO with a focus on service delivery and value for money to the public. We have 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 been open and constructive with all our requests and has provided considerable energy to and sound leadership of the organisation. Coupled with the commitment of his senior management team and other staff, there has been measurable progress in casework performance, governance and full integration of new responsibilities for prison, prison health and water complaints as well as the new statutory remit to standardise and improve complaints handling across the public sector.

The significant programme of change being pursued by the Scottish Parliament will bring increased demands on the SPSO in the coming year. I am confident from what I have seen in my role as chair of the committee that the organisation is well placed to meet those challenges. My colleagues and I will continue to provide the independent scrutiny necessary to provide public confidence in the service being delivered and to help the Ombudsman achieve his objectives.

# Independent Service Delivery Review

### Service delivery complaints to the SPSO

In 2011–12 we handled 4,534 complaints and enquiries. Of these we received 32 formal service delivery complaints. Nine were fully or partly upheld, 19 were not upheld and four were discontinued or withdrawn. 13 of these complaints were decided by the Independent Reviewer.

### The role of the Independent Reviewer

The Independent Reviewer's role is purely to look at complaints about service delivery by the SPSO. The Reviewer has no powers to review the Ombudsman's decisions. These can only be challenged by judicial review. The role of the 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 Reviewer can require evidence and explanations from the SPSO. They report their findings directly to us. We can comment on factual accuracy, or provide the Reviewer with material new evidence, but we cannot influence or change the findings and recommendations.

It is difficult to identify systemic issues on the basis on such small numbers, but we have in place mechanisms to ensure that the lessons from service delivery complaints are fed back internally. This takes place through formal reporting to the Audit and Advisory Committee and action planning at senior management team level.

The Reviewer's role is a three-year contract, and during this year the contract changed hands. For the first seven months, the work was done by an individual who carried out a similar role across a number of organisations. From mid-November the contract moved to a person who has held the position of ombudsman in another organisation. The two Reviewers' reports below are their account of the cases they handled in 2011–12.

## Reviewer's Report

April 2011– November 2011

### Ros Gardner

This is my final report as Independent Reviewer of the SPSO. After three years in the role I am retiring and this report covers the period from April 2011 to November 2011, when my contract ended. As always, this has been a busy and interesting year for the SPSO and for me as the Reviewer. I have worked closely with the Ombudsman and his senior management team and as always have received enormous support and help from them in investigating the complaints brought to me.

### Statistics and matters complained about

Between April 2011 and November 2011 the SPSO referred nine complaints to me. Of these complaints, one was withdrawn by the complainant, I did not uphold five and I partly upheld three. Matters complained about related to:

- delays in the handling of the complaint and the response to the request for a review
- dissatisfaction with the handling of the complaint by the Ombudsman
- lack of clarity in the reasons given for the Ombudsman's decision not to progress a review
- SPSO's service standards not being adhered to
- dissatisfaction with the handling of the service delivery complaint

### Key themes

The key themes that arose in this period were:

**Delays in processing complaints**
There were claims of delay at various stages in the process. Often, there are operational reasons for a complaint taking longer to process, investigate and respond to than anticipated. In these cases, the issue was that complainants were not adequately informed about the delays.

**Lack of fairness and impartiality in the handling of complaints**
Allegations of this kind tend to occur when the complainant remains dissatisfied with the outcome of the SPSO's investigation. I found no evidence in any of my investigations of any lack of impartiality by any member of SPSO staff.

**Lack of clarity in the reasons given by the Ombudsman for his decision**
These complaints usually arise following the Ombudsman's decision not to review a complaint on which he has reached a decision. The Ombudsman's criteria for review are clearly stated in the SPSO's published procedures, namely that to be eligible for a review the complainant must provide evidence that:

- is new to the investigation and/or
- has been overlooked or misrepresented in the original investigation

It would appear that when complainants were informed that their complaint has been referred to the Ombudsman himself for review, they remained unaware of the key criteria that he would use to reach his decision. This also applied to complaints where the complainant was dissatisfied with the decision not to review the complaint.

Another issue that arose was an allegation that the SPSO's published service standards had not been adhered to. I did not uphold this complaint.

### Recommendations

Among the recommendations that I made in this period were that:

- where there is potential discrepancy between the complainant's requirements and those identified by the SPSO, the SPSO should seek to provide clarification
- a summary of each element of a complaint to be included in a review should be provided and agreed between the complainant and the SPSO
- when the SPSO makes recommendations, either formal or informal, they should make clear to the complainant whether the recommendations will be implemented in relation to the specific complaint, or whether they are of a more general nature. The SPSO should always tell the complainant about policy changes that arise from a review of a complaint or a group of complaints, as this is a very positive reputation-enhancing action for the organisation

### SPSO responses

In accordance with their established procedures, the SPSO senior management team responded to my recommendations with a proposed action plan. In almost all cases, the SPSO agreed to implement the recommendations. Where, for operational reasons, this was not possible, the SPSO agreed to investigate the possibility of further action.

### Conclusion

I have thoroughly enjoyed my time working with the SPSO senior management team and have valued the relationship that we built up during the time that I was involved. I believe that establishing an Independent Service Delivery Review mechanism has enhanced the work and the reputation of the Ombudsman's office and has provided a transparency in the review of complaints handling that is essential at this level. I wish the organisation and the personnel involved, together with my successor, every success in the future.

## Reviewer's Report

November 2011 – March 2012

## David Thomas

This is my first report as Independent Service Delivery Reviewer. I dealt with four service complaints in the relevant period. That is a very small number compared to the number of cases dealt with by SPSO, so it is too early for me to draw any general conclusions to add to those of my distinguished predecessor.

Some complainants whose complaint is not upheld by the Ombudsman find it difficult to distinguish between their view of the merits of their complaint against the public body (which is not a matter for me) and their view of the way in which the case was handled (which can be for me).

Before reaching a decision on a service complaint, I carefully review the whole of the case file – so as to be able to judge, in context, the way in which the matter has been handled. The Ombudsman and his staff have consistently provided me with all the information I required.

All four of the service complaints that I handled arose from cases where the Ombudsman had not upheld the complaint against the public body. In one, I found nothing at all wrong with the way in which the case had been handled. In the other three, I did not agree with all the complainants said, but I did find handling errors.

In one, SPSO had not given the complainant sufficient notice of the limited right to ask for a review. In another, SPSO had not explained clearly and early enough that the Ombudsman could review the process by which a local authority reached a particular decision, but could not act as an 'appeal' body against that decision. In the third, an SPSO complaints reviewer had accidentally failed to follow a procedure agreed by another SPSO complaints reviewer about the way in which a single complaint brought by a group of complainants would be handled.

Where I upheld service complaints, SPSO reacted positively to my recommendations – accepting my conclusions and apologising to the complainants concerned. As more service complaints come through to me, I may be better able to judge how far any problems arise from individual human errors or whether there are any systemic issues the Ombudsman needs to consider. I will share my views with the Audit and Advisory Committee.

# 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 2011–12 we operated on an approved budget of £3.34 million with a total of 45 staff (full time equivalent). This equated to 79% of our total net expenditure being spent on staff costs, with three quarters of staff being directly involved in case handling. The table below details the major costs in our statutory accounts over the past three years.

Under provisions in the Public Services Reform (Scotland) Act 2010, we, along with all the other bodies supported by the SPCB, are now subject to greater direction from the SPCB over some aspects of our corporate services. We are keen to continue to work with the SPCB to advance the shared services agenda. We have already achieved significant savings by sharing office space with, and providing corporate services to, other offices that the SPCB support.

It is likely that we will create or be presented with other possibilities for savings over the next four years, and this will impact on our work, for example in changing where and how we carry out some of our activities. In all matters relating to changes to our remit and powers and in how we carry out our work, we will continue to maintain and protect the independence (and perception of independence) of the SPSO – this is a fundamental pillar of all ombudsmen's offices.

**Budget**

Over the three year period between 2010–11 and 2013–14 the SPSO is committed to achieving as a minimum a 15% real terms decrease in its budget. The 2011–12 budget represented a 6.5% saving on the 2010 –11 baseline budget, largely achieved through a restructuring of the organisation. The budget requirement for the year 2012–13, as stated in cash terms, is £3.29 million, a 7% decrease on the refreshed 2011–12 baseline budget. The indicative figures for 2013 –14, which we provided to the SPCB as part of the 2012–13 budget process, show a further planned reduction of 2.6%. These savings have been achieved while integrating new areas of jurisdiction, taking on additional duties leading to the development of new services, and improving productivity in case handling.

The Public Services Reform Act also requires bodies, including the SPSO, to provide information on certain expenditure. This information is available, along with our full audited accounts, on the SPSO website.

| Summary analysis of expenditure | **2012 £000s** | 2011 £000s | 2010 £000s |
|---|---|---|---|
| **Staffing costs** | **2,660** | 2,385 | 2,610 |
| **Other operating costs** | | | |
| Property* | **292** | 301 | 296 |
| Professional** | **166** | 94 | 149 |
| Office running costs***† | **324** | 310 | 248 |
| **Total operating expenditure** | **3,442** | 3,090 | 3,303 |
| **Capital** | **128** | 48 | 2 |
| **Other income** | **(93)** | (90) | (15) |
| **Net expenditure** | **3,477** | 3,048 | 3,290 |
| **Staff FTE** | **45** | 46 | 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.

# Strategic Plan 2012–16

We published our Strategic Plan for 2012–2016 at the end of March 2012. It sets out our key objectives for the next four years, based on anticipated changes in the external environment that impact on our work, and areas identified for development. As with previous plans, this Strategic Plan will be used to drive continuous improvement in the services that we provide to our stakeholders.

The five strategic objectives constitute our high level Strategic Plan and under it will sit business plans for each year. The objectives maintain the focus on our five key strands of work.

### 1. To provide a high quality, user-focussed, independent complaints handling service

By developing our capacity as complaints handlers to be able to deliver individual benefit to our customers; by being accessible and dealing with all enquiries and complaints impartially, consistently, effectively, proportionately and in a timely manner; and by producing clear, accurate and influential decisions about complaints.

### 2. To support public service improvement in Scotland

By continuing to raise informed awareness of the role of the SPSO and to feed back and capitalise on the learning from our consideration of individual enquiries and complaints, for example, through thematic reports, and by working in partnership with public service deliverers, policy makers, scrutiny bodies and regulators to promote good administrative practice.

### 3. To improve complaints handling by public service providers

By using our expertise and resources to monitor, promote and facilitate the sharing of best practice and support service providers in improving their complaints handling.

### 4. To simplify the design and operation of the complaints handling system in Scottish public services

By working in partnership with service providers, regulators and other key stakeholders to facilitate the development of and compliance with simplified, standardised and user-focussed complaints handling procedures across the public sector as an integral part of the wider administrative justice system in Scotland.

### 5. To be an accountable, best value organisation

By making best use of our resources and demonstrating continuous improvement in our operational efficiency and supporting the professional development of our staff.

## Equalities commitments

Our five equalities commitments form an integral part of the Strategic Plan. These are detailed in our Equality and Diversity chapter.

## Consulting on the draft Strategic Plan

Under the terms of the Scottish Parliamentary Commissions and Commissioners etc. Act 2010 we were required to seek comment on our draft Strategic Plan. Our consultation was posted on our website and publicised in the Ombudsman's Commentary. We also wrote directly to around 120 stakeholders inviting them to comment on the plan. These included the statutory consultee (the Scottish Parliamentary Corporate Body); Scottish Government public service reform contacts and the clerks and convenors of relevant Parliamentary Committees. We also contacted COSLA and SOLACE; the chief executives of local authorities; regulatory and scrutiny bodies; equalities bodies and advisory groups.

We published all the comments we received on our website, along with independent analysis of them and our reply to that analysis. In our reply we explained the changes we had made in light of the feedback from respondents, and expressed our thanks to those who took the time to participate in the consultation.

# 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 2012–13

Our key priorities are to:

1. deliver an efficient and effective complaint 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; 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.

## All Cases Determined 2011–2012

### Authority Sector

| Case type | Stage | Closure category | Further & higher education | Health | Housing associations | Local government | Scottish Government and devolved administration | Other and out of jurisdiction | Total |
|---|---|---|---|---|---|---|---|---|---|
| Enquiries | Advice & signposting | General enquiry | 0 | 16 | 3 | 28 | 6 | 24 | 77 |
| | | Premature | 2 | 18 | 11 | 38 | 5 | 1 | 75 |
| | | Out of jurisdiction | 0 | 0 | 1 | 6 | 0 | 447 | 454 |
| | | Outcome not achievable | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| | | No decision reached | 0 | 5 | 1 | 9 | 1 | 2 | 18 |
| | **Total enquiries** | | **2** | **39** | **16** | **83** | **12** | **474** | **626** |
| Complaints | Advice | Premature | 34 | 261 | 184 | 729 | 272 | 15 | 1,495 |
| | | Body out of jurisdiction | 0 | 1 | 0 | 0 | 0 | 15 | 16 |
| | | Matter out of jurisdiction (discretionary) | 3 | 4 | 3 | 18 | 9 | 0 | 37 |
| | | Matter out of jurisdiction (non-discretionary) | 5 | 14 | 10 | 20 | 37 | 5 | 91 |
| | | Outcome not achievable | 1 | 9 | 0 | 10 | 7 | 1 | 28 |
| | | No decision reached | 27 | 225 | 40 | 258 | 171 | 20 | 741 |
| | | **Total** | **70** | **514** | **237** | **1,035** | **496** | **56** | **2,408** |
| | Early Resolution 1 | Premature | 4 | 29 | 2 | 51 | 31 | 0 | 117 |
| | | Body out of jurisdiction | 0 | 0 | 0 | 0 | 0 | 10 | 10 |
| | | Matter out of jurisdiction (discretionary) | 4 | 29 | 1 | 53 | 16 | 0 | 103 |
| | | Matter out of jurisdiction (non-discretionary) | 6 | 15 | 9 | 43 | 33 | 2 | 108 |
| | | Outcome not achievable | 2 | 16 | 2 | 28 | 20 | 0 | 68 |
| | | No decision reached | 10 | 38 | 8 | 52 | 62 | 1 | 171 |
| | | **Total** | **26** | **127** | **22** | **227** | **162** | **13** | **577** |
| | Early Resolution 2 | Outcome not achievable | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| | | No decision reached | 0 | 8 | 1 | 3 | 11 | 0 | 23 |
| | | Fully upheld | 1 | 11 | 2 | 10 | 11 | 0 | 35 |
| | | Partly upheld | 1 | 14 | 0 | 14 | 13 | 0 | 42 |
| | | Not upheld | 4 | 34 | 11 | 78 | 109 | 0 | 236 |
| | | **Total** | **6** | **67** | **14** | **105** | **145** | **0** | **337** |
| | Investigation 1 | No decision reached | 1 | 2 | 1 | 12 | 1 | 0 | 17 |
| | | Fully upheld | 2 | 33 | 0 | 6 | 6 | 0 | 47 |
| | | Partly upheld | 3 | 67 | 2 | 38 | 15 | 0 | 125 |
| | | Not upheld | 6 | 84 | 2 | 63 | 26 | 0 | 181 |
| | | **Total** | **12** | **186** | **5** | **119** | **48** | **0** | **370** |
| | Investigation 2 | No decision reached | 0 | 1 | 0 | 2 | 0 | 0 | 3 |
| | | Fully upheld | 0 | 22 | 0 | 6 | 0 | 0 | 28 |
| | | Partly upheld | 1 | 18 | 0 | 1 | 1 | 0 | 21 |
| | | Not upheld | 0 | 2 | 0 | 2 | 0 | 0 | 4 |
| | | **Total** | **1** | **43** | **0** | **11** | **1** | **0** | **56** |
| | **Total complaints** | | **115** | **937** | **278** | **1,497** | **852** | **69** | **3,748** |
| | **Total contacts** | | **117** | **976** | **294** | **1,580** | **864** | **543** | **4,374** |

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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