



Laid before the Scottish Parliament by the Scottish Public Services
Ombudsman in pursuance of section 17(1) and (3) of the Scottish
Public Services Ombudsman Act 2002.

A handwritten signature in black ink, reading "James B. Muir". The signature is written in a cursive style with a large, looping initial "J".

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Ombudsman's Overview

Welcome to our 2014/15 annual report.

We helped almost 5,600 people last year, providing independent advice and support, and looking into the issues people brought us where we could. Our investigations led to over 1,400 recommendations for improvement to public services.

Our work on improving complaints handling across Scotland continued to have considerable success and a resonance outside Scotland, with our reputation and influence further increasing in other parts of the UK and internationally. As a result of our ground-breaking work, there is now a simple, consistent system for handling complaints across most public services in Scotland. Public authorities are also now reporting more consistently and regularly on their complaints, and this is helping to not only improve transparency but to drive up standards.

SPSO has a strong track record of achievement. However, I have stated publicly that we are facing challenges to keep pace with a year-on-year trend in rising demand and increasing complexity of cases. Our productivity rose again in 2014/15, by a further 9% on the previous year. This was against a 10% increase in the number of complaints we received. We further refined our complaints handling process and further improved both our efficiency and the quality of our service.

These successes are to my staff's great credit, and I am grateful to each of them for maintaining their high level of commitment, professionalism and compassion, despite continually rising workloads.

The pressure in demand and complexity comes at a time when we have been asked to take on new functions in relation to reviewing Scottish Welfare Funds decisions (from April 2016) and complaints arrangements under the Scottish Government's health and social care integration programme. We have long supported the simplification agenda and we welcome these expansions, so long as they can be appropriately funded. There are practical challenges for us in these changes, which require careful consideration. Our measures for managing demand – current and future – are laid out in our draft 2016–20 strategic plan which has recently gone out for consultation.

One of the points I make in the strategic plan is that it is the responsibility of public authorities to handle complaints well. On average, we uphold 50% of the complaints we investigate, all of which have already been looked at by the authority concerned. We still see too many complaints from some public authorities that are unable to resolve some issues satisfactorily themselves through their complaints process. Public authorities must learn from complaints and take action to reduce the number of repeat mistakes they make. We have provided the tools, and it is now for public authorities to make good use of them.

Ombudsman's overview



I believe that SPSO has a unique role in the public sector in Scotland and we are ideally placed to support public authorities' learning and improving from complaints. We rarely encounter resistance to our recommendations, and I am heartened by the way public authorities accept our decisions and implement the changes we ask for. We are occasionally challenged about our jurisdiction or our statutory powers to gather evidence. In these cases we will be robust in defending the SPSO's powers, while ensuring that we use them responsibly.

Our work is possible because of good and effective working relationships with public authorities and other organisations across Scotland. I would like to express my thanks in particular to the members of our three sounding boards for their time, energy and expertise. They, and many others, have helped us to help our public services handle complaints better, and deliver better outcomes for all of us.

Jim Martin, SPSO

Casework Performance

Strategic objective 1: to provide a high quality, user-focussed independent complaints handling service.

This section highlights:

- › casework volumes and profile
- › decisions and outcomes
- › discretionary decisions
- › timescales
- › service improvements including quality assurance
- › review requests and customer service complaints
- › stakeholder involvement
- › service standards
- › customer service survey

Case volumes

Our first priority is always to provide a quality complaints handling service, and rising volumes are becoming increasingly challenging. In 2014/15, our advice team handled an almost 113% increase in enquiries. We also received 10% more complaints than the previous year. Our productivity again increased, by 9%, and we maintained the quality of our service, against a background of static investigations resource. We achieved this through a number of initiatives to further streamline our casework handling process. The most significant of these is our new process for deciding cases earlier, which is outlined later in this section.

Cases received

Enquiries received

In 2014/15, we received 772 enquiries. There was a significant increase in the number of people who contacted us who we then referred to Citizens Advice and the Financial Ombudsman Service. The third highest category of referrals was to the Energy Ombudsman, again with a significant increase on the previous year. These increases are likely to reflect the straitened economic times. There is a breakdown of referrals in the table at the end of this report.

Complaints received

The number of complaints received rose for the sixth consecutive year. We received 4,895 complaints in 2014/15, an increase of 10% on the 4,456 received the previous year. The proportion of complaints received about each sector remained roughly the same, as the table on the next page shows.

Casework Performance

Complaints received by sector in 2014–15 and 2013–14 and as a % of all complaints

Sector	Complaints 14–15	% 14–15	Complaints 13–14	% 13–14
Local authority	1,880	38%	1,750	39%
Health	1,542	32%	1,379	31%
Scottish Government and devolved administration*	608	12%	535	12%
Housing associations	390	8%	351	8%
Water	288	6%	292	6.5%
Further and higher education	159	3%	125	3%
Other	28	1%	24	0.5%
Total	4,895	100%	4,456	100%

*Of the complaints received in the Scottish Government and devolved administration sector, 52% were about prisons.

Case complexity

In 2013/14 we commented on the growing complexity of complaints. 2014/15 saw a further increase in the number of cases that need detailed investigation, and the main reasons for this are:

➤ **more NHS complaints**

Over the past two years, NHS complaints have gone up by 25%. We have powers to look at professional judgement in health complaints (which we cannot do in other sectors under our jurisdiction). This means we can examine how reasonable a clinical judgement was, which is often the issue a complainant wants us to look at. These complaints typically require specialist advice and often consist of multiple issues. This complexity increases SPSO staff handling time and also puts pressure on our resources because of the direct costs of sourcing professional advice.

➤ **fewer premature complaints**

These are cases that reach us without having first gone through the complaints process of the organisation being complained about. In 2014/15, only 34% of our workload was made up of premature complaints, the same proportion as the previous year, compared with 51% five years ago. While the fall in premature complaints is positive for both complainants and public service organisations (it suggests that people are getting their complaint dealt with at the right place and using the SPSO properly as the last stage in the process), the increase in mature complaints adds to our workload as it results in more cases that are ready to be handled and that require more detailed attention.

Casework performance

Complaints decided

We made decisions on 9% more complaints, 4,802 compared with 4,408 in 2013/14. There were increases in the volume of complaints decided about our two largest sectors, local government (5.4%) and health (12%). On much smaller numbers there was a 17% increase in complaints decided about the Scottish Government and devolved administration sector, a 7% increase in complaints decided about housing associations and a 47% increase in complaints decided about the further education and higher education sectors. There was a 10% decrease in complaints decided about water providers.

Complaints decided by sector

Sector	2014-15	2013-14
Local authority	1,842	1,747
Health	1,487	1,324
Scottish Government and devolved administration*	616	528
Housing associations	385	360
Water	282	314
Further and higher education	163	111
Other	27	24
Total	4,802	4,408

**Of the 616 Scottish Government and devolved administration complaints determined in 2014/15, 319 were about prisons.*

There is a detailed table with all the outcomes of the complaints we dealt with in 2014/15 at the end of this report. Some key points are highlighted next.

Advice and support

Our advice team handled 5,574 contacts (772 enquiries and 4,802 complaints) in 2014/15. They provided support and guidance to the public, helping people make complaints to public authorities or the SPSO, or signposting them to other organisations if appropriate. All the enquiries and 2,773 complaints were decided at this stage.

Deciding cases earlier

In 2013/14, we introduced as a pilot project a triage system for speeding up our handling of complaints and providing earlier answers to people. The knock-on effect of this has been that a higher proportion of cases are handled sooner in our process and without the need for intensive review. Handling complaints in this way within a matter of days is good news for service users whose cases do not require more detailed consideration and investigation. In many cases this is because people are trying to raise issues we cannot look at for legal reasons, and it is particularly important to let people know quickly if we cannot help them as there may be other options they can pursue. In some cases, the public authority had already done what they should have, and it would not have been proportionate for us to investigate.

Casework performance

Checking final responses

With most public authorities now operating the model complaints handling procedure, authorities should be clear about how to correctly refer complainants to the SPSO at the end of their complaints procedure. It is a legal requirement that authorities do this, informing people of their right to escalate their complaint to us if they remain dissatisfied, and also making them aware of the 12-month time limit and court action rules.

As the first point of contact for the public, the advice team check whether someone's complaint has completed the complaints process and that the organisation has given a final response, referring to the SPSO. Therefore, they are ideally placed to assess whether organisations are referring someone to the SPSO properly and in accordance with their model complaints handling procedure. In 2014/15, we carried out a small study, checking that authorities were correctly referring complainants to us in their final responses. The study, from May to November 2014, took into account those authorities where we had received a complaint which had fully completed their complaints procedure. We found that compliance with what is a statutory requirement was generally good, although there were some issues identified in certain sectors.

Authorities correctly referring to SPSO in their final response:

- 12 of 14 NHS health boards
- 18 of 30 GPs & dental practices
- 27 of 32 Local authorities
- 21 of 23 Registered Social Landlords
- 6 of 7 Further & higher education institutions
- 4 of 6 Scottish Government organisations.

We recorded non-compliance and contacted the authorities concerned, seeking assurances that they would make the changes that they should. This was a useful snapshot, and as a result of our findings from this study, we will be introducing a self-assessment checklist for authorities, which will include a requirement to check that they are referring to us appropriately.

Detailed consideration

After detailed consideration, we decided that a further 997 cases did not need to go into our investigation process. We identified that these cases were premature, out of jurisdiction, incomplete, or the desired outcome was not something we could achieve. In some cases, the complainant decided to withdraw. These were cases which were not picked up by our triage process because we triage within a matter of days.

Any cases that are unclear are given detailed consideration, so we can be sure that we are not ruling anything out that we should be looking at. We also managed to resolve 88 cases at this detailed consideration stage. This was a small but significant increase on the 63 from 2013/14. By the time cases come to us, the opportunity to resolve them to both parties' satisfaction has usually passed and positions have become entrenched. Nevertheless, we do try to act on cases where the issue can be quickly resolved.

Casework performance

Investigations

In 2014/15, we gave our decision by letter in 898 cases, compared with 850 the previous year. We also published 46 detailed public investigation reports, compared with 44 the previous year.

Upheld complaints

Of the total of 944 complaints that we investigated, we upheld or partly upheld 50%, the same percentage as the previous year. 'Upheld' includes fully and partly upheld complaints where we have found fault, even if it has already been recognised by the organisation. We do this to recognise the validity of a person's complaint to us as the independent, external body that the person has applied to for a further review of the issue. We expect organisations to reflect the outcomes of SPSO complaints in the statistics they are required to gather and publish.

The rates of upholds in each sector remained fairly stable compared with the previous year (apart from complaints about housing associations which dropped from 55% to 37%, though this was on a small number of investigations (38)). In our top two areas of complaints, the rates were 47% in local authorities (down from 49%) and 56% in health (up from 55%). The table below provides a comparison of rates in all sectors.

Uphold rates by sector

Sector	2014-15	2013-14	% difference
Local authority	47%	49%	-2%
Health	56%	55%	+1%
Scottish Government and devolved administration	40%	35%	+5%
Housing associations	37%	55%	-18%
Water	52%	52%	0%
Further and higher education	34%	41%	-7%

Casework performance

SPSO and the discretionary decisions of other organisations

The varied rate of upheld complaints across sectors can partly be explained by the difference in our powers in different areas of our jurisdiction. In all areas apart from health, we are prevented by the SPSO Act 2002 from considering the merits of discretionary decisions by the organisations under our jurisdiction. A specific exception exists for health complaints where we can and do look at how reasonable clinical judgements are.

In other areas though, we cannot test the reasonableness of decisions though we can and do make sure that any discretionary decisions were made properly (in the terms of the law 'without maladministration').

Some of the decisions people bring us were made through the democratic process and, ultimately, the decision-makers are democratically accountable. In these cases, this reason for the restriction is one that we can explain to people.

However, we are increasingly finding that people are frustrated that we cannot test the judgements of non-elected officials. These can be very important and, particularly in planning where there is no alternative route for objectors to challenge the decision, can lead to high levels of dissatisfaction with the complaints process.

Timescales

We consider each complaint on its own merits and clearly the time taken to handle each one varies, depending on the level of advice, resolution work or investigation required. We do, however, set average timescale targets for staff to track and measure our performance across these three main areas of our work, which we publish on our website.

Despite the increase in case volumes, we met two of three of our timescales performance indicators. We made strong progress against the indicator we did not meet, achieving 88% compared with 70% in 2013/14, as a result of the pilot outlined earlier.

- PI-1 (target: 95% of advice stage complaints handled within 10 working days) **99.5%**
- PI-2 (target: 95% of early resolution complaints decided or moved to more complex investigation stage within 50 working days) **88%**
- PI-3 (target: 95% of investigation complaints decided within 260 working days) **97%**

Recommendations

In 2014/15, we issued 1,444 recommendations on cases we closed (up from 1,197 last year). We issue each recommendation with a deadline for implementation, and we monitor completion times closely. In 2014/15, of 1,348 recommendations due for implementation, 76% were carried out within the agreed timescale (up from 74% last year) and 98% within three months of the target date.

While we work hard to engage with public authorities to meet the timescales wherever possible, ultimately it is down to each individual organisation to implement the recommendations on a timely basis.

Casework performance

Service improvement

We have a strong focus on continuous improvement in the efficiency and quality of our service and our casework. We have a group that meets quarterly to consider all the information we receive. The information is gathered from stakeholder feedback, our quality assurance programme, requests for reviews of our decisions, and customer service complaints. We publish statistics on our website about requests for review and customer service complaints, and we share key findings, areas for improvement and good practice, both with individuals and across our office for wider learning and development.

The main areas of service improvement in 2014/15 were:

- changes to our casework handling system to improve efficiency
- refining our guidance on proportionality
- making our online complaints system easier to fill out and better integrated with our complaints handling system.

We also looked in detail at the information we provide to the public, in particular our leaflets, letters and online information. Taking on board comments from service users and our customer sounding board, we refreshed all of these communications, to further simplify and clarify the language. Our key information leaflets have been approved by the Plain Language Commission and we also made our letters and online information easier to read.

Quality Assurance

In addition to senior level review of some case decisions, we ensure quality through our QA process. Our current process involves randomly testing a 10% sample of our work on recently closed cases at different stages in our process on a quarterly basis. The findings help us identify areas for

improvement and examples of best practice, and also help us determine our focus on quality for each year. In 2014/15 we began work on further developing our QA criteria to align them more clearly with our newly developed customer service standards (there is more about the standards later).

We also listened to feedback from our staff about the QA process, changing and adapting the process of sharing feedback and findings. This has helped to ensure that this is done in a way that is as effective as possible, and allows for our complaints teams to develop their own ideas about future service improvements and efficiencies.

We did not change any decisions following QA in 2014/15. We did give careful, closer consideration to a small number of cases and found some instances where we could have given a clearer explanation or where we could have obtained more evidence to support our conclusions. We were, nevertheless, satisfied overall with the decision reached in these cases.

Reviews of our decisions

Our review process is open to both complainants and organisations and includes decisions to not look at a complaint, as well as the decisions we make after investigating. People can ask for a review if they think there is new and significant evidence about the complaint that we have not seen, or that there are factual inaccuracies in our decision.

The reviews give us the opportunity to address any concerns about what we have said and, in some cases, to provide further explanations about our powers and the reasons for our decisions. They also help us feed back to our staff how they could have communicated a decision more thoroughly or clearly.

Casework performance

We carefully analyse requests for reviews of our decisions to check that we are getting things right, and take action in any cases where we have not.

In 2014/15 we responded to 224 requests for review. This was 4.7% of our caseload and fewer than in 2013/14, despite the rise in overall case volumes. We changed the original decision in eight of these. In these cases we either did not feel we had enough evidence to reach the original conclusion, or felt we could have exercised our discretion to consider the complaint. We re-opened five complaints in light of new information received (i.e. entirely new and relevant information that we did not have during the original investigation). We publish these statistics on our website.

We have a separate process for full detailed investigation reports. Before we publish the report we send the complainant(s) and organisation involved a draft copy and ask for any comments. We consider these carefully before finalising and publishing the report.

Customer service complaints

We have a separate process for people who are unhappy with our service. It has two internal stages, followed by referral to an external Independent Customer Complaints Reviewer (the ICCR, formerly called the Independent Service Delivery Reviewer). Reports by our external reviewers are in a later chapter of this annual report.

Details of all customer service complaints in 2014/15 were recorded and reported on a quarterly basis to our senior management team, service improvement group and our Audit and Advisory Committee, along with a note of any actions taken. These reports provide detail on our performance in handling service complaints. They include statistics

showing the volumes and types of complaints, plus their outcomes and key performance details, including the time taken and stage at which complaints were resolved. Individual instances of service failure are highlighted to senior management where necessary, and to the relevant staff and managers involved where appropriate.

We received 53 service complaints in 2014/15 from 4,895 complaints (1.08% of our caseload) and responded to 51 in this period, of which 15 (29%) had elements that were upheld or partly upheld. This was a slight decrease from 2013/14 when we received 57 from 4,456 (1.28% of our caseload). The ICCR responded to 11 complaints, of which two had elements that were upheld.

Our annual service complaints report, including examples of actions we have taken to improve our service, is published in summary form later in this annual report (the full version is on our website).

Stakeholder involvement

We receive stakeholder feedback from a wide variety of sources. In addition to the small number of review requests and customer service complaints, we regularly receive informal and formal feedback that give us a good sense of how people perceive our service.

Our sounding boards are important sources of feedback. We have three, representing customers, local authorities and the NHS, and in 2014/15 they each met two or three times. Membership and minutes are posted on our website. In 2014/15 our customer sounding board helped us in particular with two projects – refreshing our customer service standards and measuring how satisfied our customers are.

Casework performance

Service standards

We refreshed our customer service standards in 2014/15. There were a number of reasons for doing this. First, we wanted to ensure the link between the standards and our quality assurance criteria was as direct as possible, as they had been developed separately. This meant that both our staff and external stakeholders could be clear on what they should be able to expect in terms of service from our office. We also wanted to ensure the standards were as robust as possible in terms of what a best practice ombudsman service might look like. Finally, we were keen to expand the standards to create a generic framework for all ombudsman schemes across the UK so, again, it would be clear to members of the public what they could expect no matter which scheme they went to.

We carried out an initial scoping exercise of what other schemes already had in place, and took into account the ISO standard for quality (ISO9001). We also wanted to ensure we reflected and incorporated the fundamental criteria and principles of ombudsman schemes. We developed a generic framework which went out for consultation to other schemes, as well as to our Independent Service Delivery Reviewer and our customer sounding board.

The final framework has three overarching commitments, which will be met by the standards and indicators outlined. The standards allow us to manage performance effectively and to help ensure customer satisfaction. We are continuing to lead work to develop a generic framework with other ombudsman schemes.

Customer survey pilot

Given the size of our organisation and our limited resources, we have not undertaken large-scale customer satisfaction surveys for a number of years. In 2014/15, we piloted a project looking at cases closed in January to March 2015 to inform our approach to future surveying. In 2015/16, we plan to survey everyone who receives a decision from us, and will publish the annual results. We also plan to carry out a survey of organisations under our jurisdiction about their views on our service in 2015/16, and will also make those results public.

In 2015/16 we also plan to review our corporate values and we will welcome feedback from our sounding boards on this.

Casework performance

Key figures 2014 – 15

the number of complaints received rose by **10%** on last year

we handled **4,802** complaints, **9%** more than last year

we made **1,444** recommendations for redress and improvements to public services (**21%** more than last year)

3,545 people received advice, support and signposting

1,085 cases were decided following detailed consideration pre-investigation

we fully investigated **944** complaints with 928* publicly reported to parliament

the proportion of premature complaints remained at **34%**, the same as last year

the overall rate of upheld complaints investigated remained **50%**, the same as last year

* Some of the cases published in 2014/15 will have been handled in 2013/14. In a small number of cases we do not put information in the public domain, usually to prevent the possibility of someone being identified.

Impact: sharing strategic lessons

Strategic objective 2: to support public service improvement in Scotland.

This section highlights:

- supporting improvement through recommendations
- helping recommendations go further
- contributing to policy

Recommendations

We make recommendations for two reasons: to try to redress any injustice done to the individual and to help prevent the problem from happening again. We find that for many of our complainants these two are interlinked; for them, the best way to redress the failing is to try to prevent the same situation from happening to someone else.

There are limitations on what we can do, and we are unable to go beyond individual complaints to investigate whether there have, in fact, been wider failings. However, where we think individual failings may impact on others, we address these by making broad recommendations.

We can also 'follow the complaint' if we find that the problem was caused by an authority other than the one initially complained about. This power is becoming more important as services become increasingly joined-up.

To give some examples from 2014/15, we recommended that:

- a health board conduct a peer review of the prevention, care and management of pressure ulcers in a hospital ward
- a health board ensure hospital A & E nurses carry out observations and check vital signs during triage
- a health board use the findings of an individual complaint as part of staff appraisals and to improve service in a ward
- a council review processes for capturing and reporting complaints information
- the Scottish Prison Service provide guidance to prison governors on dealing with exceptionally sensitive or serious complaints under the confidential process
- a college review their templates and procedures for setting up personal learning support plans following a complaint from a student with mobility problems
- a Commissioner develop a policy on naming individuals in whistleblowing cases.

We follow up our recommendations and, before we regard a recommendation as fulfilled, we require evidence of actions taken, and that includes action to make broader changes.

Impact: sharing strategic lessons

Helping recommendations go further

We publish the majority of our investigations on our website and raise awareness of key reports and recommendations through our monthly newsletter. This is important in helping the public understand our work, but it also is a key tool in helping us widen our impact beyond the authority involved in the individual complaint.

We are not currently resourced to share the broader learning from individual complaints in a systematic way, but we try to work closely with regulatory and other scrutiny bodies to help them to decide whether our recommendations can be used in their own work.

As an example of this, we were pleased that the Equality and Human Rights Commission used one of our cases to support their work to help British Sign Language (BSL) users. They reported in December 2014 that a health board had entered into an agreement with them to ensure that all deaf patients will have their communication needs met – in particular, easy and quick access to BSL. They had been approached by an individual who had had difficulty accessing BSL. In explaining why this was important, they cited a case we had publicly reported in 2013 which showed the failing they had found was not isolated.

We have also had excellent feedback from the thematic reports which we have been able to produce over the last couple of years. These have allowed us to target key areas and to allow each sector to see where others in their own area have had difficulties and, we hope, encouraged them to improve. Unfortunately, resourcing pressures have meant that there may be fewer, if any, of these in 2014/15, but we hope to continue to produce these reports in critical areas.

We have always felt that this was an area where we could add even more value, and we have been considering ways we could do this. We will ask organisations about this in our next survey, and in 2015/16 have prepared proposals for a specific unit to undertake this work. However, we need to consider carefully the resources that may or may not be available to us.

Contributing to policy

Scottish Welfare Funds

The most significant development in 2014/15 was the passing by the Scottish Parliament, on 4 March 2015, of the Welfare Funds (Scotland) Act 2015. The welfare funds provide for support to be given to those facing a crisis or an emergency, and help others to remain independent in their home rather than need to enter institutional care.

We provided advice and support as the Scottish Government and Scottish Parliament considered how best to provide for an independent review for the welfare funds. In line with our normal practice, we were neutral about the relative merits of applicants coming to us or other options being used, and in our comments explained how the review function might look if it came to us and what it might mean for our organisation.

As a result of the passing of the Act, in April 2016 the new statutory funds will come into existence and, with them, a new role for this office. We will be able to review welfare funds decisions made by local authorities and, where appropriate, change those decisions. We are currently working on an implementation plan and are holding a public consultation on significant aspects of that work.

Other significant areas of policy contribution

Throughout 2014/15 we continued to use our experience and expertise to contribute to a wide variety of policy areas. To give a sense of the breadth of this, we provided responses to consultations on:

- proposals to introduce a statutory duty of candour for health and social services
- the proposed Apologies Bill
- the Scottish Regulator's Strategic Code of Practice
- regulations relating to the integration of health and social care
- the introduction of the prison monitor system to replace prison visiting committees
- proposals to reform fatal accident inquiries legislation
- the National Care Standards review.

We keep a list of evidence sessions and consultation responses on our website.

We also used the Scottish experience to support developments in administrative justice across all the countries of the UK, and it seems increasingly likely that the complaints standards model pioneered in Scotland will be adopted elsewhere.

Case studies

This is a selection of case studies from the 928 investigations we published in 2014/15. There are many more on our website.

Health: communication, consent, record-keeping

A man had open-heart surgery for the second time in two and a half years when his symptoms returned. His heart tissue had attached to his breastbone after the first operation and he died during surgery because of complications from this. His wife complained that he hadn't been given enough information about the risks of repeat open-heart surgery and that, if they had been aware of all the risks involved, he wouldn't have given his consent to go ahead. We found that the couple weren't given enough information for informed consent, particularly about the risk of the man's heart being attached to the breastbone, and that records kept about the consent process were limited. We recommended that staff look at good practice guidance from the General Medical Council and the Society of Cardiothoracic Surgeons, and remember the importance of record-keeping. We also

found that, for repeat open-heart surgery, a CT scan should have been done to identify risks. We were very concerned about the delay of over a year for the board's discussion about the man's death at an audit meeting. Normally, these are held once a month and it seemed the meeting only happened because of our investigation. The board said this was because the man's notes were missing. However, the fact that his wife was complaining should have made the board hold the meeting and discuss her husband's case as early as possible. They could then have given her prompt information about what happened and about the changes they were going to make as a result. We said that the board must ensure that delays between deaths and audit meetings don't occur again, and they must apologise to her for their failings and for her suffering.

Case **201300380**

Scottish Government and devolved administration: complaints handling

We heard from a woman who complained about her late brother who was seriously injured when in 24-hour care. She said that the organisation took a year to investigate her complaint, yet didn't explain the delay or what they could investigate and why.

We thought that taking a year to investigate her complaint was unreasonable, as was the extra delay of four months before they explained that they couldn't look into one

part of her complaint. However, we were pleased to find that they did a thorough review of their handling of the woman's complaint so that they could learn from their mistakes. We said they should act on the findings of this review. We also recommended that they improve their communication and investigate complaints more quickly.

Case **201205330**

Case studies

Local government: handling of planning application

A woman complained to a council about the way they handled a planning application for a wind turbine development, which was near a bigger existing wind farm. The location meant that they had to consider the noise of all the turbines operating at the same time. Internal experts at the council evaluated this and told the planning committee that noise wouldn't be a problem, even though the neighbouring wind farm operators had already said that there probably would be a noise nuisance. Local residents had also paid for and submitted an expert report showing that a problem could exist. Council officers had recommended that they refuse the development application but councillors voted to approve it. Later, the council did get an expert acoustic report, which identified problems with both wind farms operating

together. We found that, before the councillors made their decision, the objections from the existing wind farm should have made the council officials seek their own report.

Councillors are democratically accountable and their decisions on planning applications are their own responsibility. We want to make sure, however, that councillors have all the relevant information before making these decisions, which in this case they didn't. We said the council must ensure that better information is provided to the planning committee in future, as well as recommending that they apologise to the woman. The council also offered to pay for the expert report paid for by the residents, which we agreed was appropriate.

Case **201204546**

Housing: right to buy

A woman complained that a housing association delayed in processing her application to buy her home. It took them five months longer than it should have done to issue her with an offer, and then delayed another three months as they said they didn't receive her acceptance of the offer. In fact, she had handed the acceptance in to the association and got a receipt, though it didn't specify what it was for. The association couldn't say what else it might have been for, and confirmed that they had tightened up their mail logging process.

We found that the initial delay was due to the time taken to establish details of the woman's tenancy. If the association was going to refuse her application, there were deadlines (one or two months depending on the reason for refusing) by which they had to do that. If they weren't refusing, they had

to issue an offer within two months of receiving the application. If that deadline wasn't met, they had another month before the purchase price would start to be reduced each month by the amount of rent being paid. This would stop when the offer was eventually issued. However, the association didn't explain this to the woman. They also should have got the property valued within three days of receiving the application, but this didn't happen for almost four months. We concluded that the delays were unreasonable and said that the association should ensure that right to buy applications were handled correctly in future. We also said that they should apologise to the woman and refund eight months' rent for the delay in processing her application.

Case **201401683**

Case studies

Health: clinical treatment

A man was in hospital for a hip replacement operation. During surgery, the cement gun for applying the joint cement broke. Another gun was found and the surgeon removed the cement from the man's hip before trying again. At the second attempt, the cement began to harden more quickly than normal. The surgeon decided to continue setting the joint in place but this caused a fracture in the man's femur, which was repaired during the operation. Afterwards, the man developed delirium. This gradually improved but his severe confusion and disorientation, plus mobility problems, meant he had to stay in hospital for a long time after the operation. His wife complained that the operation wasn't performed properly.

We found that the surgeon used his clinical judgement reasonably under difficult

circumstances, and that the surgical team dealt quickly and reasonably with the failure of the cement gun. That said, the lack of other surgical instruments and the surgeon's decision to force through the rapidly hardening cement led to major complications for the man over a long period. We recommended that the board should review the equipment kept in operating theatres so that surgical teams would have access to instruments which might be needed during an operation. We also said that the surgical staff must discuss the appropriateness of the decisions made during the operation. We were, however, pleased to learn of the steps taken by the anaesthetist to review his, and the board's, working practices as a result of the man's experiences.

Case **201204071**

Prisons: personal property

A man sent his laundry bag to the prison laundry but didn't get it back. He said it seemed that the bag and contents had been stolen and he submitted a compensation claim, which was rejected. The prison service said that any property held in use by a prisoner was at his or her own risk, as per the disclaimer on their property card. The man complained that this was unreasonable.

We found that the only way the man could have his clothes washed was to use the prison laundry service. He couldn't be expected to be responsible for his laundry

bag and belongings during the time they were at the laundry. As the prison provided the laundry service, they were responsible for returning his belongings but obviously didn't have a system for tracking prisoners' laundry. We thought it was unreasonable for the prison to use the property card disclaimer to try to get out of this responsibility. We recommended that the prison service apologise to the man and reconsider his claim for lost property.

Case **201304372**

Case studies

Local government: Scottish Welfare Funds

A woman applied to a council for a community care grant, which is a grant to help people on a low income live independently in the community and is paid from the Scottish Welfare Funds. The woman applied for help with buying household items. The council decided not to award the grant because they said she didn't meet the criteria. They said she bought the items before the decision on her application was made, and pointed out that they normally awarded items in goods, not cash. She complained about the way the council handled her application, saying she wasn't told that the grant would be in goods, and that the council didn't respond to her complaint properly.

We listened to a recording of the phone call when she applied for the grant. It confirmed she wasn't told that, if her application was successful, the council would provide the relevant goods. We found the council are

entitled to decide about awarding goods or cash, but they should have clearly explained this to her at the start. We were concerned that the call handler wasn't clear and gave inaccurate information about the application process, and also made inappropriate comments about other benefits that the woman received. Despite the evidence from the call recording, when they replied to the woman's complaint, the council wrongly said she was advised on the phone that any award would be provided as goods, and that they could find no evidence of call handlers asking unnecessary questions. We upheld her complaints, and recommended an apology and a payment in recognition of their customer service failings. We also said the council should ensure the relevant publications clearly explain that the council may award goods or cash at their discretion.

Case **201302099**

Health: nursing care, risk assessment

A woman with a long history of anxiety and depression began treatment with lithium. When she again showed signs of depression, she was admitted to hospital for assessment and a review of her medication. Her condition got worse and she suffered serious injuries in a fall. She was moved to another hospital, where she died a few months later. Her daughter was concerned that her mother had developed lithium toxicity because hospital staff hadn't made sure that she was drinking enough fluid. She also complained that staff had not ensured her mother's physical safety, which led to the fall. She described how her mother became more and more frail so that, after two weeks in hospital, she needed a wheelchair to get around.

We found that the nursing staff did not treat the woman's low fluid intake as a cause for concern, and that their monitoring and record-keeping of fluids was poor. We also found that they failed to properly assess the woman's falls risk, and we were particularly critical of the failure to regularly reassess her. However, it is positive that the board has since identified ways to improve fluid intake monitoring and record-keeping for people on lithium treatment, as well as ways to ensure falls risk assessments are regularly made. We asked them to provide feedback on these measures and anything else they have done to improve, and we also made further recommendations about staff training.

Case **201305924**

Case studies

Water: incorrect billing, communication

A couple ran a business from a small building in their garden. An audit identified the building as a commercial property not being charged for water services, and a water company were appointed as the water provider. They created an account, backdated to the time of the audit, and issued an invoice for almost £1,700 for non-domestic water and sewerage rates.

The couple explained that the building had no water supply and the business didn't use water. They went into their house to make tea and use the toilet but, as the water used was already paid for through their domestic council tax, they felt they were being charged for a service that the water company had not provided. They complained but the water company said they had to pay for unmetered charges on the commercial part of their property.

Many aspects of our investigation concerned the wholesale provider as much as the water company. Both organisations gave reasons why they thought water services should be charged for the building, quoting health and safety guidance and water legislation. We weren't convinced though, as the actions on

health and safety grounds weren't compulsory, and it wasn't clear how some of the legislation applied. We felt it was reasonable for the wholesale provider to charge for water used for commercial purposes but not for a service that had not been provided. We found nothing in the water industry rules that supported the decision to apply charges to a commercial property just because the owners have access to a domestic water supply already paid for through council tax. Before we issued our report, the wholesale provider said they had decided to cancel all charges for the building. They also started to review their charging policies, so we asked them to keep us updated.

We found that the water company's communication with the couple was detailed and tried to address the issues, but they passed on information from the wholesale provider without checking that it was correct. We recommended that they check this in future, as well as apologising to the couple, and ensuring that their account is closed and cleared of charges.

Case **201304505**

Health: delay in diagnosis, referral

A woman was diagnosed with bowel cancer. She had been going to her medical practice for ten months about her symptoms as, after ovarian cancer was ruled out, her case had been treated as routine. She complained about the delay in diagnosis and the practice accepted that they should have referred her to hospital. They conducted a significant event analysis to make sure that they learned from this experience though, as this took place months after we told them that we were investigating her complaint, it was very delayed.

We found that the practice took an approach that assumed a low-risk explanation, rather than treating warning symptoms as suspicious, which is necessary in diagnosing cancer early. We were concerned that the practice didn't support their nurse practitioner in identifying warning symptoms and knowing when to ask for help. We made a number of recommendations for them to improve their service and asked the practice to make an apology.

Case **201304325**

Improving complaints handling

Strategic objective 3: to simplify the design and operation of the complaints handling system in Scottish public services.

Strategic objective 4: to improve complaints handling by public service providers.

This section highlights our work to:

- support organisations in improving their complaints handling, including by moving to more detailed reporting and learning from their complaints handling
- provide advice, support and guidance on good practice
- facilitate wider sharing of good practice through complaints handlers networks
- support the next phase of changes to simplify and improve public sector complaints handling
- deliver engagement and training

In our last annual report we highlighted the significant work that had been completed in a very short time by the Complaints Standards Authority (CSA). This is a small team in our office – the equivalent of one and a half people – and this work has been possible because of effective working relationships with public organisations across Scotland.

As a result of this work, there is now a simple system for handling complaints across most public services in Scotland. The system is built around a focus on quick, early resolution of complaints, with support and training for frontline staff critical to

its success. It is clear that organisations are now reporting more consistently and regularly on their complaints, and this is helping to drive up standards as well as improve transparency.

Monitoring complaints performance

In 2014/15 the primary focus was on building on the positive progress in implementing the model complaints handling procedure (CHP) by supporting the use of performance information to further improve through benchmarking. This included helping organisations use complaints information more effectively to learn from complaints. This monitoring is critical to helping them understand their own strengths and weaknesses, enabling them not only to improve their response to complaints, but also to identify issues in their complaints handling. We have also been working with scrutiny and improvement bodies in some sectors to help build monitoring of complaints performance and learning into existing structures, and to help encourage ownership of this information by the sectors themselves. Key to this has been the complaints handlers networks in these sectors.

Improving complaints handling

Performance indicators

All organisations operating the model CHP are now required to report performance and learning quarterly and annually in line with the requirements of the CHP. They are required to publish annual performance against the following indicators:

- **Indicator 1** number of complaints received
- **Indicator 2** proportion of complaints handled at the frontline
- **Indicator 3** complaints upheld, partially upheld and not upheld
- **Indicator 4** average times
- **Indicator 5** performance against timescales
- **Indicator 6** number of cases where an extension is authorised
- **Indicator 7** customer satisfaction
- **Indicator 8** learning from complaints

The indicators are deliberately both quantitative and qualitative, and the last two are particularly critical to understanding how responsive an organisation is to complaints. Organisations are required to show how they:

- use complaints data to identify the root cause of complaints
- take action to reduce the risk of recurrence
- record the details of corrective action in the complaints file, and
- systematically review complaints performance reports to improve service delivery.

The model also details the practical steps that should be taken when an organisation identifies the need for service improvement, noting:

- the action needed to improve services must be authorised
- which person or team has been designated the 'owner' of the issue, with responsibility for ensuring the action is taken
- the target date by which the action must be taken.

If it is appropriate, service provision should be monitored going forward to ensure that the issue has been resolved.

The sector that is most advanced in this area is local government, largely because the sector was the first to implement the model CHP and because of the significant success of the local authority complaints handlers network. All councils reported against the SPSO's detailed indicators for the local government sector for 2013/14, the first full year of operation of the model CHP for the sector.

Improving complaints handling

Benchmarking

Members of the local authority complaints handlers network used this information to compare, contrast and benchmark their performance against one another. The results of the performance information were encouraging, with one notable figure showing local authorities were resolving, as an average, 85% of complaints at the frontline resolution stage of the model CHP.

Other areas of the indicators, including on learning, provided a challenge for many local authorities and, indeed, many other organisations. We have worked closely with the local government sector to address some of the challenges and to identify ways in which the sector can take more ownership for learning at a strategic level.

We met with the Accounts Commission, the Improvement Service, COSLA, SOLACE, the Scottish Government and Audit Scotland to explore ways to improve the analysis of the local government annual complaints reports at a national level. The meeting was helpful in developing a shared understanding of the respective roles of the organisations, with all parties recognising the valuable progress that has been achieved in partnership between the local government sector and SPSO. The Improvement Service agreed to assume responsibility for the analysis of the information reported by local authorities against the SPSO's performance indicators, including strategic responsibility for the complaints handlers network. The Improvement Service is currently analysing the annual reports of all councils for the year 2014/15.

While local authorities are ahead of the rest of the public service in this work, it is also being taken forward in other areas and this type of reporting will become more and more common across other sectors. Similar positive results for the first year of operation of the CHP have been gathered and analysed by the CSA for the further education sector, in partnership with the sector's complaints handlers network. In housing, Registered Social Landlords (RSLs) continue to provide detailed information to the Scottish Housing Regulator as part of their annual returns on Scottish Social Housing Charter.

Networks

There are now four established networks of public service complaints handlers. These are run by the members and aim to share good practice, develop tools and guidance, support practitioners and facilitate benchmarking of complaints performance information. The four networks cover local authority, housing, further education and higher education sectors. The CSA hosts a website to share good practice, and organises meetings, events and conferences to provide expertise and advice on good complaints handling.

Improving complaints handling

Advice, support and guidance

One core activity of the CSA is providing individual advice, support and guidance on complaints handling to Scotland's public bodies. In 2014/15, we responded to 603 enquiries from stakeholders seeking such assistance. The majority, representing almost one third of all requests, came from the local government sector. The re-launch of the housing sector's complaints handlers network generated a significant increase in enquiries from this sector, including requests for information on membership and the role of the network. The number of NHS queries was low but we expect this to increase as work progresses in this sector.

The table below provides a breakdown of contacts for the year 2014/15:

	2014-15
Local government	219
Housing	97
Central government agencies <i>(inc. Scottish Prison Service)</i>	74
Further education	53
Higher education	37
NHS	26
Water	2
Other <i>(inc. members of the public, students, UK and Ireland Ombudsmen)</i>	23
SPSO internal case advice on organisations' complaints handling	72
Total	603

Valuing complaints website

We continue to use our CSA website to share advice and guidance, and in 2014/15 provided:

- information on the work of the CSA and model CHPs
- good practice guidance on model CHPs, and supporting materials on implementation and compliance
- information on performance reporting, including performance indicators
- complaints handling guidance on dealing with unacceptable behaviour
- key updates for complaints handler networks
- access to new and current good complaints handling and investigations skills training courses by direct delivery or e-learning.

Improving complaints handling

Supporting improvement and sharing best practice

In 2014/15 the CSA participated in 48 external meetings, events and conferences relating to complaints. These allowed us to support improvements and share best practice. Some of the most significant of these are outlined below to give a flavour of the breadth of this work:

- contributing to research into local authority administrative justice (including complaints) with the Scottish Tribunals and Administrative Justice Advisory Committee, Audit Scotland, COSLA, the Improvement Service, and the Accounts Commission
- discussing with the Scottish Housing Regulator the potential alignment of their collection of performance information on RSL complaints handling and proposed thematic inspection of RSL complaints handling
- attending events held by and with the Scottish Housing Best Value Network to support progress and performance management of the model CHP for the housing sector
- holding regular meetings with the Scottish Prison Service (SPS), including a workshop for prison complaint managers to discuss key findings arising from SPSO's observations of SPS's internal audit of prison complaints
- holding, with the College Development Network Quality Steering Group, a sector-wide benchmarking forum for further education on annual complaints performance reporting, including the benchmarking of complaints performance
- participating in discussions with Citizens Advice Scotland, the Care Inspectorate, the Mental Welfare Commission, Alliance Scotland, local government and NHS representatives to support progress on the development of complaints arrangements for integrated services
- attending meetings with the Scottish Government, Healthcare Improvement Scotland, Scottish Health Council, NHS Education for Scotland and other key stakeholders to progress plans to bring about a more accessible and person-centred CHP for NHSScotland
- providing expert advice to the National Audit Office on their research into redress in public services
- discussing the role of mediation in complaints handling with the Scottish Mediation Network and Queen Margaret University
- providing input to the British Standard Institute to support the development of a new BSI standard on complaints handling.

Improving complaints handling

Supporting the next phase of changes and improvement

Looking ahead, now that the model CHPs are embedded and performance is being reported, our aim is to continue to work with the public sector to support them in continuously assessing and improving complaints handling. Over 2014/15 we began the development of a Complaints Improvement Framework. The purpose of this tool is to help organisations self-assess the effectiveness of their overall complaints handling arrangements at a strategic level within the framework of six key themes:

- > organisational culture
- > process and procedure
- > accessibility
- > quality
- > complaints performance
- > learning from complaints.

The initial framework was used by Healthcare Improvement Scotland in 2014/15 to support their inspection of an NHS board, and has been the basis of discussions with the Scottish Housing Regulator on their approach to their thematic inspection of RSL complaints handling. Again, it is important that the focus of the tool is not on the numbers but on the quality of the experience for users and the way the organisations have used and responded to complaints. Our aim is to further develop this tool along with other supporting tools to support specific improvements in quality, learning and root cause analysis.

We also continue to raise concerns about areas where we feel the process to simplify and improve complaints handling has not yet been achieved. In particular, in our policy work, we have continuously highlighted concerns about the complexity of complaints arrangements as part of the integration of

health and social care, including social work processes, which are now very outdated. We anticipate significant work in these areas in the coming years.

NHS complaints

In April 2014, we were also asked by the Scottish Health Council to take the lead on developing a more standardised NHS complaints model CHP. The health sector already operates a standardised complaints process underpinned by detailed government regulations and guidance. We have been asked to lead a process of review to help create an even simpler person-centred complaints process for NHSScotland with a sharper focus, in particular, on encouraging early resolution. The proposed changes aim to support NHS service providers to improve outcomes for people using their services, by enabling them to resolve complaints quickly and at an early stage. We are already working with a large number of stakeholders to take this forward. This included delivery of a masterclass event and a programme of 'Patient Experience, Feedback and Early Resolution' events with NHS Education for Scotland in January – March 2015. These allowed us to communicate to NHS middle managers (such as senior charge nurses) the proposed changes to the NHS complaints procedure, including providing key skills and tools for achieving early resolution.

This work will likely be a central CSA project in our 2015/16 and 2016/17 business plans. Looking further ahead, our role will be to support implementation by NHS boards and provide ongoing advice, support and guidance to those sectors that are already implementing the model CHP.

Improving complaints handling

Training

Our training unit has continued to be popular. It is also a small team – we have one training co-ordinator who works part-time for us, and some administration support.

In 2014/15 we personally delivered 32 courses. These are one-day and half-day courses and in most cases we go to the location of the organisation to deliver them. We provide these to anyone under our jurisdiction.

We delivered:

- > six courses in further education
- > nine courses to local authorities
- > seven to housing associations
- > five to Scottish Government and associated public authorities
- > two to water providers
- > one to a health provider
- > two to a mix of organisations.

We also devised and delivered a special complaints handling course to support a Health and Social Care Partnership and supported the design of its new procedure for integrated service delivery.

We charge for these courses because of the resources they require. We know they are very competitively priced, and we do not seek to make a profit from our courses, but simply to recover our costs.

Our training continues to be highly regarded and we delivered our first course outside Scotland, to the Consumer Council for Water in Birmingham.

E-learning

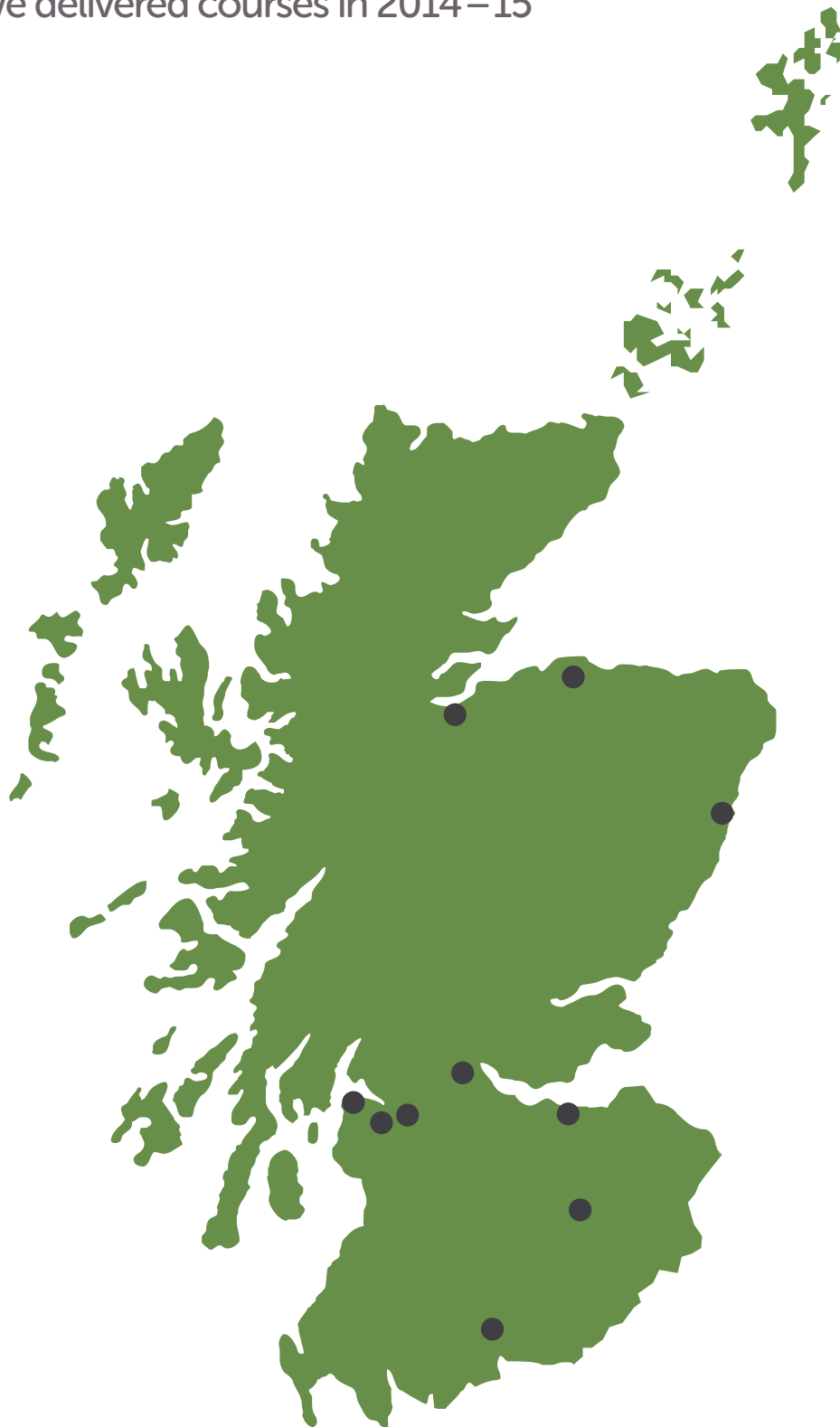
Our e-learning courses are free and, at the time of writing, almost 3,500 registered users have accessed the complaints modules for frontline staff directly from our website. In addition to this, many public authorities, in particular councils, have adapted the e-learning package for use on their own internal systems. We cannot track the numbers who access the e-learning in this way but it is likely to be larger than the number who register directly.

We continued to work with NHS Education for Scotland (NES) to develop e-learning modules and a resource called *Feedback and Complaints: A learning resource for clinical nursing and midwifery leaders in Scotland*.

With NES, we are also developing a new package of e-learning which will play a crucial role in the proposed changes to NHS complaints.

Improving complaints handling

Where we delivered courses in 2014 – 15



Corporate performance

This section highlights:

- > strategic planning and delivery
- > improving operational efficiency
- > how we support our staff
- > statutory reporting
- > financial performance

Strategic planning and delivery

In 2014/15, we delivered year three of our 2012–16 strategic plan, which sets out our five strategic objectives reflecting the statutory functions of the Ombudsman. It also contains our equalities commitments and provides the framework for developing annual business plans and accompanying annual performance measures. Our plans and measures, along with minutes of meetings to record and monitor progress, are on our website.

Progress against our strategic plan and annual business plans and measures is reviewed regularly by operational management, the senior management team, the Audit and Advisory Committee, and shared with Scottish Parliamentary Corporate Body officials.

Improving operational efficiency

The corporate planning process plays a key role in ensuring operational efficiency and effectiveness. We also use information from external and internal audit to drive efficiency and effectively manage risk. The outcome of the external audit engagement for the year 2014/15 was an unqualified certificate from the external auditors, Audit Scotland.

In 2014/15 our internal auditors, the Scottish Legal Aid Board, looked at the areas of payroll, public records management, risk management and absence management.

The auditors raised no issues of significance. Full external and internal audit reports are available on our website.

We had a strong record of ICT systems' reliability in 2014/15. We also continued to improve our case-handling application by automating the transfer of information from our online complaint form into our complaints database. This allows us to process these complaints more efficiently. To further our goal of becoming a paperless office we have moved to electronic-only case files for the first stage of the process, only creating a paper file when the case progresses. We also implemented an electronic management system for non-casework records in line with requirements of the Public Records (Scotland) Act. These initiatives are designed to improve our efficiency by making it easier to access and share documents.

Our people

We review our learning and development requirements, and deliver training programmes and development opportunities on a rolling basis, to ensure that our staff have the knowledge, skills, tools and support they need to manage and deliver our service. Group training sessions are delivered by a mix of internal and external experts and, in 2014/15, this included areas such as: legal matters and issues; dealing with emotional and challenging conversations; unconscious bias in the workplace; telephone communication; weighing up the evidence; finance for non-finance managers; building emotional resilience; coaching conversations; effective presentation skills; mental health and well-being; and an introduction to Breathing Space.

Statutory reporting

Information Requests

We received 207 requests, including multiple requests from a small number of individuals. There were 14 review requests and one appeal notification in 2014/15. The appeal decision to the Scottish Information Commissioner's Office was partially upheld against the SPSO, without any further action required.

Environmental and sustainable development

We are committed to supporting the Scottish Government's policies on Environmental and Sustainable Development and understand our obligations in these areas. We have continued to decrease our carbon emissions from primary energy supplies by 11.5% in 2014/15. This is 28% below our baseline figure from 2009/10. We publish an annual sustainability report, monitoring carbon emissions and waste management activities. In 2014/15 we trialled the climate change public bodies duties 'required' reporting form in preparation for the statutory reporting requirements in 2016.

Financial performance

Our budget for 2014/15 was £3.2 million. We continued our efficiency drive through reducing costs as a result of the revenue generated by our training unit and the shared services agreements we have developed (we share our Edinburgh office with the Scottish Human Rights Commission and provide HR expertise to Scotland's Commissioner for Children and Young People).

We publish information on our website on specific expenditure areas, as required under the Public Services Reform Act. Our full audited accounts are also published on our website.

Financial position

The Ombudsman's expenditure on operating activities for the year ended 31 March 2015, before other operating income, totalled £3,504,000 (2013–14 £3,490,000).

This was on:

- staffing costs £2,659,000 (2013–14 £2,643,000)
- other operating costs £734,000 (2013–14 £733,000) and
- depreciation £111,000 (2013–14 £114,000).

Gross income of £122,000 (2013–14 £154,000) was earned resulting in net expenditure on operating activities of £3,382,000 (2013–14 £3,336,000). Nothing was spent on non-current asset purchases (2013–14 £3,000), leaving the total expenditure for the year of £3,382,000 (2013–14 £3,339,000), including depreciation.

The Scottish Parliament awarded the Ombudsman a budget of £3,241,000 for the financial year, excluding depreciation (2013–14 £3,207,000). The budget was increased in year to £3,271,500 to cover unbudgeted contingencies of judicial review, long-term absence and lift repair works. The Ombudsman's actual cash funding (excluding depreciation) was £3,271,413 (2013–14 £3,209,649).

Equality and Diversity

In this section we highlight:

- the results of our equalities monitoring
- improving our service
- an example of relevant casework

Understanding who brings us complaints

Along with most public organisations, we ask people to tell us about themselves when they bring us a complaint. This is voluntary and the information is not linked to their complaint. It helps us to understand who is using our service, but also to see if any particular group is under-represented.

We reported in 2012/13 that we were concerned the completion rate of our monitoring forms had gone down significantly. We made changes to how this was sent out and in 2014/15 we received information from 1,772 people, which was a considerable increase. This provides us with a useful picture of who is choosing to access our service. We assess this against information provided by the Scottish Government in the census and other official statistics to see how our users reflect the general population.

Low numbers for many categories make them prone to annual fluctuation, but we are pleased to report that the trend is definitely towards users who better reflect the general population in terms of ethnicity and gender. For example, in 2009/10, we reported our concerns that people saying they came from a minority ethnic background were under-represented. This year, 4% of people who completed the form identified as coming from a minority ethnic background, which is in line with the 2011 census figure and is a significant improvement. Again, we have

noted in the past that those identifying as male have been over-represented. This year, for the first time ever, more people told us they were female than male, although the difference in number was marginal and roughly 48% of all respondents identified as male and 48% as female. We did see fewer people identify as white non-British compared to the census figures. This may reflect a lower use of public services or a lower confidence in raising issues when they are unhappy and it is something we will continue to monitor.

A very small number of young people brought us complaints. This is something we have noted before and we have given evidence on changes to the role of the Children's Commissioner, who will be more actively involved in complaints from 2016, as a possible way to help support young people to raise issues.

27% of people who completed the form told us they had a disability. This is higher than the 20% reported in the census but closer to figures reported in the Scottish Health Survey for people identifying as having a disability or limiting long-term condition.

Improving our service

It is important that we continue to ensure our service is accessible. In 2014/15 we made a number of reasonable adjustments to help people use our service, for example, using large font or providing translation services. It is the case that most organisations, including ourselves, are now well used to organising such adjustments, and it is important to us to make sure that we continue seeking ways to improve the accessibility of our service.

Equality and Diversity

In other examples, we have changed our systems to allow us to use the gender-neutral term Mx, and our advice team worked closely with a local advocacy agency to help ensure we can appropriately support people who may struggle to put their complaints in writing.

We are committed to improving this area as an ongoing process. Our refreshed service standards continue to require us to ensure we act without discrimination and prejudice, and to ensure we are accessible, and we intend to continue our equalities commitments into the next strategic plan.

We also demonstrate our commitment to equalities and human rights by considering this carefully when new areas of jurisdiction are being considered. We asked the Scottish Government to put specific clauses in the legislation which give us the power when reviewing decisions of the Scottish Welfare Funds to take complaints orally and not compel people to put their issues in writing, and also to have rules for oral hearings. These measures will allow us to be more accessible and to ensure we meet human rights obligations in this area.

Casework

Casework is the most powerful tool we have to influence others, and we highlight below a case where we sought specific advice from an equalities adviser and made a number of significant recommendations.

Case **201304380**

We received a complaint about how a university responded to a period of ill health a student had while studying there. The student complained that they did not do enough to support him through a difficult time, and did

not make reasonable adjustments to enable him to continue his studies. He said this led to him having to withdraw from the course. We sought independent advice from an equality and diversity specialist, who noted that the university had referred the student to sources of support. However, she said that they did not take reasonable steps to inform and assist him. They had not implemented the university's policies about equality of access and fees refunds. She took the view that a different approach might have allowed the student to continue his studies. She also noted that they had not sought advice from occupational health before making a decision about the student's future studies.

The student also complained about the number of people that he had to inform about his health issues, saying this breached his privacy. Our review of the university's policies and procedures identified who he was required to tell about his sickness absence. We noted that, on occasion, the student chose to share personal health information with staff when he was absent due to ill health, beyond the requirements of the university's procedures. However, we found that there was a lack of procedures in relation to situations other than reporting illness. We were critical of this, as it meant that information could have been shared with more people than was necessary.

We made a number of recommendations in this case. Some related to resolving the issue for the student, but we also suggested they look in close detail at the case to see how they could make improvements for others in the future.

Governance and Accountability

Report from Dr Tom Frawley, Chair of the SPSO Audit and Advisory Committee

Introduction

- 1** The Audit and Advice Committee (the committee) has, for the past number of years, produced an annual report. The report's purpose is to update the Ombudsman, and other key stakeholders, on the work programme of the committee during the year, specifically articulating how it: discharged its responsibilities; the actions it took; and the ways in which it has sought to add value to the governance processes within the office of the Scottish Public Services Ombudsman.
- 2** The committee meets in accordance with its terms of reference which, in turn, are informed by the work schedule laid out in the Scottish Government Audit Committee Handbook (2008).
- 3** The principal role of the committee is to provide the Ombudsman with advice and assurance on the adequacy of internal control and risk management within the SPSO, including: the framework of internal control; risk management processes; and the quality and reliability of financial reporting and related matters.
- 4** These issues are considered through the regular review of the risk management processes undertaken by management, in conjunction with consideration of the work undertaken by internal and external audit throughout the course of the financial year.
- 5** The committee met on four occasions during 2014/15.

Committee structure and membership

- 6** The committee membership during 2014/15 comprised three non-executive directors, these being: Tom Frawley; Douglas Sinclair; and Heather Logan. In line with Scottish Government best practice guidance on the operation of audit committees, the committee is chaired by Tom Frawley, a non-executive member. Each meeting was quorate.
- 7** The committee's terms of reference are kept under regular review as guidance in the field of corporate governance and audit committees is developed. A particularly useful guide for evaluating the effectiveness of the committee is the *The Audit Committee Self-Assessment Checklist*, contained within the Scottish Government Audit Committee Handbook referred to above. We took the opportunity to review the performance of the committee using this checklist prior to a meeting of the Audit Committee in February 2015. Nick McDonald, Internal Auditor, led us through the review process and, while we agreed a small number of limited refinements, we agreed the current approach we had adopted was working well.

Governance and accountability

Attendees

- 8** Patricia Fraser, External Auditor, Audit Scotland; Nick McDonald, Internal Audit provider; Jim Martin, Ombudsman; Niki Maclean, SPSO Director (Secretary); Emma Gray, SPSO Head of Policy and External Communications; Paul McFadden, SPSO Head of Complaints Standards; Fiona Paterson, PA to Ombudsman (Minutes); Rachel Nicholson, SPSO Executive Casework Officer; and David Thomas, Independent Service Delivery Reviewer.
- 9** The committee receives regular oral reports from representatives of both the external and internal auditors on their work programmes, and these perspectives are supplemented by formal audit reports at appropriate points during the financial year.

The work of the committee

- 10** The committee considered the following range of issues, summarising some of the key aspects of its duties deriving from its terms of reference: internal audit; external audit; risk management; and internal control.
- 11** Specific reviews involved evaluating, and advising on, the following issues, through a series of recurring and specific items dealt with at meetings:
- the accounts for the financial year just concluded prior to their finalisation and submission for audit;
 - the content of the Governance Statement for the year, presented alongside the finalised accounts;
 - internal audit's finalised periodic work plan for the financial year;
 - internal audit opinion for the financial year just finished;
 - the internal audit strategy and the periodic work plan for the financial year;

- emerging findings from internal audit engagements;
- the emerging external audit opinion for the financial year just finished and advising the Accounting Officer in relation to signing off the accounts and the draft Governance Statement;
- the external auditor's report for the previous year, any emerging findings from the current interim/in-year work of external audit, and external audit's approach to their work;
- any residual actions arising from the previous year's work of both internal and external audit; and
- re-visiting emerging findings from auditors and review actions.

12 The committee also reviewed arrangements made by management in relation to risk management, including how ongoing risks are identified, assessed, monitored, managed and reviewed.

13 The committee regularly reviews Risk Registers prepared by the SPSO. In relation to strategic processes for risk, control and governance, the committee, in the course of its work, sought to secure assurance that:

- the risk management culture was appropriate;
- there was a comprehensive process for identifying and evaluating risk, and for reviewing what levels of risk were acceptable;
- the Risk Register accurately recorded and reflected the risks facing the SPSO;
- management had an appropriate view of how effective internal control was;
- risk management was carried out in a way that benefited the SPSO and added value;

Governance and accountability

- all staff had an awareness of the importance of risk management and the need to identify risk priorities;
- the system of internal control was effective; and
- the Accounting Officer's annual Governance Statement was meaningful, and supported by meaningful evidence.

Audit engagements

External audit

- 14** The committee found the proactive approach adopted by Audit Scotland in planning for the external audit to be most helpful. This process was beneficial in that it succinctly scoped the ambit of the audit, having regard for: the organisationally-specific risks and priorities facing SPSO; the national risks relevant to the local environment SPSO is operating in; the impact of changing international auditing and accounting standards; the responsibilities of external audit under the terms of Audit Scotland's Code of Audit Practice; and issues that have been carried forward from the previous audit report.
- 15** The outcome of the external audit engagement for the year 2014–15 was an unqualified certificate from Audit Scotland.
- 16** In the opinion of the external auditor, in all material respects, expenditure and income had been applied for the purposes intended by the Parliament and the financial transactions conform to the authorities which govern them. The external auditor further noted that they did not have any observations to make on the financial statements.

Internal audit

- 17** Equally important to the role of external audit, is internal audit that provides the committee with objective assurance that the SPSO's control frameworks are operating effectively. Effective control systems are the foundation of effective risk management arrangements and, in receiving and evaluating the reports of internal audit, a critical aspect of the committee's accountability role is discharged. During 2014–15, the internal auditors undertook reviews of payroll, procurement, case management and risk management. The overall opinion reached by internal audit in all audits was that of satisfactory level of assurance.
- 18** Internal audit's Annual Assurance Report provided the Ombudsman with a 'satisfactory' level of assurance, based on the conclusions of their various engagements during the course of 2014–15.

Commentary

- 19** During the course of the year, the committee noted that any significant areas of concern identified in the course of the programme of audit engagements had been addressed. Moreover, neither auditor at any time indicated any area of particular concern that should be brought to the committee's attention.
- 20** The committee was also assured that the necessary co-operation had been forthcoming from both the SPSO management and staff. The committee also wishes to acknowledge the commitment demonstrated by staff and management in taking all necessary steps to implement recommendations resulting from the programme of review undertaken by both internal and external audit during 2014–15.

Governance and accountability

- 21** The committee at all times sought to provide a forum for focussed debate, involving key internal and external stakeholders, with the ultimate aim of providing assurances to the Accountable Officer on the adequacy of internal control and risk management within the SPSO, including: the framework of internal control; risk management processes; and the quality and reliability of financial reporting and related matters.
- 22** The committee believes it has effectively discharged its functions in this regard by utilising the following sources of evidence: terms of reference informed by best practice guidance in the field of public sector corporate governance; a series of regular meetings considering all of the matters noted above; and meeting, on a continuous basis, with senior management to discuss matters of mutual interest, whilst taking assurance from the opinions expressed by the auditors, both internal and external. Consequently, the committee provided assurance to the Accountable Officer, at the appropriate point in the reporting cycle, that the assertions made in the Governance Statement were meaningful and supported by a sound evidence base.

The Future

- 23** The committee will continue to monitor progress on all areas under its remit during the forthcoming year, which is projected to be at a time of continuing change for the SPSO, particularly against the context of extensions to jurisdiction. The committee believes the SPSO is well positioned to respond to the developing challenges it is facing but with the caveat that this circumstance can only be sustained if it receives the additional resources it is seeking to meet the increased workload it is managing, given the high standards of performance that have been evidenced in the course of the last year.
- 24** The committee will continue to monitor the progress of the SPSO and ensure that the levels of attainment evidenced in the course of the year are maintained and, where judged necessary, enhanced and refined.
- 25** The committee would like to thank the external and internal auditors and the management and staff of the SPSO who facilitated its work during the year, in particular the excellent administrative support provided to us.

Complaints about SPSO

People can complain about our service through our customer complaints scheme. Although the law does not say we have to have such a scheme, we decided to put a process in place. It has two internal stages, and complainants can ask for a final external review by our independent reviewer. This section contains:

- two reports by the external independent reviewers
- statistics about SPSO service complaints in 2014/15
- what we learned from them and what we did as a result of the learning.

Report from David Thomas

Independent Service Delivery Reviewer

The role of Independent Service Delivery Reviewer is an important one, because it provides an independent and external appeal in respect of service delivery complaints. It is to SPSO's credit that it set a precedent for public-sector ombudsman schemes by establishing the post in 2007.

I have filled the role since 2011. But I am afraid that pressure of other commitments means that I am unable to continue. So this is my final report. I wish my successor well. Throughout my term, the Ombudsman and his staff have cooperated positively with me and have accepted my recommendations.

Many of those who referred service delivery complaints to me found it difficult to distinguish their view of the merits of their complaint against the public body (which is not a matter for me) from their view of the way in which SPSO handled the case. Some had unrealistic expectations. SPSO cannot exceed the legal limits to its statutory powers. And it is for SPSO, and not the complainant, to direct

the course of the investigation – including to ensure impartiality.

During the period May to October 2014 I dealt with service delivery complaints in seven cases. In all of the cases, the Ombudsman and his staff provided me with all of the information that I required. Besides looking at the specific service delivery concerns raised with me, I also carefully reviewed the whole of the case files in question.

I did not uphold the service delivery complaint in six of the cases. I was satisfied that SPSO had dealt with these cases effectively, efficiently and fairly. In the seventh case, I partly upheld the complaint – because I did not think SPSO had done enough to dispel the complainant's misunderstanding about one aspect of SPSO's procedure, though it did not affect the outcome of the case. SPSO accepted my conclusions and apologised to the complainant.

Report from Jodi Berg and Elizabeth Derrington

Independent Customer Complaints Reviewers

We were appointed as external reviewers of customer complaints about SPSO with effect from the beginning of December 2014, following in the footsteps of David Thomas. We are keen to deliver a service that will continue to help provide closure for complainants and constructive external feedback and recommendations to SPSO.

In the four months to April 2015 we received eight referrals and completed three full reviews. In a fourth case we carried out an initial assessment and concluded that we could not help the complainant achieve the result he was seeking and, therefore, that a review by us would not be productive. Work on the remaining four cases continued into 2015–16.

Complaints about SPSO

It is of course early days but, in the matters we have handled so far, we have been impressed by SPSO's responsiveness to our requests for information and documents and the clear presentation of the files that we have received.

In the three cases we reviewed we found that SPSO had treated complainants professionally and with respect and had, on the whole, lived up to its service standards. We did not uphold any of the specific complaint issues we had agreed with the complainants, but we did find in one case that there had been a lack of clear communication regarding the complaint issues to be investigated, and made recommendations for this to be acknowledged to the complainant, and for SPSO to consider providing extra guidance for staff and/or updating its published guidance.

The first complaint raised issues about SPSO's interpretation of the matters that the complainant wanted investigated, and whether SPSO had lived up to its service standards. With regard to interpreting the complaint, we found that SPSO had followed its own guidance in identifying the issues which were within its remit and where it would be possible to achieve a clear outcome. We did not therefore uphold this part of the complaint. We found, however, that SPSO had not clearly explained the reasons why it could not investigate all the issues the complainant had listed in his referral. We also felt that the approach to identifying complaint issues could be better explained in SPSO's published guidance. We therefore recommended that SPSO should apologise to the complainant for not making clear its approach to identifying issues for investigation, and that it should consider whether it would be helpful to provide extra guidance for staff or the public on this issue. SPSO accepted our recommendations. We found no evidence at all that SPSO had failed to treat the

complainant politely, professionally and with respect as required by its service standards and accordingly did not uphold the second limb of the complaint.

The second complaint also related to the effectiveness of communication in the early stages of SPSO's investigation, and whether SPSO had made appropriate efforts to understand the complainant's point of view and to investigate the correct complaint issues. A decision review by the Ombudsman had already acknowledged that there had been some misinterpretation of the original complaint, but had found that this had not affected the final outcome. We found that SPSO had correctly tried to focus on the issues on which it would be able to make a clear finding, and that to have tried to investigate the specific concerns raised by the complainant would not have been productive. Although communication with the complainant on this aspect of the process had not been as effective as it might have been, we were satisfied that this had been recognised by SPSO and that appropriate apologies had been offered. Accordingly, we did not uphold the complaint.

The third complaint also related to SPSO's interpretation of the original complaint issues. In addition, it raised concerns about whether SPSO had followed appropriate procedures regarding the use of clinical advisers. We were satisfied that SPSO had complied with its established procedures for the use of clinical advisers. With regard to communication, we recognised that there had been problems but were satisfied that these had already been properly acknowledged by SPSO. In the circumstances, we did not take the complaint forward as a full review. We wrote to the complainant and SPSO explaining the reasons for this decision.

Complaints about SPSO

Using complaints to improve our service

In line with CSA requirements, details of all customer service complaints about SPSO are recorded and reported on a quarterly and annual basis. A summary of the outcome of complaints received and responded to during the year is published on our website on a quarterly basis, along with a note of any actions taken in response. The reports include statistics showing the volumes and types of complaints, plus their outcomes and key performance details, including the time taken and stage at which complaints were resolved.

Our annual customer service complaints report includes a summary of our handling of complaints for 2014/15. The full report can be found on our website. We publish this information to help ensure transparency in our handling of customer service complaints and to demonstrate to our customers that complaints do influence changes to our service.

The table below shows a breakdown of closed complaints by stage and outcome (including ISDR/ICCR). Each complaint contains a number of individual aspects of complaint so the decision outlined represents an aggregate of the outcome of these.

Key points from SPSO annual customer service complaints report 2014–15

- We received 53 service complaints in 2014/15 (representing 1.08% of cases closed), which was a decrease from the 57 complaints we received in 2013/14
- We closed 51 service complaints in the year, responding to 10 of these at both stages of our internal process (therefore 61 responses in total). This is a slight decrease on the previous year's figure of 53.
- The Independent Customer Complaints Reviewer (ICCR) responded to 11 complaints in 2014/15. There were eight responded to by ICCR in the previous year.
- Upheld/some upheld rates were 29% for those complaints responded to by SPSO, a slight reduction from 30% the previous year. Of the 11 ICCR cases, nine were not upheld and two were upheld (18%).
- Average timescales for stage 1 and stage 2 complaints were 3.6 and 19 working days respectively, within our target timescales. We responded to 84% of complaints at stage 1 and 77% at stage 2 within target timescales of 5 and 20 working days respectively, which is a significant improvement on the previous year.

Complaints determined about SPSO 2014–15

Customer complaint type	Fully upheld	Not upheld	Some upheld	Total	% upheld
Stage 1 Officer/Manager	9	22	0	31	29%
Stage 2 Senior Management	0	24	6	30	20%
Stage 3 ISDR/ICCR	0	9	2	11	18%
Total	9	55	8	72	24%

Complaints about SPSO

Learning from complaints

Information, including all service failures, how we responded to these and how we used the learning, can be found in full in the report on our website. We provide some illustrative extracts below. In addition to putting things right for our customer where possible, when our service has not met our service standards we always seek to learn the lessons from any service failures and address any systemic issues that may be identified.

In the course of reviewing service complaints, individual instances of service failure are highlighted to our senior management team where necessary, and to the relevant staff and managers involved where appropriate.

A summary report of complaints is provided to our senior management team, service improvement group and Audit and Advisory Committee each quarter.

Failing identified

- 1** SPSO delay in progressing the complaint and the reasons for the delay were not always explained to the complainant.

- 2** The complainant had told us in their complaint form that they were vulnerable, with severe mental health problems, and had a mental health nurse. In those circumstances, we should have given the case priority and we should have given the complainant a call within the first two weeks of having received the case.

- 3** Inconvenience caused by personal postage costs in returning information to SPSO.

What we did in response

We apologised to the complainant.

We spoke with the complainant and acknowledged that they had informed us of mental health problems. We acknowledged failings in the way we had treated the complainant and apologised for this.

We apologised for the wording contained in one of our letters. We agreed to look through the file to help progress the complaint.

We apologised to the complainant and compensated the customer with stamps to cover the cost of postage.

Statistics

All cases determined 2014/2015

Case type	Stage	Outcome Group	Further & Higher Education	Health	Housing Associations	Local Government	Scottish Government and Devolved Administration	Water	Other	Total		
Enquiry	Advice & signposting	Enquiry	1	6	2	13	5	2	0	29		
	Total enquiries	Out of jurisdiction	0	0	0	0	0	0	743	743		
Complaint	Advice	Not duly made or withdrawn	1	6	2	13	5	2	743	772		
		Out of jurisdiction (discretionary)	26	339	81	380	108	40	4	978		
		Out of jurisdiction (non-discretionary)	5	17	3	29	8	3	0	0	65	
		Outcome not achievable	5	8	8	25	26	0	0	19	91	
		Premature	2	33	12	42	8	5	0	0	102	
		Resolved	41	325	177	713	148	125	2	2	1,531	
		Total	79	722	283	1,193	298	173	25	2,773		
		Early Resolution 1	Not duly made or withdrawn	8	51	5	36	31	7	0	138	
			Out of jurisdiction (discretionary)	4	47	4	56	9	4	0	0	124
			Out of jurisdiction (non-discretionary)	30	22	29	140	63	29	2	2	315
	Outcome not achievable	6	99	12	107	61	10	0	0	295		
	Premature	0	51	7	42	16	9	0	0	125		
	Resolved	4	20	7	35	16	6	0	0	88		
	Total	52	290	64	416	196	65	2	1,085			
Early Resolution 2	Fully upheld	0	24	3	33	15	1	0	0	76		
	Some upheld	4	3	4	18	7	3	0	0	39		
	Not upheld	13	50	18	56	52	11	0	0	200		
	Not duly made or withdrawn	0	4	0	0	2	0	0	0	6		
	Resolved	0	0	1	3	0	2	0	0	6		
	Total	17	81	26	110	76	17	0	327			
Investigation 1	Fully upheld	2	113	3	28	14	11	0	0	171		
	Some upheld	5	85	4	26	13	6	0	0	139		
	Not upheld	8	153	5	63	12	8	0	0	249		
	Not duly made or withdrawn	0	3	0	1	7	0	0	0	11		
	Resolved	0	0	0	1	0	0	0	0	1		
	Total	15	354	12	119	46	25	0	571			
Investigation 2	Fully upheld	0	36	0	3	0	1	0	0	40		
	Some upheld	0	3	0	1	0	1	0	0	5		
	Not upheld	0	1	0	0	0	0	0	0	1		
	Total	0	40	0	4	0	2	0	46			
Total complaints			163	1,487	385	1,842	616	282	27	4,802		
Total contacts			164	1,493	387	1,855	621	284	770	5,574		

Statistics

Enquiries signposted by SPSO advice team 2013/14 and 2014/15

	2013/14	2014/15
ABTA	0	2
Age Concern Helpline	11	1
Association of Residential Letting Agents	0	1
Audit Scotland	3	4
Bus Passengers Platform	1	1
Care Inspectorate	3	2
Citizens Advice Bureau	59	144
Commission for Ethical Standards in Public Life in Scotland	3	5
Consumer Direct	1	8
Drinking Water Quality Regulator	1	5
Financial Ombudsman Service	47	109
Homeowner Housing Panel	0	13
Information Commissioner Office – Scotland (DPA)	15	31
Law Society of Scotland	2	0
Office of the Scottish Charity Regulator	6	7
Ombudsman Services: Communications	15	29
Ombudsman Services: Energy	22	76
Ombudsman Services: Pensions	3	6
Ombudsman Services: Property	6	21
Other	35	66
Parliamentary and Health Service Ombudsman	24	44
Passenger Focus	1	2
Planning Aid for Scotland	2	5
Police Investigations & Review Commissioner	12	21
Private Rented Housing Panel (PRHP)	8	14
Public Concern at Work	5	4
Public Services Ombudsman for Wales	0	1
Public Standards Commissioner for Scotland	1	4
Referred to Employer / Human Resources	11	15
Referred to Legal Advice	10	24
Samaritans	1	1
Scotlands Commissioner for Children and Young People	1	3
Scottish Information Commissioner (FOI)	0	4
Scottish Legal Aid Board	1	6
Scottish Legal Complaints Commission	6	21
Scottish Parliament Corporate Body	0	2
Scottish Parliamentary Standards Commissioner	1	5
Shelter Housing Advice Line	12	16
Standards Commission for Scotland	0	2
Telecommunications Ombudsman (Otelco)	0	1
The Property Ombudsman	0	1
Water Industry Commission for Scotland	1	16
Total	320	743

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