Annual Report 2008–2009

SPSO
Scottish
Public
Services
Ombudsman

contents

SPSO Scottish Public Services Ombudsman

Ombudsman's Introduction

I was delighted to take up my appointment in May 2009, succeeding Professor Alice Brown. On joining the SPSO, I paid tribute to Professor Brown in achieving the challenging task of merging three previous offices and setting up Scotland's one-stop shop for complaints.

In my first few months in the job, I have been struck by the calibre and commitment of SPSO staff. They deal day-in and day-out with the emotionally and intellectually demanding task of listening to dissatisfied people and trying to help resolve their often complex concerns. I have found a high level of skill and dedication among SPSO staff, and a determination to continually improve the complaints service they provide. While we do not please everyone – no Ombudsman office does – staff are constantly seeking ways of providing the best service they can to the public and our other stakeholders.

I am pleased that the results of the survey of satisfaction of users of our service indicate overall improvement. This is heartening, and we hope to build on this progress. Going forward, one of my priorities is to reduce the time the SPSO takes to examine complaints. I am also changing how we present our timescales since the facts show that our staff have dealt more speedily with cases than they are sometimes given credit for.

As important as finding answers and solutions for individuals is our role in helping organisations use complaints to bring about wider improvements in services. Every meeting and event at which I have spoken with complaint handlers from the various sectors under our remit has underlined the importance of two things – 'sharing the learning' and dealing with complaints well when they first arise.

'Sharing the learning' is a responsibility we share with the authorities concerned and with those who devise and deliver policy. There are more creative, smarter ways we could all employ to more effectively learn from the issues that lead people to make complaints. We need to use the findings of complaints better to inform national policy, drive positive change in organisations, weed out bad practice and share good practice and improve the public sector's customer service culture.

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.

'Getting it right first time' is the common sense approach for all of us who are involved in dealing with complaints. It is clearly in the interest of the complainant, the service provider and the SPSO, and it is also what the Government and Parliament reviews are asking of us all.

In the recommendations of the Sinclair report, endorsed earlier this year by the Parliament and the Government, the SPSO has been charged with a 'design authority' role. We are asked to work with others to devise principles to streamline and simplify complaints handling across the public sector. We have held discussions with SOLACE, COSLA, the Improvement Service, the NHS, the Government, the SPCB and many others to progress this work. It is important that we continue to examine the implications of the Sinclair report and come up with the solutions that best serve the public.

In this connection I would mention the Administrative Justice Group's second report on the administrative justice system which was published in June this year. The report provides an overview and analysis of all aspects of administrative justice in Scotland, and considers how the system should respond to, and be focused on, the needs of the citizens who use it.

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. As the Government and Parliament's proposals move forward, I would welcome stakeholders' contributions to the debate about the complaints handling systems we have in place at present, and the role of the SPSO in improving those processes.

Jim Martin
Ombudsman

Making a difference – justice for individuals and improvements in public services

Helping the public – securing justice for the individual

In the year to 31 March 2009, we responded to 4,040 enquiries and complaints from or on behalf of members of the public. In the vast majority of cases, we were able to quickly resolve the issue raised, by giving advice to people about how to pursue their complaint with service providers or, if we examined or investigated the complaint, by providing information and explanations about what may have happened. We published 173 investigation reports on 189 complaints – of these, 66% of the complaints were fully or partially upheld.

The public who bring their complaints to us are at the heart of what we do. We aim to be independent, impartial, fair and expert in responding to complaints and we work to make our procedures simple and clear, and to ensure that we are accessible to everyone who approaches us with an unresolved dispute. Our aim is to level the playing field, so that any service user who has a valid complaint that they cannot sort out with the organisation concerned can be assured that their concerns will be listened to by us and, where appropriate, investigated. If the SPSO finds that something has gone wrong, the Ombudsman will usually make recommendations to redress the matter, as far as possible putting the person back into the situation they would have been in had the problem not arisen.

Improving public services – feeding back the learning

Each month we lay investigation reports before the Scottish Parliament. The reports are accompanied by the Ombudsman's Commentary summarising the reports, which is distributed to over 1,200 key organisations and individuals across Scotland and beyond. We use the Commentaries to highlight specific issues that have arisen from the investigations and where the Ombudsman has recommended that action be taken.

Many more of the complaints that are brought to us are determined without a formal investigation – usually where there is no evidence of maladministration or service failure. In these cases, however, we frequently make recommendations to service providers, aimed at improvement and prevention of future occurrences of the problems that have been experienced.

As well as publicising the recommendations through our Commentaries, we use other platforms such as presentations, seminars, training events, our website and newsletters, so that the learning from complaints is spread throughout the sectors.

We are pleased that local and national newspapers as well as broadcast media use our e-newsletter and press releases to inform the public about our work. Last year, local newspaper coverage was more than twice as high as national coverage.

Making a difference
SPSO recommendations

Our recommendations, which we make in both determination letters and investigation reports, aim to put things right for the individual and to try to prevent the same thing happening to someone else. In our 2008-09 investigation reports alone, we made **over 300 recommendations** about **almost 500 issues** in **almost 90 different bodies**:

44 different GP practices or hospitals in 11 different Health Boards were asked to take action, including to:

- Apologise for suffering caused by poor treatment, misdiagnosis and inadequate nursing care
- Improve procedures for investigating, diagnosing and communicating to patients and their families illnesses such as cancer and heart conditions
- Improve systems of recording, monitoring and auditing nursing notes including records of injury to patients
- Improve reporting of ultrasound and CT scan results
- Review procedures governing the removal of patients from practice lists
- Ensure that the lessons from investigations are used in staff appraisals/annual reviews to inform development/training needs
- Conduct an audit of a hospital cleaning regime and the use of MRSA screening
- Improve complaints procedures and handling
- Improve systems of referral between hospitals and medical practices
- Review procedures for obtaining consent for treatment

24 different councils were asked to take action, including to:

- Provide free school transport
- Review policies for assessing housing adaptations for a disabled occupant
- Review and improve school exclusion policies
- Improve complaints procedures and handling
- Review wording of conditions used in planning consents
- Consider consultation with community councils
- Apologise for providing a Planning Committee with inaccurate information on a planning application
- Improve communication on social work inter-authority case transfers
- Make or increase offers of monetary payments made (for example, in recognition of service failure and time and trouble)
- Deliver on payment promises
- Introduce an independent system for complaints about a Chief Executive
- Apologise for anxiety and disruption caused by poor communication or inadequate service provision
- Ensure that staff training addresses the failings identified in reports

10 different Scottish Government bodies were asked to take action, including to:

- Apologise for inconvenience caused by poor communication
- Consider waiving overpaid amounts
- Improve complaints procedures and handling

6 different housing associations were asked to take action, including to:

- Encourage tenants to engage in mediation to resolve neighbour disputes
- Ensure that tenant consultations are meaningful and properly recorded
- Improve complaints procedures and handling

5 different further or higher education institutions were asked to take action, including to:

- Ensure explanations of appeals processes and outcomes are clear
- Improve record-keeping
- Improve complaints procedures and handling

Improving public services – better complaint handling

We promote and support good complaint handling through sharing best practice and guidance on our website for practitioners: www.valuingcomplaints.org.uk.

Our outreach and partnership work has several aims:

- supporting and guiding public bodies in improving their complaint handling practices
- raising informed awareness of our role and remit
- making sure that our work complements that of other improvement agencies: regulators, inspectorates and scrutiny bodies.

Throughout 2008–09, SPSO staff gave dozens of presentations to interested parties, ran training events and attended meetings with bodies under our jurisdiction. We continue to increase our level of written communication with service providers, by issuing leaflets and newsletters tailored to different sectors and organisations and by putting an increasing amount of information on our websites.

Working in partnership and listening to stakeholders

Many other organisations have an important part to play in helping us deliver justice for individuals and improvements in public services. A vital relationship is of course with the organisations we take complaints about. We sought the views of this key group of stakeholders in a survey earlier this year, sending questionnaires to all the organisations that had been the subject of a complaint and that had received a decision from us in the six months ending 31 March. The questions related to two areas – satisfaction with our service, and awareness of our service. Respondents were asked to send their completed surveys to an independent consultancy firm, which analysed the results on our behalf.

While recognising that the sample was small, we were pleased to note the many positive findings, in particular that among respondents:

- service providers agreed that SPSO decisions influence their organisation and working with the SPSO was seen as a positive driver for improvement in the area of complaint handling as well as more widely across their organisation
- service providers agreed that the work of the SPSO contributed to improving public services across Scotland
- satisfaction with our case handling service was high
- satisfaction with our general advice and guidance on complaint handling was also high.

We are very grateful to the organisations that responded for providing their views to help us improve our service.

Besides engaging directly with service providers, we are in regular contact with sectoral bodies who can help us feed back the learning from complaints. We gave evidence to a number of Scottish Parliamentary Committees and met many MSPs in relation to particular cases or to discuss our work in general. We continued to engage with Ministers and Directorates of the Scottish Government on the improvement agenda and it has been heartening to see examples of cases that have driven real change. As an office we continue to identify opportunities for working in partnership and sharing services with other similar organisations.

Key facts and figures for 2008–09

- We dealt with **1,165** enquiries – helping people decide whether to pursue a complaint, and directing them to the right place
- We received **2,953** complaints (22% more than last year)
- We determined **2,875** complaints (just six fewer than in 2007–08)
- We made decisions on **66%** of complaints within 2 weeks; **84%** within 14 weeks; and **94%** within 52 weeks (the figures for 2007–08 were 49%, 72% and 88% respectively)
- **173** investigation reports were published about **189** complaints
- Ombudsman's Commentaries containing summaries of the investigation reports and our recommendations were sent electronically to over **1,200** stakeholders each month
- We held over **100** outreach meetings and training events – up 25% on last year

Casework Trends and Performance

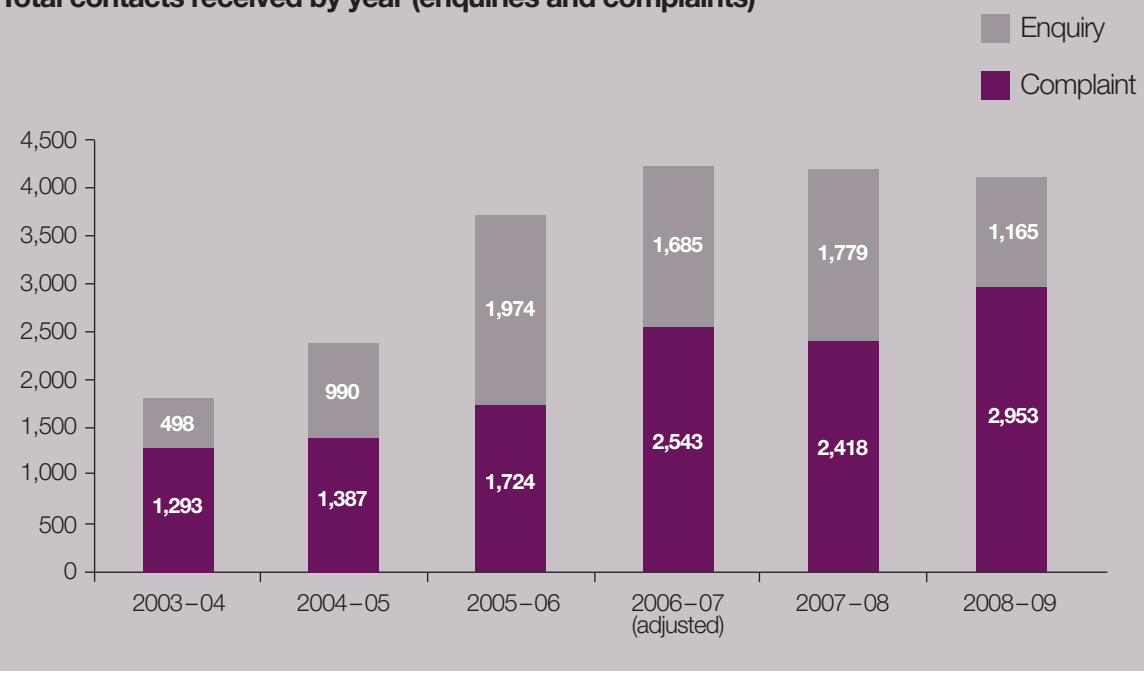
The enquiries and complaints we received

Our role is to investigate complaints about public services. Most people who approach us bring a concern they want us to look into. A significant number, though, are simply seeking information – for example, how they should pursue an issue with a public body or where they should take a particular problem they have with a service.

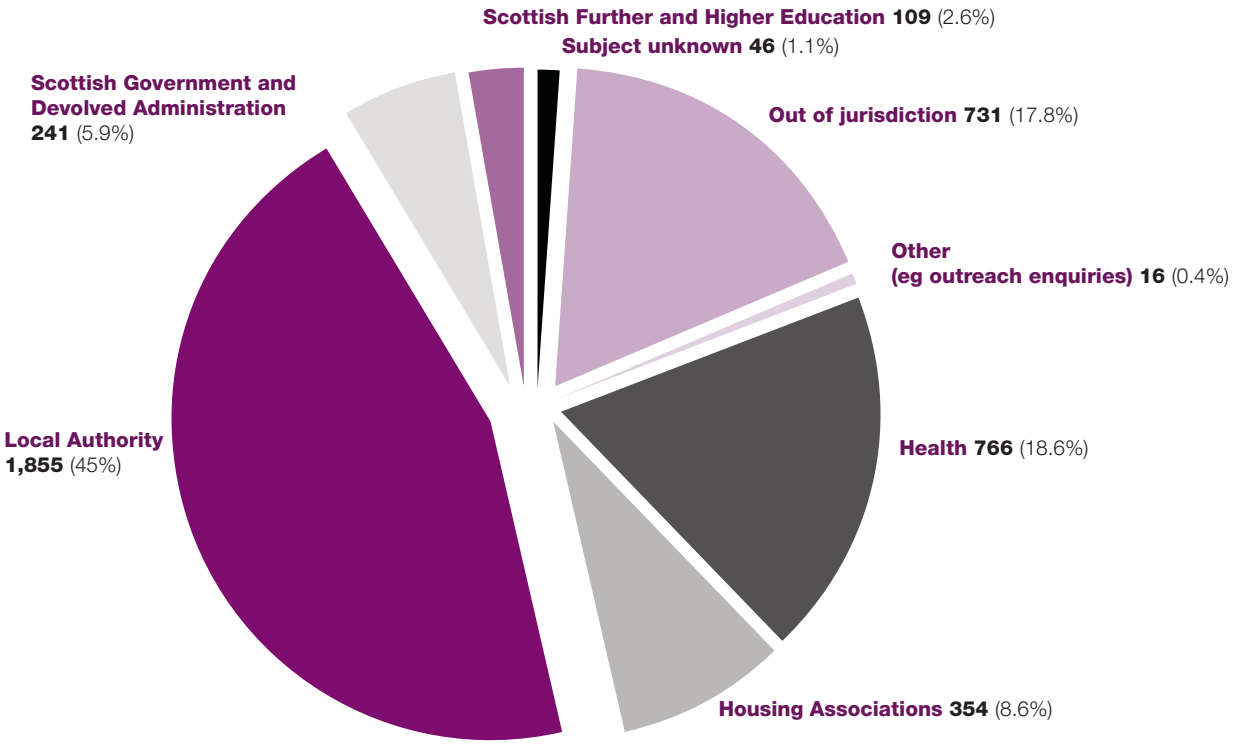
We received 4,118 enquiries and complaints from members of the public in 2008–09. Of these, 2,953 were complaints (a 22% increase on the previous year) and 1,165 were enquiries (a 35% decrease on the previous year). It may be that these changes at least partly reflect a better public understanding of what we can and cannot do. We have put a good deal of effort into providing clear, easily accessible information on our website which received an average of 5,657 visits a month in 2008–09 (up 8% on the previous year). We have also produced a number of information leaflets for the public and service providers, some of which are mentioned later in this report.

The extent to which particular organisations are the subject of enquiries and complaints to us tends to reflect the extent to which they are involved in delivering services to the public. So, as in previous years, enquiries and complaints about councils – which day-to-day provide hundreds of services to all the citizens of Scotland – formed about half of the caseload. Again, as in previous years, the NHS formed the next largest section of the caseload followed by housing associations (Registered Social Landlords or RSLs).

Total contacts received by year (enquiries and complaints)



Total contacts received by sector (4,118) in 2008 – 09

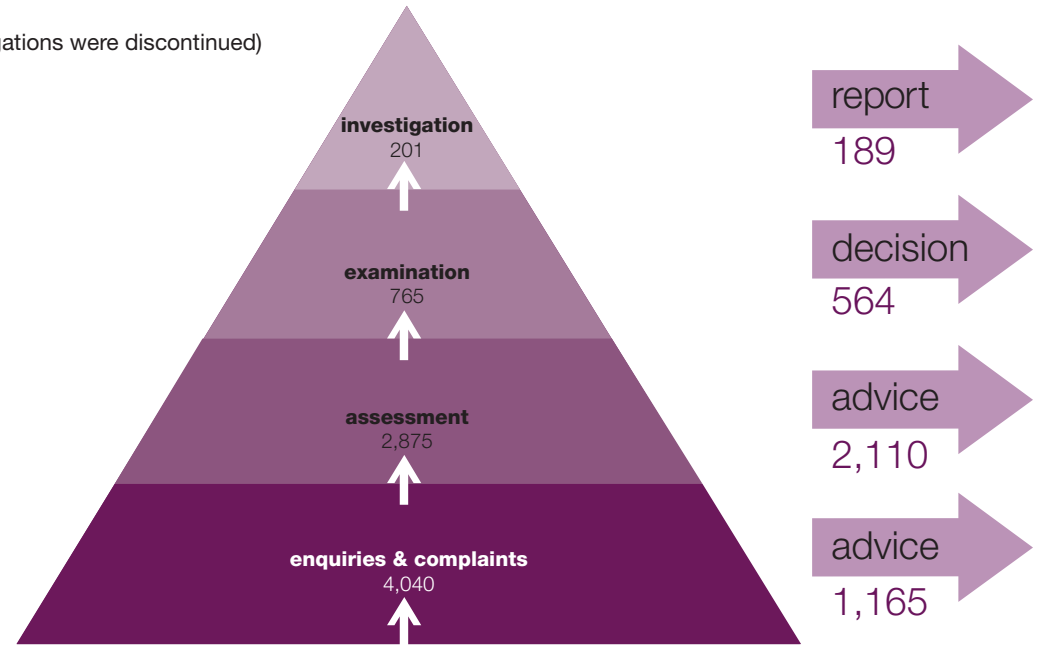


How we dealt with enquiries and complaints

In 2008 – 09 we dealt with 1,165 enquiries – helping people decide whether to pursue a complaint, and directing them to the right place – and we considered and reached decisions on 2,875 complaints.

Complaints resolved at different stages 2008 – 09

(12 investigations were discontinued)



Enquiries

At this stage, we give support and guidance to people who contact us about their problem with a public service, giving advice about how to pursue a complaint, and, where appropriate, directing people to an organisation that may be better placed to help. Mostly this is done by telephone but our staff also deal with the wide variety of concerns that are brought to us each day by people who visit our office (we are open to the public during normal opening hours), or who make contact by text or email. The 1,165 enquiries we answered in 2008–09 covered issues ranging from the relatively minor such as how to sort out a problem with a leaking roof, to sensitive conversations with bereaved people concerned by the treatment or care received by a relative.

Complaints

In considering complaints, the law requires us to ask ourselves a number of questions: is this a complaint that we can consider (either now or at all); if so, what is the most appropriate way to deal with it; is a quick resolution possible; might there be benefit to the complainant or the wider public in a formal investigation report laid before the Scottish Parliament? The consideration of a complaint can, therefore, involve up to three stages which we define as assessment, examination and investigation.

Assessment

All complaints we receive are assessed to establish whether we can look into them – in other words, whether they are about a service provider and a matter which, by law, we can investigate. If so, the next question to be asked is whether we can look at the complaint now – normally we can only investigate a complaint if the organisation itself has been given a full opportunity to consider and respond to it. Sometimes we need more information from the complainant to come to a view on these matters. In 2008–09 we reached decisions on 2,110 complaints at the assessment stage. Many of these were 'premature complaints' (i.e. they had not yet been pursued through the organisation's own complaints procedure – just over half of the complaints (51%) we determined in 2008 – 09 fell into this category). In these cases we provided advice on how the complainant could pursue the matter with the organisation concerned. Other cases could not be examined because, for example, the complaint was not something we could look at for legal reasons (what we refer to as 'out of jurisdiction'), or the complainant withdrew the complaint or failed to provide enough information for us to proceed.

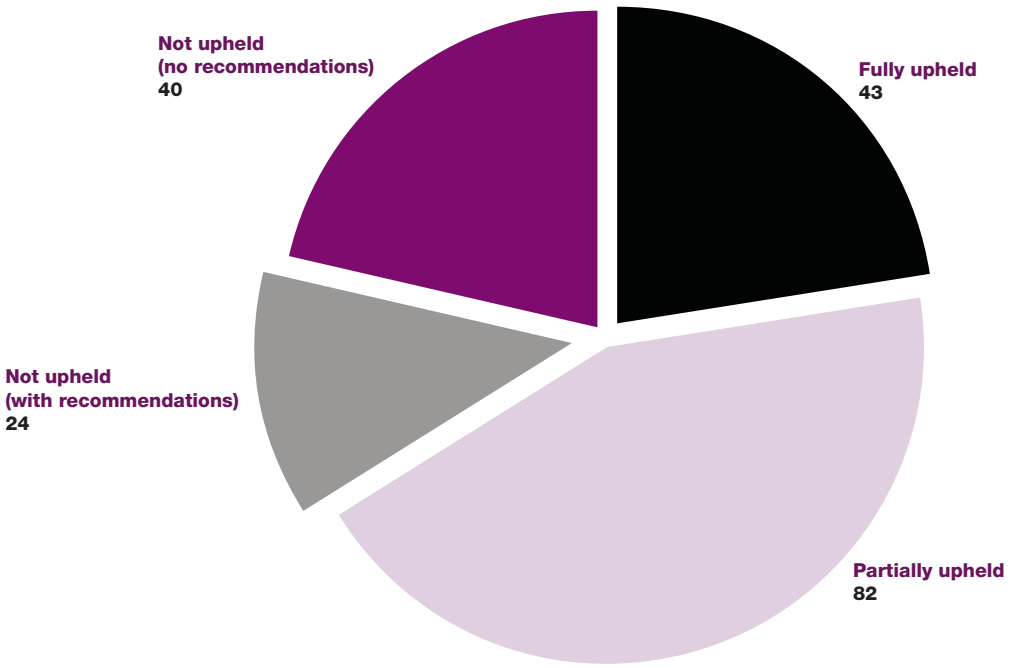
Examination

If we do not reach a decision on a complaint at the assessment stage it receives further examination. This involves gathering and examining evidence including, where necessary, getting expert advice and carrying out interviews and site visits. In most cases, we then report our conclusions in what we call a determination letter. We usually do this if the organisation has already accepted there were failings, apologised and taken action to prevent the problem from happening again; if from the evidence it appears that the organisation did not do anything wrong; or if there is not enough evidence available for us to reach a conclusion and it is unlikely that further investigation would uncover more. We reached decisions on 564 cases at the examination stage during 2008–09.

Investigation

We may decide to move from examination to investigation if more evidence is needed to reach a conclusion and it would be both practical and proportionate to carry out in-depth investigation to obtain that evidence. We may also decide there is a public interest in placing the facts of the case in the public domain by producing an investigation report. By law, all our investigation reports must be laid before the Scottish Parliament, which places them in the public domain. We also post all investigation reports on our website so that they are easily accessible. Investigation reports name the organisation which is the subject of complaint but not the person who made the complaint or any other individual. In 2008–09, we published 173 reports on 189 complaints. Twelve investigations were discontinued without the production of a report. The outcome of all the investigations that were reported to the Scottish Parliament is shown in the chart opposite.

Outcome of investigations reported to the Scottish Parliament 2008 – 09*



Fully upheld **43 (23%)**

Not upheld **64 (34%)**
(24 with recommendations)

Partially upheld **82 (43%)**

How quickly we dealt with complaints

We are making steady progress in improving the speed with which we deal with complaints.

In 2007 – 08

49% of complainants received decisions within two weeks;

72% received decisions within 14 weeks;

88% received decisions within one year.

In 2008 – 09

66% of complainants received decisions within two weeks;

84% received decisions within 14 weeks;

94% received decisions within one year.

Jim Martin, the new Ombudsman, has made it a priority to reduce the time taken to resolve complaints. To ensure that our Key Performance Indicators (KPIs) reflect more accurately the work we do, we have adjusted our KPIs in 2009 – 10 to the following:

1. KPI 1 measures complaints that are not for the SPSO at all, or not for the SPSO yet (target – 90% cases closed within two weeks)
2. KPI 2 measures complaints that are for the SPSO but not formally reported to Parliament (target – 80% cases closed within four months)
3. KPI 3 measures formally reported cases to draft report stage (target – 90% cases drafted within 12 months).

Note: These numbers differ from those published in the June 2009 *SPSO Performance Update*, which wrongly stated the numbers due to incorrect classification of outcomes.

Feedback from users of our service

The views of people who have contact with us always provide valuable feedback from which we can learn. As explained in our last Annual Report we carried out our first comprehensive survey of complainants' views in 2007–08. One of the actions we committed to in light of that survey's findings was a rolling survey of complainants' views.

We based our questions on our revised service standards:

1. **Accessibility**
2. **Clear and regular contact**
3. **Dealing with cases as promptly as we can**
4. **Listening to you**

We sent a survey form to everyone on whose complaint we had made a decision from the start of April 2008, asking them what they thought of our service. Almost 500 people replied, and we are very grateful to them for taking the trouble to give us their views. Overall satisfaction has risen compared with our 2007 complainant satisfaction survey, and there were high scores on how well we provided information and the helpfulness, courtesy and reliability of our staff. Scores on how quickly we resolved complaints and perceptions of our impartiality were lower, but are broadly in line with those of other public service ombudsman offices. More than half of complainants said they would use the SPSO again and half also stated that they would recommend the SPSO to others – again, in line with scores for ombudsman services that handle complaints about the public sector.

Local Government

Because of the range of matters for which local authorities are responsible and their closeness to local communities, they have a more immediate effect on the day-to-day lives of people than most other sectors of public administration. They are also individually democratically accountable through elected councillors in a way that other public service providers are not. Local authorities deliver a wide range of services to everyone in Scotland, often on a daily basis. Inevitably, things sometimes go wrong and peoples' expectations cannot always be met, and this can give rise to complaints.

There is a real desire in the sector to get things right and to learn lessons when things have gone wrong. We seek to support that culture by ensuring that complaints are firmly linked with improvement and are valued for providing customer feedback or early warning of services that need attention.

The enquiries and complaints we received

We received 1,604 complaints about local authorities in 2008–09, accounting for 54% of all complaints received (roughly the same percentage as in the last two years). We also received 251 enquiries about local authorities. The top 12 subjects complained about are shown in the chart below.

Top twelve subjects of complaint about local government 2008 – 09	
Housing	459
Planning	269
Social Work	188
Finance	148
Education	89
Roads & Transport	87
Legal & Admin	79
Environmental Health & Cleansing	69
Recreation & Leisure	44
Land & Property	32
Building Control	27
Valuation Joint Boards	24

This distribution is broadly similar to previous years, with complaints about housing, planning and social work accounting for well over half of the total. Housing complaints are dealt with in a later chapter.

What happens to the local authority complaints that come to the SPSO?

In the course of the year, we reached decisions on 1,546 complaints about the sector (this figure includes some carry-forward from the previous year). Of the 62 local authority cases about which we published investigation reports, 37 (60%) were fully or partially upheld, and 25 (40%) were not upheld. As a result of our consideration of complaints we asked 24 different councils to take action to sort out individual problems and to reduce the risk of them recurring. These recommendations included:

- Providing free school transport
- Reviewing and improving school exclusion policies
- Improving complaint procedures and handling
- Reviewing wording of conditions used in planning consents
- Considering consultation with community councils
- Apologising for providing a Planning Committee with inaccurate information on a planning application
- Improving communication on social work inter-authority case transfers
- Making or increasing offers of monetary payments made (for example, in recognition of service failure and time and trouble)
- Delivering on payment promises
- Introducing an independent system for complaints about a Chief Executive
- Apologising for anxiety and disruption caused by poor communication or inadequate service provision
- Ensuring that staff training addresses the failings identified in reports

More information about the investigations leading to some of these recommendations is given in the case studies at the end of this chapter.

Issues in local authority complaints

Of the 1,546 complaints determined during the year, 923 (60%) were premature (i.e. they had not completed the full complaints process of the council). As in previous years, this is a very large proportion of the complaints determined. A key principle of good complaint handling is that wherever possible speedy resolution is sought as close as possible to the source of the problem. This makes sense for both the complainant and the body complained about. Complaints that are not sorted out quickly can lead to increased dissatisfaction for the complainant and significant amounts of extra work for the organisation. This is particularly so if a complaint is prematurely escalated outside the organisation and has to be referred back again. We are continuing to work with councils and other bodies to see how best to address this issue.

As we said in last year's Annual Report, there are different possible explanations for premature complaints but we consider there may be a link between the accessibility, simplicity and quality of bodies' complaints processes and the incidence of premature complaints to our office. This is one reason we have advocated an integrated, standardised and simplified system of complaint handling across public services. This was endorsed by Professor Crerar's Independent Review of Regulation, Audit, Investigation and Complaint Handling of Public Services in Scotland (September 2007) and Douglas Sinclair's subsequent Report to Ministers from the Fit-for-purpose Complaints System Action Group (July 2008) and the report of the Scottish Parliament's Committee on SPCB supported bodies (May 2009). The Scottish Government has acknowledged that complaints processes that are easy to access, understand and use will help the less articulate and less confident to complain, and that simplification will also have benefits for service providers. The Scottish Government propose to include the necessary provisions for a new complaints handling process in the Public Services Reform (Scotland) Bill by means of amendments to the Bill lodged at Stage 2. The SPSO looks forward to continuing to work with the Scottish Government, local authorities and other complaint handling bodies in taking forward these proposals for simplification and improvement.

As in previous years, complaints about planning matters form a substantial part of the case load. It is clear that many members of the public are frustrated by their engagement with the planning system and in some cases have unrealistic expectations about what it can achieve – or prevent. Responsibility for making decisions about planning applications properly lies with democratically accountable local authorities, acting in accordance with planning law and there are established appeals procedures in relation to refused applications. It is not within the power of the SPSO to stop development or amend planning decisions. Similarly, where breaches of planning control or approval conditions occur, the decision of whether or not to initiate enforcement action is a matter for the discretion of the relevant council, which has to take account of whether the resource intensive nature of such action is warranted in the overall public interest. However, such issues are not readily understood by interested third parties. When we consider complaints relating to planning matters it is not our role to assess or challenge the merits of decisions. Our function is to judge whether councils have fulfilled their administrative duties and functions reasonably.

We published two leaflets on planning issues in September 2008, intended to help explain what the SPSO can and cannot do in this area. We revised the leaflets in September 2009 after the Planning etc. (Scotland) Act 2006 came into force and will continue to consider whether further guidance is needed. The Scottish Government has implemented a general reform of the planning system alongside the changes introduced by the Act. As part of this reform, we are working with COSLA, the Standards Commission and the Improvement Service to conduct a review of the way that planning complaints are handled by planning authorities and by external adjudicators. The working group aims to establish a framework of best practice principles for dealing with planning complaints on which planning authorities and councillors can draw when formulating their own procedures.

One of the case studies at the end of this chapter concerns the investigation of a complaint about a council's consultation over the withdrawal of services to bring about savings. In the current financial climate, councils – and other public service providers – will inevitably face difficult decisions about what they can afford. Policy decisions on such issues are properly for democratically elected councillors but need to be informed by a proper understanding of relevant factors. Prior public consultation will not always be possible but where it does take place it should be meaningful and in accordance with any relevant statutory provision or guidance and policies. As with planning matters, it is not the SPSO's role to act as an appeal authority in respect of decisions about service provision. Rather, when we receive complaints about such matters, we consider whether public bodies have fulfilled their administrative duties and functions in a reasonable way.

Case Studies

School transport > Case: 200700989

Parents of a primary school pupil raised a number of concerns about the school transport provision for their daughter. They felt that the arrangements were not safe and said they were never told that the school their daughter attends was not the one zoned for her. We found that the Council failed to take adequate steps to ensure that the parents knew which primary school their daughter was zoned to attend nor did they explain the transport implications. The Council accepted our recommendation that they provide free school transport to the child and her sister until the end of their primary schooling from the pick up/drop off point which would have been agreed had they been within the catchment area of the school. They also agreed to look favourably on future applications for transport to the school for any of the child's other siblings.

Breach of planning consent > Case: 200603184

A couple raised concerns about the handling by the Council of their representations about breaches of a planning consent granted for change of use of adjacent premises to a restaurant/takeaway and for the installation of an external flue.

We partially upheld complaints that the Council failed to enforce conditions attached to the planning consent which were imposed to protect the amenity of neighbours; and failed to resolve the effect on the couple's amenity of noise and odours emanating from the premises. Planning officers at the Council clearly foresaw a difficulty in granting planning consent for a restaurant/takeaway close to residential properties. Members of the Planning Committee decided to exercise their discretion to grant full conditional planning consent. While conditions were imposed with the intention (amongst other things) of allowing the Council to control the hours of operation and noise and fumes emanating from the premises, they were written in a way that implied that neighbours should not experience any odours or noise from the premises. It was clear from the history of the complaint that the Council had neither been able totally to prevent noise and odours affecting neighbouring residents, nor did they appear to have tried to explain to them that this might well not be possible.

Our recommendations included that the Council review the wording of conditions used in their planning consents and actively continue to monitor compliance with the planning consent.

Permitted development > Case: 200603334

A man raised concerns that the Council had wrongly classified as permitted development the construction of a raised decking structure adjacent to a stretch of river for which his company owns the fishing rights. He also complained that the Council failed to take enforcement action when they became aware of their mistake.

The Council accepted that the initial advice given to the owners of the river bank was incorrect and that the decking did require planning permission. They said that at the time the standard advice they gave was that decking structures did not require planning permission. However, because of its particular situation, the decking in this case was not permitted development and so it was not appropriate for the Council to give the standard advice.

The Council expressed the view if the decking had been the subject of a planning application, consent would have been granted. Nevertheless, the complainant's company were deprived of the opportunity to participate in the planning process in relation to a development which affected them. This caused them frustration and uncertainty. We upheld the complaint about the incorrect advice. We did not uphold the complaint about the decision not to take enforcement action. The Ombudsman cannot question the merits of a discretionary decision taken without maladministration. Decisions on whether to take enforcement action fall within the discretion of councils. In this case the Council considered whether to take enforcement action and decided that it would not be appropriate to do so in this case. The Council's decision was taken with knowledge of the circumstances and with reference to the relevant planning guidance. We could find no evidence of maladministration in the way this decision was reached and therefore did not uphold this complaint.

Our recommendations included taking steps to ensure that planning officers obtain enough information about a proposed structure to be able to give specific rather than standard advice.

Consultation about withdrawal of services > Case: 200703152

A man raised a number of concerns about a decision by his local council to remove warden provision from sheltered housing. He said there had been a failure to consult with tenants and that information available to Councillors when the decision was made was inadequate. He also complained about the process of implementation, the transition provisions, and communication generally, including the Council's response to complaints raised. The changes arose in the context of the need to make savings and Councillors rejected a motion that they should be delayed until, among other things, a consultation was undertaken. The complainant suggested that the failure to consult breached the Housing (Scotland) Act 2001, which requires landlords to consult where changes are likely to significantly affect the tenant.

It is not the role of the SPSO to interpret legislation. Ultimately, that is for the courts. However, in this case we took the view that any decisions made by council officers and Councillors on whether consultation should be undertaken could only be soundly based if they were informed by legal advice in relation to the provisions of the 2001 Act. This did not happen. Therefore, we upheld this complaint to the extent that the decision that consultation was not required was not soundly based. We did not uphold the complaint that information provided to Councillors prior to the decision was inadequate. During the investigation we interviewed three Councillors and all said that they had enough information to decide whether this was a proposal they could or could not support.

We upheld the complaints that there was insufficient planning for the process of implementation and transition provisions, and about communication. The planning prior to the decision focussed on costs rather than implementation. There was some analysis of risk but the level of practical difficulties that the Council had to resolve and the speed with which these were identified indicated that a fuller analysis should and could have been undertaken. We were particularly concerned that issues arose between Social Services and Housing which should have been resolved in discussions before the decision was made. Considerable efforts were made to communicate with those affected by the decision and while the tenants interviewed during our investigation were unhappy with how the decision had been handled, they still commented that at times contact with the Council was good. However, this was a particularly vulnerable group and once the initial stage of informing everyone of the decision was complete, it did not appear this was reviewed in a structured manner. Greater consideration should have been given both before and during the implementation and post-implementation stages to having and maintaining a clear, consistent communication plan.

Our recommendations were that the Council should:

- review their procedures for ensuring appropriate legal advice is obtained and recorded prior to significant decisions
- use the implementation of this decision as a case study, to ensure appropriate planning is in place for future service changes
- ensure that, for future service changes, adequate and appropriate communication planning is undertaken and monitored; and
- review the information currently provided to tenants about the new system and ensure that systems are in place to allow tenants to communicate with the Council simply and effectively.

Health

The enquiries and complaints we received

We received 766 contacts about the NHS in 2008–09, a 3% increase on the previous year but 8% less than in 2006–07. The contacts in 2008–09 were made up of 684 complaints, a 14% increase compared with the previous year; and 82 enquiries, a 42% decrease since 2007–08. As we commented earlier in this report in relation to SPSO's overall caseload, the increase in complaints and reductions in enquiries may at least partly reflect a better public understanding of what we can and cannot do.

Of the 684 complaints received 354 (52%) were about hospital services, 152 (22%) about general practitioners and 55 (8%) about dental and orthodontic services. The remaining 123 complaints covered NHS 24, the Scottish Ambulance Service and a wide range of other NHS services. The percentage breakdown was broadly similar to that in 2007–08 although there was some increase in the proportion of complaints about GPs and dentists. The top categories of complaint are shown in the following table. These are broadly similar to previous years.

Top subjects of complaint about health 2008 – 09	
General Practitioners and Practices	**152**
Hospitals – Psychiatry	**59**
Dental & Orthodontic Services	**55**
Hospitals – Care of the Elderly	**53**
Hospitals – General Medical	**52**
Hospitals – General Surgical	**32**
Hospitals – Orthopaedics	**23**
Hospitals – Oncology	**19**
NHS National Services	**19**
Hospitals – Urology	**18**
Hospitals – Gynaecology & Obstetrics (Maternity)	**18**
Hospitals – Accident & Emergency	**16**
Hospitals – Cardiology	**16**

What happens to the health complaints that come to the SPSO?

We reached decisions on 659 complaints about the NHS during 2008–09 (including some carry-forward from the previous year). In 193 cases which underwent detailed examination we decided that an investigation was not appropriate. We published reports on 99 complaints about the NHS – 72 of the complaints were fully or partially upheld; 27 were not upheld. As a result of our consideration of complaints we made recommendations to 44 different practitioners or hospitals in 11 different Health Boards to sort out individual problems and to reduce the risk of them recurring. These recommendations included:

- Apologising for suffering caused by poor treatment, misdiagnosis and inadequate nursing care
- Improving procedures for investigating, diagnosing and communicating to patients and their families illnesses such as cancer and heart conditions
- Improving systems of recording, monitoring and auditing nursing notes including records of injury to patients
- Improving reporting of ultrasound and CT scan results
- Reviewing procedures governing the removal of patients from practice lists
- Ensuring that the lessons from investigations are used in staff appraisals/annual reviews to inform development/training needs
- Conducting an audit of a hospital cleaning regime and the use of MRSA screening
- Improving complaint procedures and handling
- Improving systems of referral between hospitals and medical practices
- Reviewing procedures for obtaining consent for treatment

Issues in health complaints

2008 saw the 60th anniversary of the founding of the NHS. Much has changed since those early days when general practices, pharmacies, opticians and dental surgeries had to cope with a torrent of demand from patients who previously could not afford treatment or essential appliances. The NHS in Scotland has pioneered key changes since adopted worldwide: establishing the first UK nursing studies unit in 1959 and developing the Glasgow Coma score in 1974 being just two examples. What has not changed since 1948 is that people hold the NHS in very high regard and turn to it at some of the most vulnerable points in their lives. All of this is reflected in generally high levels of satisfaction with NHS services and in a widespread reluctance to complain when things do go wrong. The findings of research[1] commissioned by the Scottish Health Council at the invitation of the Scottish Government showed that more than two thirds (69%) of respondents had never had a problem with any of the NHS services they had used. Over half (53%) of those who had a problem did not take any action. A quarter (27%) of those who had had a problem had expressed concern or in some other way given feedback, but had not made a formal complaint. So it is particularly important that when complaints are made they are responded to appropriately and any necessary lessons are identified and used to improve services.

As always, poor communication in the broadest sense – failures to provide information to patients and carers, information not passing from one member of a clinical team to another, care hampered by inadequate records – underlay many of the complaints we considered this year. One of the case studies at the end of this chapter, involving planning for an elderly woman's discharge from hospital, illustrates the problems and distress such shortcomings can cause.

The public are understandably concerned about hospital cleanliness in the light of publicity given to outbreaks of hospital-acquired infections such as that at the Vale of Leven Hospital in 2007 and 2008. In October 2008, the Health Secretary announced measures aimed at reducing levels of infection in hospitals, saying: "Hospital infections cause pain, distress and suffering for patients and for their families. And they undermine confidence in our health service". Those concerns are reflected in complaints coming to the SPSO, two of which are outlined in the case studies at the end of this chapter.

Something that has changed very much since 1948 is the extent to which it is accepted and expected that users of the NHS should be active partners in the management of their health and in making decisions about their treatment. This trend was acknowledged when in 2008 the Scottish Government formulated its vision for a mutual NHS with patients and the public as partners rather than recipients of care. The last of the case studies at the end of this chapter explains how we concluded that a consultant's decision not to give a young woman particular information relating to her medical condition, while conscientiously arrived in exercise of his clinical judgment, had resulted in her receiving a poorer service from the NHS than she was entitled to expect.

1 http://www.scottishhealthcouncil.org/shcp/files/R09_Making_It_Better_NHS_Complaints_summary.pdf

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Case Studies

Discharge planning > Case: 200601244

Two sisters complained that their late mother's discharge from hospital had not been properly planned.

The complaint was fully upheld. There were a number of occasions where the daughters were given to believe that their mother was to be discharged imminently without their being consulted. The lack of any clear evidence or a formal plan for discharge gave rise to considerable confusion and caused distress for the family. A multi-disciplinary meeting involving the family would have permitted an exchange of information and sharing of knowledge as well as ensuring proper planning for and management of the woman's discharge. The lack of a plan and of effective communication gave rise to a poorly managed discharge process over a number of weeks.

Our recommendations included:

- ensuring that discussions take place within the clinical team on the ward to agree the appropriate standard of practice with regards to the importance of thorough examination of a patient prior to discharge, with particular reference to patients with pre-existing medical problems and multiple medications
- considering the use of fully unified records, i.e. including therapy follow-up records with the joint medical/nursing records
- where family conflicts or carer anxieties are raised, considering case conference meetings when the key disciplines and family and carers can meet to exchange information and plan discharges.

Nursing care and hospital cleanliness > Cases: 200702695 & 200603453

In the first case a woman raised a number of concerns about the level of nursing care that her late husband received during two hospital admissions and about the cleanliness of the ward in which he was nursed. The complaints were upheld and we recommended that the NHS Board which manages the hospital conduct an audit of the cleaning regime throughout the hospital as well as take a number of steps to improve nursing care.

In the second case, involving a different NHS Board, a man complained that while he was in hospital his room was not adequately cleaned. The complaint was upheld to the extent that any evidence to back up the Board's position that cleaning was adequate had been mislaid and that the Board's response was not adequately evidenced. We recommended that the Board remind the relevant cleaning contractor of the importance of good record-keeping; and that they obtain all of the available evidence when investigating a complaint and verify any statements provided during the course of the investigation.

GP referral and hospital treatment > Cases: 200603988 & 200701202

A woman raised a number of concerns about the diagnosis of her late husband and his treatment for small bowel obstruction. Specifically, she complained that his GP practice had delayed referring him to hospital and that the treatment provided when he was admitted to hospital was inadequate.

We upheld the complaint about delays by the GP in diagnosis and referral. The woman telephoned the practice when her husband had been suffering from severe abdominal pain for three to four days. The GP who took the call considered that he had a typical history of gastritis and gave advice accordingly. The Ombudsman recognises the importance of telephone consultations. However, in this case, the GP should have put herself in a position to exclude a more serious cause of the man's abdominal pain.

The complaint about hospital treatment was not upheld: the diagnosis made there was appropriately and promptly made and was compatible with good practice. Sadly, the man died within a few hours of admission, before his treatment regime could be established.

Our recommendations to the GP practice included reviewing their protocol for telephone consultations to ensure that patients are seen by a doctor when necessary in order to exclude more serious diagnoses; and reconsidering the management of severe abdominal pain over the telephone.

Information about epilepsy > Cases: 200700075

A woman raised concerns about the quality and quantity of information given to her late daughter following a diagnosis of epilepsy. She considered that her daughter was denied an opportunity to fully understand the consequences of not taking her prescribed medication on a regular basis and that this may in turn have contributed to her premature death. In particular, she was very concerned that her daughter was not forewarned about the risk of SUDEP[2].

The complainant's daughter was diagnosed with epilepsy in April 2006 when she was aged 18 and still living at home. She died in her sleep later the same year while living away from home, shortly after starting university. The cause of death was given as SUDEP. Post-mortem results showed no sign of anti-epileptic medication.

The consultant neurologist who treated the complainant's daughter felt that there was nothing that could have been done to reduce the risk of SUDEP. In such circumstances he, like a number of neurologists, considers that a patient has a right not to know about certain potentially distressing aspects of their condition, particularly where this would be (in his view) to no purpose. Conversely, a number of neurologists and patient support groups believe that a patient has the right to know as much as possible about their condition.

There was no suggestion in this case that the diagnosis and drug treatment provided was clinically inappropriate or deficient. Equally, it was clear that the Consultant's position on what information to provide was carefully considered and arrived at conscientiously. The Ombudsman recognised that the decision on whether or not to tell is difficult and complex. She concluded that the Consultant did not fail in his clinical judgement in not telling the young woman of the risk of SUDEP. However, she did not consider that the reasons given by the Consultant for not telling of the risk were in tune with NHS Scotland's move towards a mutual NHS. There has been a clear shift in approach to a presumption in favour of sharing information and knowledge. This change must be recognised by all those working within the NHS and should be reflected in NHS Boards' oversight of the actions of their staff. The Ombudsman therefore considered that in this case the NHS Board failed to provide the young woman with the level of service she was entitled to receive as an NHS patient by not giving her specific information about SUDEP.

Our recommendations included providing written information to patients on a proactive basis following diagnosis. We also asked the Directorate of Health and Wellbeing to consider the need for more research into patient views on information giving and into the possible risk factors for SUDEP and the use of this research to inform ethical guidance.

2 Sudden Death in Epilepsy – a term used when a person with epilepsy suddenly dies and the reason for the death is not known. The cause of SUDEP is unknown. There are around 500 SUDEP related deaths per annum in the UK.

Housing

In Scotland over half a million dwellings are in the social rented sector, that is, homes rented from councils or registered social landlords (RSLs – mainly housing associations and cooperatives). Because similar concerns and issues arise across the social rented sector this chapter looks at housing information for councils and RSLs together.

A recent report by the Scottish Housing Regulator *Social Landlords in Scotland: Shaping up for improvement* (July 2009) commented 'Social landlords are important to the wellbeing of individuals and communities across Scotland. Local authorities and registered social landlords … provide homes for one in four households and contribute to the economy through significant stock investment and new house building. … We have seen some excellent performance and innovative practice in a sector that has a strong track record of providing affordable housing for many in Scotland. And we have worked with some talented and dedicated staff, governing bodies and councillors.' But the report also identified areas in which improvement was needed, one of which was that 'Landlords could do more to train and empower frontline staff to handle complaints; record complaints properly; and use complaints information to drive improvement'.

As we said in last year's Annual Report, we know that housing staff take very seriously their obligations to provide a good service, including dealing effectively with complaints. We are pleased at the way they continue to engage with us to cultivate a culture of valuing complaints.

The enquiries and complaints we received

Taking contacts about local authority housing and RSLs together, we received a total of 95 enquiries and 762 complaints in 2008–09; more than we received about the NHS. Just under 60% of the cases were about local authorities, who have just over 60% of the social rented housing stock. The top twelve categories of complaint are shown in the following table. These are broadly similar to previous years except that there has been a very marked increase in complaints about rent and service charge issues.

Top twelve subjects of complaint about housing 2008 – 09

Repairs and maintenance of housing stock	**187**
Policy/administration	**119**
Neighbour disputes and anti-social behaviour	**110**
Applications, allocations, transfers & exchanges	**96**
Rent and/or service charges	**52**
Complaints handling	**50**
Capital works, renovations, improvements, alterations and modifications (incl central heating and double glazing)	**42**
Homeless person issues	**33**
Finance – housing benefit and council tax benefit*	**25**
Right to buy	**12**
Estate management, open space & environment work	**10**
Abandonments, evictions and terminations	**10**

** Local Authority only*

What happens to the housing complaints that come to the SPSO?

We reached decisions on 760 housing complaints (for local authorities and RSLs combined) in 2008 – 09, including some carry-forward from the previous year. Of these, 644 were determined at the assessment stage (mainly because they had not completed the service provider's complaint process); 94 at the examination stage; and 22 were investigated. Of the complaints investigated, one was fully upheld, seven were partially upheld, eight were not upheld, and six investigations were discontinued or suspended. As a result of our consideration of complaints we asked seven different councils and six different housing associations to take action to sort out individual problems and to reduce the risk of them recurring.

The recommendations included:

- Encouraging tenants to engage in mediation to resolve neighbour disputes
- Reviewing policies for assessing housing adaptations for a disabled occupant
- Ensuring that tenant consultations are meaningful and properly recorded
- Improving complaint procedures and handling

Issues in housing complaints

We continue to be concerned that complaints about housing generate the highest number of premature complaints to our office. In 2008 – 09, the rate of premature complaints about the housing functions of councils was 71% and for housing associations 70% (the equivalent figures last year were 61% and 69% respectively). These rates are considerably higher than for other sectors and we continue to work with the sector to try to establish the reasons for this and to seek to reduce the incidence of premature complaints. The Scottish Housing Regulator's report *Social Landlords in Scotland: Shaping up for improvement*, mentioned earlier in this chapter, commented: 'We also receive a fairly large number of complaints from tenants and owners, many of which have not gone through the landlord's own complaints process. We have found that social landlords have got better at telling tenants how to complain. But landlords should improve their complaints handling, or the way they guide particular complainants through the process, to address the issue of premature complaints. We agree with a joint report[3] from the Chartered Institute of Housing and the SPSO that landlords need to do more to train and empower frontline staff to handle complaints; record complaints properly; and use complaints information to drive improvement. These conclusions have equal relevance for RSLs and local authority landlords'.

We continue to receive significant numbers of complaints relating to alleged anti-social behaviour. These are particularly difficult issues for landlords to deal with: perceptions of what constitutes anti-social behaviour differ and gathering evidence to form a basis for taking action is seldom straightforward. Underlying many of the complaints coming to us is a breakdown in relationships between neighbours which in itself can blight the lives of all concerned. The case studies below outline two investigations where we did not uphold complaints but nevertheless urged the landlords to seek ways to help resolve issues between the complainants and their neighbours.

3 *Seeing Beyond the Negative*, July 2008, www.cih.org/scotland/policy/SPSOfinal-jul08.pdf

Case Studies

Anti-social behaviour > Cases: 200601742 & 200700150

These cases involved complaints by tenants of different housing associations that the association had not responded adequately to representations made about what the tenants considered to be anti-social behaviour from their neighbours. Neither complaint was upheld: both Associations had acted reasonably in responding to the allegations presented to them and dealing with the complaints they received. However, in both cases we recommended that the Association seek ways to help resolve issues between the complainants and their neighbours. In one case we suggested that the Association consider taking steps to try to encourage the complainants and their neighbours to participate in mediation; in the other we suggested that the Association consider offering the complainant alternative means of dispute resolution outwith the formal complaints procedure.

Withdrawal of meals service > Case: 200600929

The complaint was that a housing association withdrew a meals service provided to an elderly woman contrary to the terms of her tenancy agreement. The complaint was upheld. The Association said there had been consultation via the Tenant's Newsletter but in our view this was so vague and generalised as to be meaningless, and neither this, nor the minutes of the Tenant's Forum indicated that any specific reference was made to the meals service being withdrawn. The Association did not produce any evidence of meaningful discussion with the woman herself about the withdrawal of the service.
We also upheld a complaint about how the Association dealt with representations which the woman's son-in-law made on her behalf. We recommended that the Association apologise to the woman and her son-in-law and ensure that future tenant consultations are meaningful and properly recorded.

Housing for a disabled man and his family > Case: 200602104

The complaint was that a council failed to arrange appropriate housing to meet the needs of a man and his family after he was disabled in a traffic accident. The complaint was upheld. It was clear that a number of council staff had committed a considerable amount of time and energy to the man's case over the years. Beyond the man's own physical impairment, the tragedy in this case was that all this time and effort had been substantially without result. There were failures to undertake adequate assessments of the family's needs in a timely manner, failures to properly apply the council's private sector housing improvement grant policy (because of informal policy operating over and above the official policy) and a failure to resolve matters (caused by the lack of proper dispute identification and resolution mechanisms). All these failures meant that the man did not get the support to which he was entitled. We made a number of recommendations relating to council policy and procedures. In relation to this particular case we recommended that as a matter of urgency the council produce a statement of needs for the man and his family, the adaptations needed to meet these needs and a plan for how these adaptations might be achieved; and in recognition of the avoidable delays which have occurred in meeting the man's long-term needs and the distress caused by this, make a payment to him of £5,000.

Repairs > Case: 200601252

A woman raised concerns with regard to a delay by a council in replacing windows in her home, in carrying out a repair to a damaged window lintel, and about the way her contact with the Council was recorded. The complaint relating to the lintel was upheld and the other complaints were partially upheld. It was clear that there were significant delays in entering three works orders in this case and that their entry was as a result of the woman's persistence. If the works orders had been entered without delay initially, relevant staff could have given her clear advice on targets for implementation and that would have precluded the need for the series of telephone calls she made. The Council accepted our recommendations that they should apologise to the woman and make her an appropriate payment in recognition of the costs she incurred in pursuing matters with them.

Scottish Government and Devolved Administration

Through its departments and directorates the devolved Scottish Government exercises policy responsibilities including health, education, justice, rural affairs, and transport. Scottish Non-Departmental Public Bodies and other devolved Scottish public bodies (or cross-border authorities acting in a Scottish capacity) deal with issues relating to crofting, enterprise, environmental protection and much else. The administrative actions of all these bodies are generally within the jurisdiction of the SPSO. However, because bodies in this sector are less involved in direct service delivery than local authorities or health boards the numbers of complaints about them are relatively low.

Many of the organisations, however, in particular the Scottish Government and some of its agencies, have responsibility for the formulation of the legislation and policy that provide the framework for the delivery of public services. The SPSO's engagement with these bodies in terms of learning lessons is also, therefore, very important.

The enquiries and complaints we received

We received 31 enquiries and 210 complaints about bodies in this sector this year – this represents around 6% of our total caseload and is a 15% increase on the total contacts for 2007–08. The areas concerned are shown in the next table, along with the numbers of complaints received for each subject. Financial matters include complaints about legal aid, pensions, awards for students, and the funding of various bodies. The most significant changes since last year are marked increases in the number of complaints about planning and courts administration.

All subjects of complaint about the Scottish Government and devolved administration 2008 – 09

Planning	**39**
Financial matters	**29**
Courts administration	**27**
Care & health	**23**
Justice	**16**
Agriculture, environment, fishing & rural affairs	**14**
Enterprise bodies	**11**
Education	**9**
Ombudsmen	**8**
Records	**8**
Housing	**6**
Other	**6**
Roads & Transport	**6**
Arts, culture, heritage, leisure, sport & tourism	**5**
Subject Unknown	**2**
Governance	**1**

In the course of the year, we determined 213 complaints (including some carry-forward from the previous year) of which 199 were resolved without the need for investigation. Of those that were reported to the Parliament, one was fully upheld, seven were partially upheld and five were not upheld. One investigation was discontinued.

Scottish Government

145 complaints were received about Departments or Directorates of the Scottish Government or its Agencies – almost 70% of the total for this sector. 143 complaints were determined (including some carry-forward from the previous year), six of them following formal investigation – of these one was fully upheld, three were partially upheld, one was not upheld and one investigation was discontinued.

Scottish Public Authorities

For NDPBs and cross-border authorities at arm's length from central government a total of 65 complaints were received. 70 complaints were determined (including some carry-over from the previous year), eight of them following formal investigation – of these none was fully upheld, four were partially upheld and four were not upheld.

We made recommendations to ten different bodies. These included:

- Apologising for inconvenience caused by poor communication
- Considering waiving overpaid amounts
- Improving complaint procedures and handling

Case Study

Single Farm Payment Scheme > Case: 200502842

A man raised a number of concerns on behalf of his wife about the way the Scottish Executive Environment and Rural Affairs Department, now the Scottish Government Environment Directorate, handled her application for the Single Farm Payment Scheme – National Reserve 2005.

We partially upheld the complaint that the Directorate failed to handle the application properly. They mislaid the application and when this was drawn to their attention they invited the woman to resubmit her application (although they also indicated this was unlikely to succeed). They should have apologised to the applicant for this, but failed to do so. The Directorate have been unable to explain the loss of the application. However, it is clear that their procedures at the time were not sufficiently robust to enable staff to retain and process all submitted applications. There was also some confusion in the correspondence between the Directorate and the complainant. There was no connection between the continued responses to her complaint, and the responses to her resubmitted application. This confusion was maladministration and should not have happened.

The Directorate accepted our recommendations that they should remind their staff of the importance of apologising for mistakes; apologise to the woman for the lost application; remind staff of the importance of ensuring they provide consistent responses to all correspondence; and ensure advice on agricultural scheme requirements is explicit in all literature.

Further and Higher Education

We received 16 enquiries and 93 complaints about further and higher education institutions during 2008–09 (20 enquiries and 79 complaints were received in 2007–08). We reached decisions on 93 complaints. We asked five different further or higher education institutions to take action to sort out individual problems and to reduce the risk of them recurring. These recommendations included:

- Ensuring explanations of appeals processes and outcomes are clear
- Improving record-keeping
- Improving complaint procedures and handling

Further Education

We received a total of four enquiries and 34 complaints about further education institutions in 2008–09, a 79% increase in complaints on the previous year. The subjects of complaint are listed below, and are broadly similar to the areas about which we received complaints the previous year although the number and proportion of complaints about appeals and related matters decreased.

All subjects of complaint about further education 2008 – 09	
Policy/administration	**16**
Complaints handling	**4**
Student discipline	**3**
Teaching and supervision	**3**
Grants/allowances/bursaries	**2**
Academic appeal/exam results/ degree classification	**2**
Personnel matters	**1**
Special needs – assessment and provision	**1**
Welfare	**1**
Out of Jurisdiction	**1**

We determined 37 complaints in 2008–09 including some carry-forward from the previous year. Of these, only one resulted in an investigation report, in which we partially upheld the complaint.

Issues in further education complaints

It is difficult to identify trends or themes from the small number or complaints received. Understandably, issues to do with student discipline and teaching and supervision feature in a significant number of complaints. These are areas where clarity about what can reasonably be expected of, and by, both parties and clear recording of what has been agreed and what is to happen can be particularly important in avoiding misunderstanding and difficulties.

Higher Education

We received a total of 12 enquiries and 59 complaints about higher education in 2008–09, which closely matched the number of complaints received in 2007–2008. The subjects of complaint are listed below, and are similar to the areas about which we received complaints the previous year.

All subjects of complaint about higher education 2008 – 09	
Policy/administration	**22**
Academic appeal/exam results/ degree classification	**22**
Teaching and supervision	**5**
Complaints handling	**2**
Plagiarism and intellectual property	**2**
Special needs – assessment and provision	**1**
Welfare	**1**
Personnel matters	**1**
Student discipline	**1**
Other	**1**
Unknown	**1**

We determined 56 complaints in 2008–09 including some carry-forward from the previous year. Of these, eight resulted in an investigation report. In four cases we partially upheld the complaint and in the other four we did not uphold any aspect of the complaint.

Issues in higher education complaints

As in previous years, complaints about appeal processes formed a very significant part of the caseload. When we consider such complaints it is not our role to assess or challenge the merits of decisions. We cannot look at issues of academic judgment. Our function is to judge whether there are reasonable procedures in place and to reach a view on whether they have been followed correctly. The process of appealing and then awaiting the outcome can be very stressful for students and it is important that the processes are clear, are clearly explained and that students receive appropriate support in navigating them. These factors are vital in maintaining trust in the system.

Case Studies

Student Support > Case: 200702229

The complaint was that a college did not give a student appropriate support. In particular, we were told that tutorial provision was inadequate and the circumstances surrounding an audition for a higher-level course were unsatisfactory; as was the way the student was told she was not successful in this application. The woman was also unhappy with the way the College dealt with her subsequent complaint. The complaints were partially upheld to the extent that information provided was inaccurate and there was inconsistency in the way students were informed about the outcome of their auditions. The College also mishandled their response to the complaint. The College accepted our recommendations which included ensuring that the information provided to students about tutorials and the role of the Course Tutor is in line with current practice; reviewing their policy surrounding the methods used to inform applicants of the results of auditions; and reviewing the support and guidance given to staff investigating complaints.

Removal from course > Case: 200503430

A woman complained that she had been unfairly removed from her university course and that the University had failed to follow procedures in removing her. We did not uphold the complaint but we recommended that to ensure future continuing improvement, the University consider whether records should be made of meetings with students, especially failing students, who are being counselled on their academic performance and where there is a likelihood that they could be withdrawn; reflect on the wording of the standard resit letter to see if it is as clear as it could be; and consider whether final decision letters at the conclusion of an unsuccessful appeal should give a fuller explanation.

Teacher training placement > Case: 200501574

The complaint was that a university did not support or communicate with a student adequately during teacher training placements in secondary schools, did not challenge schools when placements were terminated or find alternative placements quickly enough and, in relation to one specific school placement, her tutor did not tell the student that an informal visit would result in a formal report. In addition, it was suggested that the University should have proposed practical remedies to placement problems that had been identified between the faculty in which the woman was studying and schools. None of the complaints were upheld. However, given that termination of placements, although rare, are distressing for schools, students and faculty staff we recommended that the University reflect on this complaint and consider how best to deal with termination of placements and the need to arrange an alternative placement at short notice.

Governance & Accountability

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

The current Audit Advisory Committee (AAC) 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. It was a pleasure to work with Professor Brown over the past two years and the Committee would like to take this opportunity to thank her for the commitment she has shown to the SPSO.

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

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

The AAC look forward to working with Jim Martin as the new Ombudsman to further strengthen the effective monitoring of financial and governance policies and procedures, and to address the significant service changes initiated by the Scottish Parliament. He has commenced that task with energy and clarity of purpose.

The Committee met three times in 2008–09. Representatives from the SPSO's external and internal auditors attend our meetings and advise us in private each time, before we discuss with the Ombudsman the key operational priorities and risks.

There were a number of key areas of focus for the AAC in 2008–09 including supporting the Ombudsman in introducing and developing a quality assurance process, upgrading the organisation's case handling software and establishing an independent service delivery reviewer to the SPSO. We also concerned ourselves with externally reviewing the governance and accountability arrangements of the Office (which formed part of a Parliamentary Committee review) and the proposed Public Services Reform (Scotland) Bill.

The AAC look forward to working with Jim Martin as the new Ombudsman to further strengthen the effective monitoring of financial and governance policies and procedures, and to address the significant service changes initiated by the Scottish Parliament. He has commenced that task with energy and clarity of purpose.

Sir Neil McIntosh

Chair of the SPSO Audit Advisory Committee

Independent Service Delivery Reviewer's Report

I was delighted to be appointed as the first Independent Service Delivery Reviewer for the SPSO in January 2009. This appointment demonstrated the commitment of the Ombudsman and her team to transparency and improvement in the quality of the service delivered by the SPSO.

The concept of a review by someone who is external to the operational structure is encouraged by all best practice and provides reassurance to a complainant who remains dissatisfied with the service they have received. It should allow an objective look at how the complaint has been handled, and help identify areas where service delivery could be improved.

The Independent Review can fulfil some key functions:

- Provide resolution to the complainant
- Make recommendations about the SPSO's handling of complaints referred to them by the public
- Identify and analyse training needs, and develop and deliver appropriate programmes

My remit is to review a complainant's claim that there has been poor service delivered by the SPSO. I have no remit to amend, alter or influence the decision taken by the Ombudsman, or the content of reports laid before the Scottish Parliament.

Areas of service delivery that fall within my remit are:

- Excessive delays
- Poor or misleading advice
- Staff behaviour, including discourtesy
- Failure to follow the SPSO's own procedures
- Not answering the complaint fully and promptly
- Failure to apologise for mistakes

During the financial year ending March 2009, I received two complaints. I upheld a number of service failings, including:

- Lack of clarity regarding the Ombudsman's remit, leading to mismanaged expectations on the part of the complainant
- Lack of clarity in communication
- Significant delays at various stages in the complaint examination and investigation
- Failure to adhere to the SPSO's Service Delivery Complaints procedure

I have been encouraged by my initial meeting with the new Ombudsman, Jim Martin. I believe he supports the role of an Independent Reviewer, and I look forward to working with him and his team in the year ahead. I look forward to working closely with SPSO to continue to improve the quality of the service provided to all its complainants and other stakeholders.

Ros Gardner
Independent Service Delivery Reviewer

Financial performance

The SPSO's annual budget application is considered by the Scottish Parliament's Finance Committee and the Scottish Government by 1 March each year as part of the Scottish Parliamentary Corporate Body's (SPCB) expenditure plan. 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 2008 – 09 we operated on a budget of £3.274 million with a total of 47 staff (full time equivalent) – this equated to 74% of our total net expenditure being spent on staff costs, with over two-thirds of staff being directly involved in case handling. The table below details our major costs over the past three years. In 2009, capital expenditure included costs of a new web-based case-handling system.

Analysis of expenditure (summary)	Actual year ended 31 March 2009	Actual year ended 31 March 2008	Actual year ended 31 March 2007
	£000s	**£000s**	**£000s**
Staffing costs	2,419	2,325	1,958
Other operating costs			
Property costs*	287	261	284
Professional fees**	148	195	259
Office running costs***	271	244	262
Total operating expenditure	3,125	3,025	2,763
Capital expenditure	160	28	15
Other income	-11	-17	-34
Net expenditure for the year	3,274	3,036	2,744

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

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

Statistics

All cases determined in 2008 – 09 by sector and outcome

Stage	Outcome	Health	Housing Associations	Local Authority	SG&D	Further & Higher Education	Unknown / OJ	Other	Total
Enquiry Total		83	51	250	31	16	718	16	1,165
Assessment	Complaint Premature	182	215	923	116	37	5	0	1,478
	Complaint out of jurisdiction	52	22	102	19	8	34	0	237
	Withdrawn / Failed to provide info before investigation	129	28	158	28	11	18	0	372
	Discontinued or suspended before investigation	3	2	12	2	2	2	0	23
Examination	Determined after detailed consideration	193	32	279	34	26	0	0	564
Investigation	Report issued – not upheld	27	3	25	5	4	0	0	64
	Report issued – partially upheld	46	2	22	7	5	0	0	82
	Report issued – fully upheld	26	1	15	1	0	0	0	43
	Withdrawn / failed to provide info during investigation	0	0	1	0	0	0	0	1
	Discontinued or suspended during investigation	1	0	9	1	0	0	0	11
Complaints Total		659	305	1,546	213	93	59	0	2,875
Assessment Total		366	267	1,195	165	58	59	0	2,110
Examination Total		193	32	279	34	26	0	0	564
Investigation Total		100	6	72	14	9	0	0	201
Complaints Total		659	305	1,546	213	93	59	0	2,875

All cases determined in 2007 – 08 by sector and outcome (for comparison)

Stage	Outcome	Health	Housing Associations	Local Authority	SG&D	Further & Higher Education	Unknown / OJ	Other	Total
Enquiry Total		142	94	564	68	20	865	27	1,780
Assessment	Complaint Premature	143	156	760	53	21	6	0	1,139
	Complaint out of jurisdiction	89	14	154	41	17	23	0	338
	Withdrawn / Failed to provide info before investigation	135	19	178	14	12	13	0	371
	Discontinued or suspended before investigation	11	2	42	3	4	2	0	64
Examination	Determined after detailed consideration	211	28	240	41	23	0	0	543
Investigation	Report issued – not upheld	69	3	82	14	9	0	0	177
	Report issued – partially upheld	65	1	62	8	3	0	0	139
	Report issued – fully upheld	48	0	23	2	1	0	0	74
	Withdrawn / failed to provide info during investigation	3	0	4	0	0	0	0	7
	Discontinued or suspended during investigation	11	4	13	0	1	0	0	29
Complaint Total		785	227	1,558	176	91	44	0	2,881
Assessment Total		378	191	1,134	111	54	44	0	1,912
Examination Total		211	28	240	41	23	0	0	543
Investigation Total		196	8	184	24	14	0	0	426
Complaint Total		785	227	1,558	176	91	44	0	2,881

Vision, Values and Corporate Strategic Plan 2008 – 11

VISION

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

VALUES

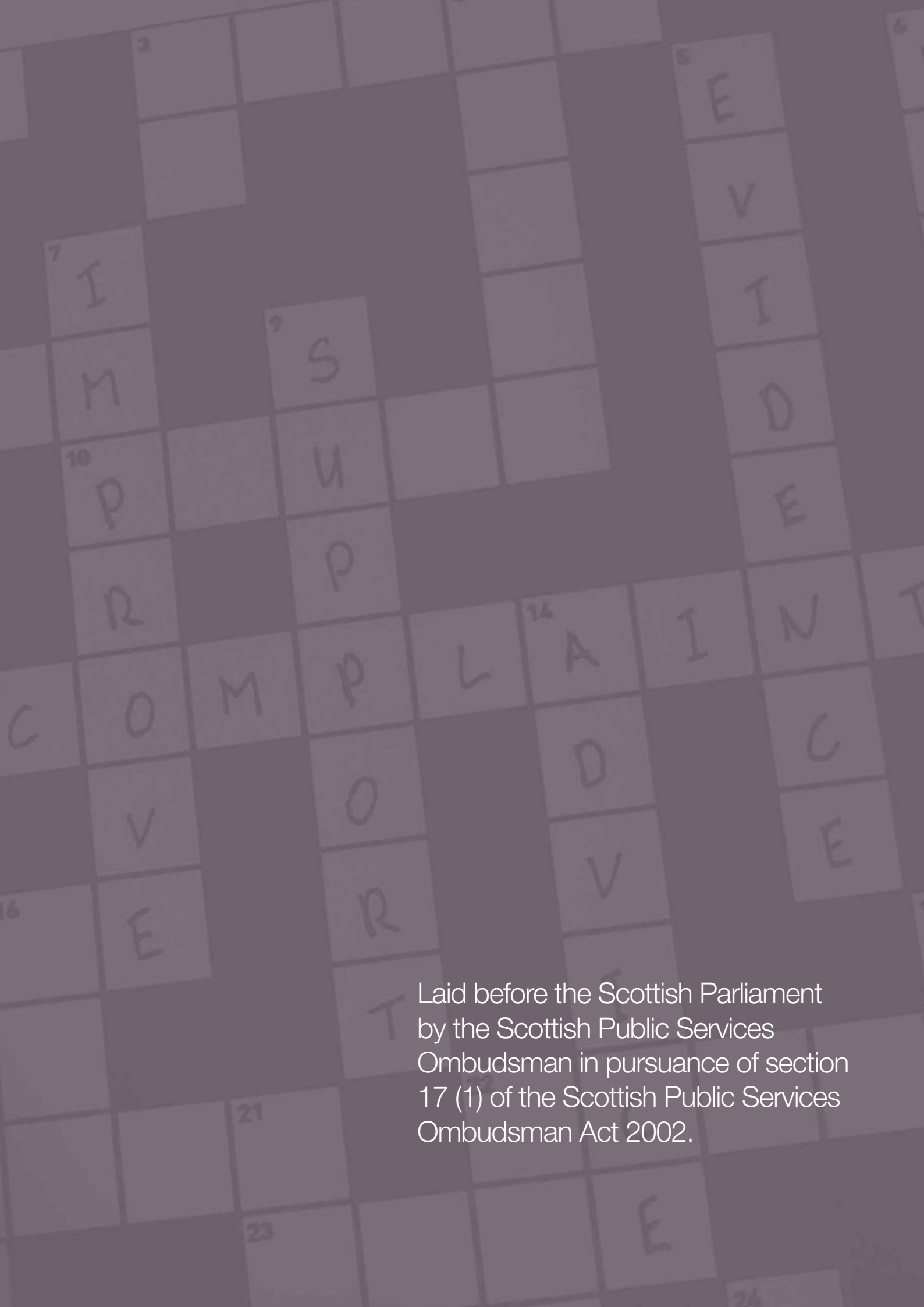
We aim to be:

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

STRATEGIC OBJECTIVES

Over the period 2008 – 11 our five objectives are:

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



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

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