SCOTTISH PUBLIC SERVICES OMBUDSMAN

Annual Report 2004–2005

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The Scottish Public Services Ombudsman provides an open accountable and accessible complaints system

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a welcome from the Ombudsman

This has been an important year for my office and the development of a one-stop-shop for handling complaints about public services in Scotland. As reported in previous Annual Reports, in the period since our establishment at the end of 2002, we have spent time merging the offices of the former Ombudsmen in Scotland and designing new processes and systems in order to deliver a modern complaints handling service. In the past I have outlined the work we have done to make our office more open and accessible.

In moving to the next phase of development I have looked at ways in which my office can enhance the accountability of the service we offer and also how we can help improve the accountability of the many bodies under the jurisdiction of the Scottish Public Services Ombudsman. Therefore, the theme for this year's Annual Report is *Accountability*.

As Ombudsman I recognise that my office is uniquely placed in having a comprehensive overview of the delivery of public services. My remit covers an extensive range of services that are crucial to the lives of people living in Scotland. We can receive complaints about local government and the many services it delivers, the Health Service, including individual doctors, dentists, opticians and pharmacists, housing associations, government departments and government agencies, the enterprise network and the Scottish Parliamentary Corporate Body. In our role it is possible for us to identify what is working and what is not working well. Such an overview provides evidence of common problems, trends and issues across and within sectors and also the cultural and other differences that exist. More positively it also provides evidence of what can be done to improve public services in a way that can offer real benefits for both members of the public and those responsible for the delivery of services.

There is a central role for my office in helping this process. While we take individual complaints from the public, many of these complaints also raise wider issues from which lessons can be learned and changes can be made. We will continue, therefore, to seek ways in which we can add value by providing feedback from our work and identifying opportunities for systems to be simplified and improved.

The key messages in this year's Report relate to the theme of accountability. In my Overview of the Year below I discuss proposals for enhancing the accountability of my office and other public services and the benefits offered by working together to this end. As one example, I make the case for introducing legislation that would allow public bodies to provide an apology when things go wrong without fear of the consequences of admitting liability. The case is also made for greater simplicity in complaint handling systems across the public services including a proposal for a 'model' complaints handling process.

THE OMBUDSMAN, PROFESSOR ALICE BROWN, AND DEPUTY OMBUDSMEN CAROLYN HIRST, ERIC DRAKE AND LEWIS SHAND SMITH

In looking towards the future I consider our place within the administrative justice system in Scotland and raise questions about revisiting our legislative framework.

I am assisted in my work by my Deputies, Eric Drake, Carolyn Hirst and Lewis Shand Smith. Each has either the lead or secondary responsibility for different sectors under my jurisdiction and provide a point of contact for policy makers and other stakeholders. They have an important role too in making connections across sectors to ensure a co-ordinated approach to complaint handling. In the sections that follow they illustrate some of the core issues raised in this Report.

I would like to take this opportunity to thank them for their ongoing support and advice. I also wish to record my gratitude to all my staff for their valuable work and the positive way they have responded as the office continues to evolve and change. Finally, can I extend my thanks to the many external organisations and individuals with whom we have worked over the year. My office can now move forward confident in the knowledge that we are now a unified organisation and that we have established strong foundations on which we can build and improve the service we offer in the future.

PROFESSOR ALICE BROWN
SCOTTISH PUBLIC SERVICES OMBUDSMAN

My office is uniquely placed in having a comprehensive overview of the delivery of public services. My remit covers an extensive range of services that are crucial to the lives of people living in Scotland.

accessibility

justice

overview of the year
Alice Brown

We received 2377 complaints and enquiries over the year 2004-2005 compared with 1791 in the previous year (*Figure 1*).

Figure 2 shows the distribution of these complaints and enquiries across the different sectors. Of those that were within jurisdiction, 61% were about Local Government, 14% about the NHS, 9% about Housing Associations and 5% about the Scottish Executive and its agencies.

In considering the subjects that generated complaints, *Figure 3* illustrates the top ten categories.

It is also instructive to look at the distribution of complaints and enquiries received from different parts of Scotland. *Figure 4* at the end of this section provides such information.

Looking back over the year I am struck by just how much we have achieved as an office but also just how much we still want to do to develop our processes, procedures and practices. The overarching objective we set ourselves for the year was to improve accountability in terms of our service but also in terms of the service provided by the bodies under the jurisdiction of the office of the Scottish Public Services Ombudsman.

FIGURE 1 **Total complaints & enquiries received**

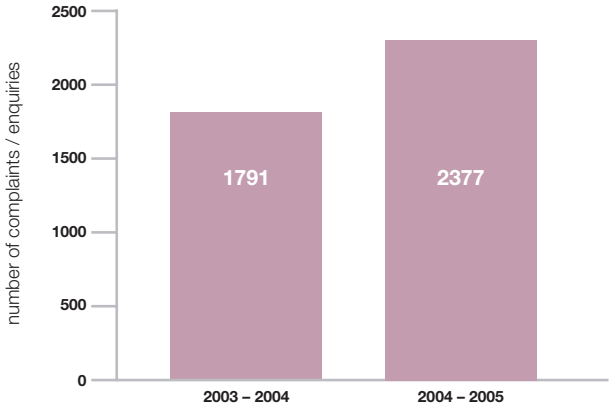
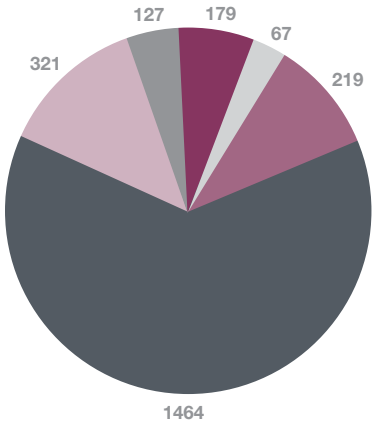
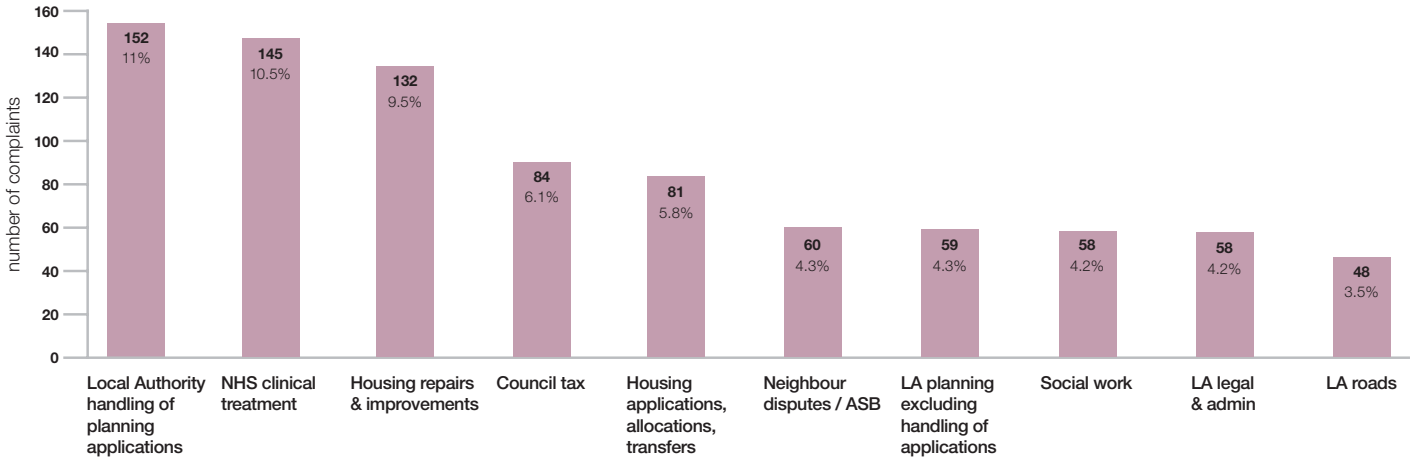


FIGURE 2 **Total complaints & enquiries received in 2004 – 2005 (2377)**



- Local Authorities **61%**
- National Health Service **14%**
- Scottish Executive & Devolved Agencies **5%**
- No Subject / Organisation Provided **8%**
- Organisation Out of Jurisdiction **3%**
- Housing (not Local Authority) **9%**

FIGURE 3 **'Top ten' categories of complaints 2004 – 2005**



Note: percentages relate to total number of complaints

Accountability

Defining accountability

What do we mean by accountability? As a service we aim to account to others for what we do in terms of our processes and standards of investigation. But this has to be set in the context of the independence of the office of Ombudsman.

To whom and for what?

In reaching decisions on the complaints we examine and investigate, we are sometimes asked 'to whom are you accountable'? The short answer is that – in terms of decisions on individual complaints – the Ombudsman's findings are final and can only be challenged by judicial review. This is because of the underlying philosophy that bringing a complaint to the Ombudsman should be seen as the last resort with his or her judgement on the matter helping the parties to draw a line and move on from a dispute.

However, with regard to the budget for running the office, we are accountable to the Scottish Parliament and my Annual Report and reports of investigations must be laid before Parliament. I comment further on these reports below. So an important part of my office's accountability is ensuring that Members of the Scottish Parliament have a proper understanding of what we do. To this end my office has given presentations to Committee Clerks and to political party groups, and has provided evidence to the Health Committee.

There are other ways in which my office can account for the way in which we do our work and these are detailed below.

Accountablity of the SPSO

It is important that if we are asking others to be more accountable for what they do then we should also address the accountability of our own work. In other words, we aim to practice what we preach. To this end we:

- **set targets for the delivery of our service**
- **provide clear reasons for the decisions we take on complaints brought to us**
- **offer a process for reviewing a decision**
- **take 'Complaints About Us' and the service we have provided**
- **assess the quality and consistency of our work on a regular basis**
- **invest in staff training and development**
- **change our processes to reflect feedback and good practice**
- **support both internal and external audits of our service through our Audit and Risk Committee and our new Advisory Group**
- **report the outcome of our decisions to the Scottish Parliament and others**

consideration

response

overview of the year Alice Brown

There are four different types of report that we can make to the Scottish Parliament. First, we must lay an Annual Report before the Parliament; and second, we must lay reports of all investigations into complaints. We may also lay two others: a Special Report where we consider that there is hardship or injustice that has not been remedied (this normally occurs when we have made recommendations for redress after we have found maladministration or service failure when investigating a complaint and the body concerned does not implement our recommendations); and Other Reports where we may wish to report on systemic or other issues identified during the course of our work.

In considering and responding to feedback from others and particularly complainants we are planning a significant change to the way in which we report the outcome of our decisions on complaints. The term investigation has particular implications in our Act and as outlined above we are required to report the outcome of our investigations to the Scottish Parliament. In the past it has been our aim to reach informal resolution of complaints through examination and, where appropriate, to avoid a long, formal and often stressful investigation process for the complainant as well as the staff in the body subject to the complaint. We have been successful in this objective in that just nine of our complaints have gone to full investigation this year. One investigation was discontinued and the other eight resulted in Reports to Parliament (summaries and copies of the reports are available on our website: www.scottishombudsman.org.uk).

Such an approach is in line with the thrust of our legislation and we will continue to seek informal resolution in the future. We are concerned, however, that an unintended consequence is that it has not been possible for us to share the full value of our work and information about what is working well or where changes are required in public services. Thus opportunities for lesson learning and improvement can be missed.

Further, our current practice of distinguishing between examining and investigating a case is sometimes confusing for complainants who do not necessarily make the distinction between the two. We, therefore, intend to simplify our language and to use the term investigation when we look further into all complaints that are under our jurisdiction. This will allow us to report to the Parliament on every such case although we will continue to maintain confidentiality by protecting the anonymity of individual complainants.

The new process will be launched in the autumn of 2005. As a result, we will be reporting decisions on all investigated complaints to the Scottish Parliament and the information will also be collated and made available on our website. We will endeavour to produce this information in different ways that might be of value, for example by sector, geographical area, subject and so on.

Accountability of bodies under jurisdiction

The new process of reporting all investigations by this office will not only improve the accountability of the SPSO but that of bodies under our jurisdiction. In discussing the intended change to our process with a sample of Chief Executives in the public services we are pleased to record that we have received positive feedback from them. We have made the case that good complaint handling should be integral to high quality delivery of public services and that information gathered through the complaints process is invaluable management data that should be available to inform the work at all levels of an

A key message that cannot be over-stressed is that poor communication is at the core of most complaints.

organisation. Complaints provide free market research that can help to improve public services and systems of corporate governance.

It is our practice to follow up recommendations made in our Reports in order to ensure that bodies implement any actions we have proposed. We will continue to develop this practice under our new reporting system. Further we intend to send an annual letter to all Chief Executives that will provide a summary of the outcome of our investigations of complaints into their organisations together with an analysis of the trends and issues. It will also identify the key lessons to be learned and make suggestions for changes to processes and procedures. Where possible we will supplement these letters with individual meetings with the Ombudsman or one of the Deputies.

In addition to specific issues that need to be raised with individual Chief Executives there are common and recurring themes in the complaints received by the SPSO. A key message that cannot be over-stressed is that poor communication is at the core of most complaints. Also the way in which organisations first respond to complaints normally sets the tone for what happens next and whether or not the complaint can be resolved relatively easily and quickly. Failure to take complaints seriously, to give complainants the information they request or an explanation of what went wrong and why can also add to what is often a negative and frustrating experience.

Our work also shows that many people simply want an apology for what has gone wrong and an assurance that changes have been made to help prevent the same thing happening to others. But, as we reported in last year's Annual Report 'sorry seems to be the hardest word'. A key barrier to saying 'sorry' and providing an apology is often fear of litigation. There is evidence to demonstrate that failure to give an apology when things have gone wrong can in itself contribute to the escalation of a complaint and can increase the likelihood that a complainant will consider pursuing a legal remedy to their complaint.

In considering a way forward we have looked at how this issue has been addressed in other countries and in particular the practice in Australia. Most Australian states have recently introduced legislation to limit the scope of civil liability, including an explicit provision that an apology is not an admission of liability. These changes have dramatically reduced the number of cases being brought to court. They also seem to be helping to create a climate in which public authorities feel able to be more open in admitting to mistakes and learning from them.

In the words of one Australian Commissioner for Complaints[1]:

'It is clear that the fear of litigation often produces a defensive unhelpful response to complainants …which leaves complainants with an even deeper sense of grievance and distrust. In my view, this defensive response in fact increases the risk of litigation.'

We would recommend that this is a route that Scotland should consider. We will be raising this issue with parliamentarians and Ministers, drawing their attention to the benefits of this approach.

Proposal: Legislation to allow for providing an apology without admission of liability.

[1] *Rob Knowles, Australian Commissioner for Complaints, Annual Report, 2001-2002*

clarity

outreach

overview of the year Alice Brown

Working with others to improve accountability

The change to our practice of reporting our investigations will impact on bodies under jurisdiction. It also has potential implications for others especially if we develop our practice of working together to improve accountability.

Our legislation and that of other organisations places certain constraints on our ability to share information and knowledge. We have entered into Memoranda of Understanding with bodies as one way of overcoming such barriers and to reduce the confusion felt by many complainants and public services in dealing with different organisations over issues that may straddle their respective remits.

Our new practice of reporting on all investigations will make it easier for us to share general information. As a way of improving accountability it is important that the reports of our investigations are considered together with reports and evidence from other agencies such as Audit Scotland or NHS Quality Improvement Scotland (QIS) or the Care Commission to name just a few. In this way an overall picture of the performance of public services in Scotland can be drawn.

A wider perspective will be of value to Committees of the Scottish Parliament when they are calling for evidence or scrutinising legislation. It will be of value too to the Scottish Executive in assessing the performance of public services and holding them to account and indeed in assessing the performance of their own departments and government agencies.

Need for greater simplicity

One of the key aspirations underpinning our founding legislation – the Scottish Public Services Ombudsman Act 2002 – was to simplify the system for members of the public wishing to bring a complaint about public services. Creating a one-stop-shop for handling complaints was seen as a prerequisite for achieving this aim. But creating a single office for handling complaints is only one step towards simplifying the system and more needs to be done to ensure greater simplicity and clarity. If systems are unnecessarily complicated then they are less likely to be understood and accessed by the public. This has consequences for public accountability.

In handling complaints, particularly those that involve different agencies, we are struck by the diversity of complaints procedures across and within the public services in Scotland. Unfortunately in this case, diversity does not add value but rather adds to the confusion that exists for people wishing to bring a complaint when things have gone wrong. This confusion is widely recognised, however, and in a survey we conducted of the complaints processes of public authorities we found that there is a willingness to improve and to seek advice on developing new systems.

There have been considerable changes to the procedure for making complaints to the NHS in Scotland and Eric Drake discusses the progress that has been made in his section on the health sector. The objective has been to both simplify and reduce the delay in raising and processing such complaints within the NHS and bringing a complaint to the SPSO. We welcome this reform and will be monitoring the impact of the new system.

There is strong evidence to suggest that public trust and confidence in public services and public servants can be built or destroyed by the way in which people experience the delivery of services, especially the response they receive when things go wrong.

In other sectors, such as local government, there is considerable variation across the 32 different authorities. Lewis Shand Smith addresses this issue in his section on local government and the proposal that the SPSO is making for a 'model' complaints handling process to be adopted and implemented.

In her section, Carolyn Hirst makes reference to a good practice guide for Registered Social Landlords in handling housing complaints.

We would wish to see a 'model' complaints process expanded to all areas under the remit of the SPSO. Indeed, taking into account the shift towards more joint delivery of services, we would also propose a 'model' for the whole of the public services in Scotland. This would not only simplify matters for members of the public but would assist the accountability process when things go wrong with the delivery of services either separately or collectively. We will be working with others to achieve this aim.

Proposal: 'Model' complaints handling process for public services in Scotland.

Engendering trust and confidence in public services

There is strong evidence to suggest that public trust and confidence in public services and public servants can be built or destroyed by the way in which people experience the delivery of services, especially the response they receive when things go wrong. The UK National Complaints Culture Surveys found that satisfied complainants are likely to be well informed and well-disposed towards an organisation. In contrast dissatisfied complainants are likely to tell around 10-25 other people about their bad experience. Interestingly the surveys also showed that staff satisfaction increased if they feel well supported when dealing with complaints and empowered to seek resolution.

A MORI survey on trust reported that the key things people want are:

- **services that meet their needs**
- **good treatment by staff**
- **admitting responsibility for mistakes**
- **providing information**
- **learning from mistakes**
- **treating all people equally**

In its commissioned survey of public attitudes towards conduct in public life, the Committee on Standards in Public Life concluded that the findings of the survey reflected patterns found elsewhere in research on trust. It noted that people express higher levels of trust in 'frontline' professionals and those whom they perceive to be impartial or independent than they do in senior managers and administrators and those whom they perceive to be politically motivated. They found that the principle of honesty and the public service ethic emerged as key priorities for the general public[2].

There are important messages here for Chief Executives and leaders of public services. These concern the need to value, support, train and empower staff in the 'frontline' and those who handle complaints and to see their work as crucial to the delivery of high quality public services. Having good processes and procedures for dealing with complaints is important and can enhance the accountability of the organisation. Such systems need to be matched, however, with the type of attitudes, behaviour and culture that engender public trust and confidence.

Proposal: Need to value, support, train and empower staff in the 'frontline' and those who handle complaints and to see their work as crucial to the delivery of high quality public services.

[2] *Committee on Standards in Public Life, Survey of Public Attitudes Towards Conduct in Public Life, September 2004.*

transparency

consistency

overview of the year Alice Brown

Looking forward

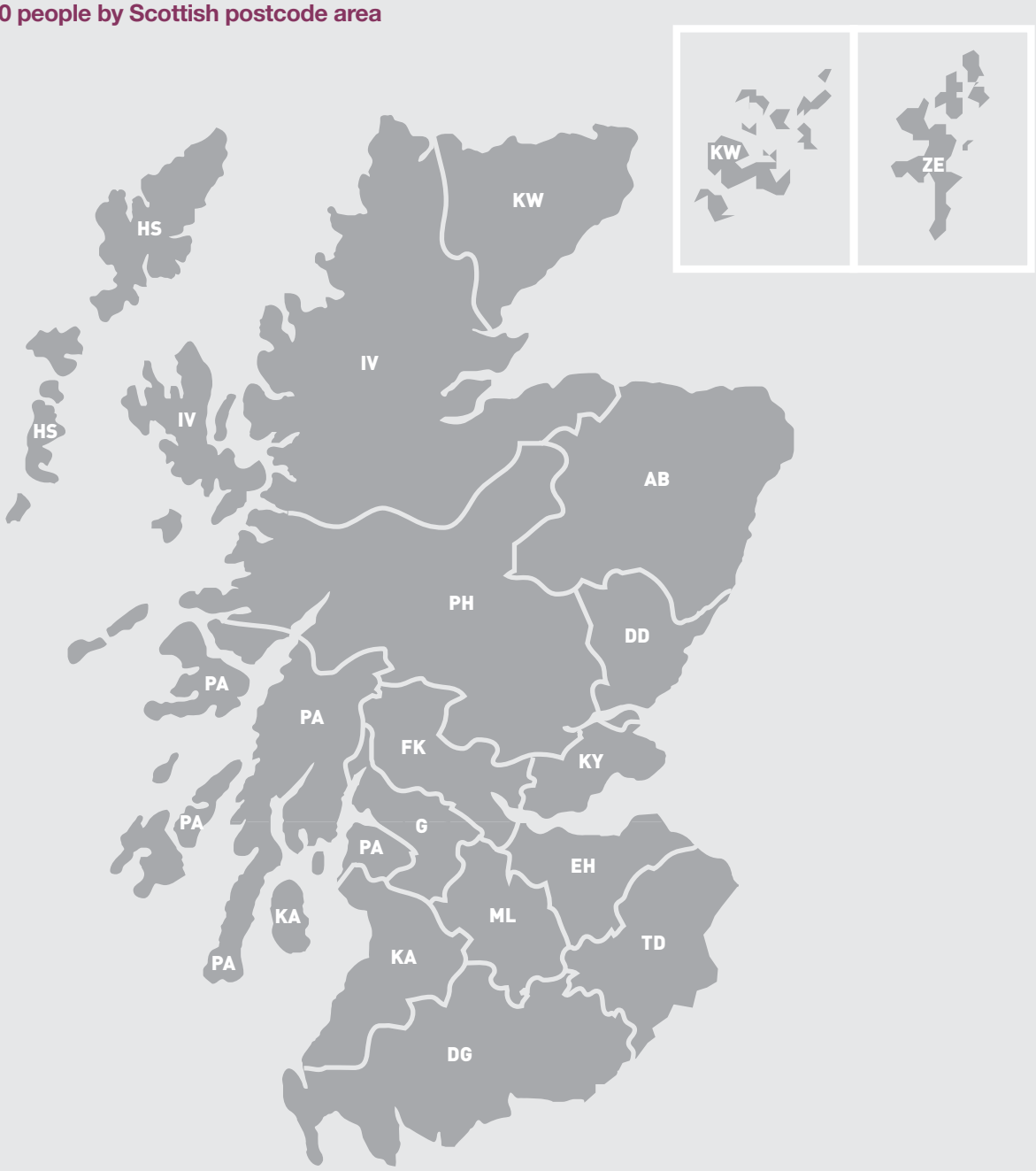
There are new challenges facing the SPSO in the year ahead. I have already outlined our plans to introduce a new process for reporting investigations and our proposals for other reforms. The year will be marked also by Further and Higher Education institutions coming under the jurisdiction of the Ombudsman for the first time. This takes effect from October 2005 and we have made plans to receive complaints and enquiries from students, staff and members of the public about the administration and delivery of services in these sectors. We have been working with representatives in the sectors and student bodies to ensure a smooth transition to the new system and to raise awareness of the role of the Ombudsman.

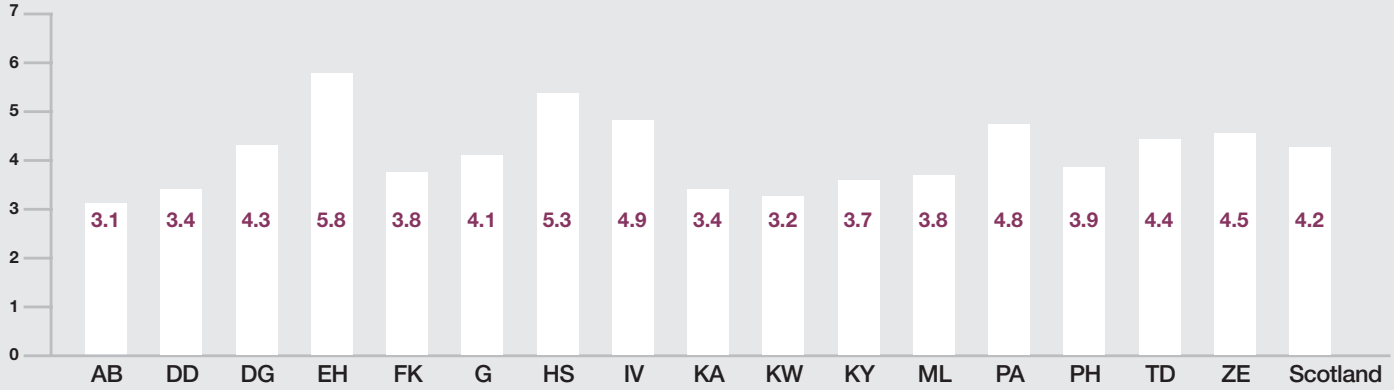
With imminent changes to the Tribunal system in the UK the SPSO will also be considering its place in the administrative justice framework in Scotland. We will be exploring the rights agenda and its possible impact on our work as well as the alternatives to the use of the courts in resolving disputes.

As an office we will continue to assess our approach to our work to reflect new circumstances and expectations. As part of that process it will be important too to revisit our founding legislation and ask whether the aspirations that informed our Act are being realised and if not why not. The practice of reviewing the impact of legislation and considering proposals for change is in line with the philosophy of the Consultative Steering Group which recommended the procedures and principles underpinning the work of the Scottish Parliament. This is reflected in the Parliament's approach to post-legislative scrutiny. We will identify areas where we consider there are constraints to providing a 'one-stop-shop' and delivering as effective a service as possible. One such example relates to the way in which our legislation restricts our ability to take complaints about contractual matters. The wording of the legislation does not accord with the accompanying guide to the legislation produced by the Scottish Executive. It may be that this is one area that would benefit from an amendment to our Act and bring our legislation more in line with the intention of the parliamentarians.

Like other organisations in a rapidly changing and evolving environment we will continue to examine what we do and how we do it. Through this process we will seek improvement which will be our theme for our Annual Report next year.

FIGURE 4 **Complaints and enquiries received per 10,000 people by Scottish postcode area**



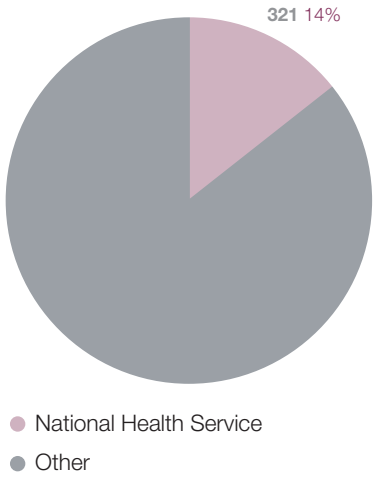


reports from the deputies
Health Sector Eric Drake

Complaint numbers and processes

Complaints and enquiries about the NHS form the second largest element of our caseload: 321 cases received in 2004-2005 – 14% of the total (*Figure 5*). This represents an increase in the number of complaints from the previous year when we received 306 NHS cases (17% of our caseload).

FIGURE 5 **Health complaints & enquiries received**



Compared with the scale of NHS services and the number of patient contacts taking place every day these figures are tiny. To take just one example from a particular sector of the NHS: there are over 1,000 GP practices in Scotland yet in 2004-2005 we received just 42 complaints and enquiries about GP services. Earlier in this report the Ombudsman referred to the research evidence that people express the highest level of trust in 'frontline' professionals. There is no doubt that this is true in the NHS and that the public are rightly appreciative of the skill and dedication of health professionals and aware of the pressures on them.

But things can go wrong in the NHS as elsewhere and when they do it is important that service users feel able to raise concerns and are confident that if they do they will be taken seriously and responded to fully and fairly. Year on year NHS Scotland deals with some 10 – 11,000 written complaints. That proportionally few of these complaints go on to the Ombudsman is certainly, at one level, a tribute to the care with which NHS organisations and practitioners respond to them. However, I know from my discussions with NHS complaints officers that they would be the first to acknowledge that the picture is not that simple. Whether people choose to complain at all and if they do, how far they pursue a complaint can be affected by a range of factors which may or may not relate to the seriousness of the issues at stake and the adequacy of the responses they receive. That a complaint comes

DEPUTY OMBUDSMAN ERIC DRAKE

to the Ombudsman does not necessarily mean that the response received earlier in the complaints process was inadequate. Equally, the fact that someone chooses not to take a complaint as far as this office is not, in itself, evidence that they have received a satisfactory response.

The new NHS complaints procedure

People can be put off pursuing a complaint if they find the process for doing so too time consuming or complex or if they doubt its fairness. The NHS complaints procedure introduced across the UK in 1996 provided for local resolution by the organisation or practitioner concerned and then, if the complainant remained dissatisfied, a second stage under which a Convener (usually a non-executive director of the relevant NHS body) decided whether an independent panel should review the complaint. A UK-wide review of the system in 2001 found widespread dissatisfaction. Reasons for this included:

- **the time taken to complete the process**
- **poor complaints handling, including poor communication with patients**
- **perceived bias**
- **an inconsistent standard of panel members**
- **an inability to compel clinicians to attend a panel**
- **lack of a coherent system to allow learning from a patient's experience or to make improvements following a complaint**

In the light of these findings an advisory group, of which I was a member, developed proposals for creating an NHS Complaints Procedure in Scotland which envisaged improving local resolution and replacing the existing independent review process by either:

- **establishing a National Complaints Authority** or
- **involving the Ombudsman at an earlier stage**

People can be put off pursuing a complaint if they find the process for doing so too time consuming or complex or if they doubt its fairness.

justice

integrity

reports from the deputies Health Sector

Following a consultation process the Scottish Executive announced that they were in favour of the option of bringing in the Ombudsman earlier in the process. They considered that this offered the simplest and most robust approach to the final stage of the complaints process, and guaranteed independence.

This decision was announced in November 2003 although in the event it was not implemented until April 2005. We were therefore able to use 2004-2005 to prepare for the changes which we knew would lead to an increase in our caseload and alter the way we worked with the NHS.

As part of this process of preparation, during the autumn of 2004 we held a series of Roadshows in each geographical NHS Board to raise awareness of the role of the Ombudsman and promote discussion of complaints-related issues with NHS staff and advice and advocacy bodies that might help people bring complaints to us. These events proved extremely valuable. The presentations given at the Roadshows and a summary of the most frequently asked questions can be found under the 'Outreach' heading on our website (www.scottishombudsman.org.uk).

As well as allowing NHS staff and those from advice and advocacy agencies to ask specific questions the Roadshows gave them an opportunity to discuss more general issues with us and among themselves. One that came up frequently was neatly summarised by one NHS complaints officer as 'how do we get more people to complain?' Users of the NHS can feel very vulnerable and, particularly in small or remote communities, may worry that complaining could adversely affect their future access to services or relationship with their GP. It is important that advice and support in making complaints is available for those who need it.

A matter of concern

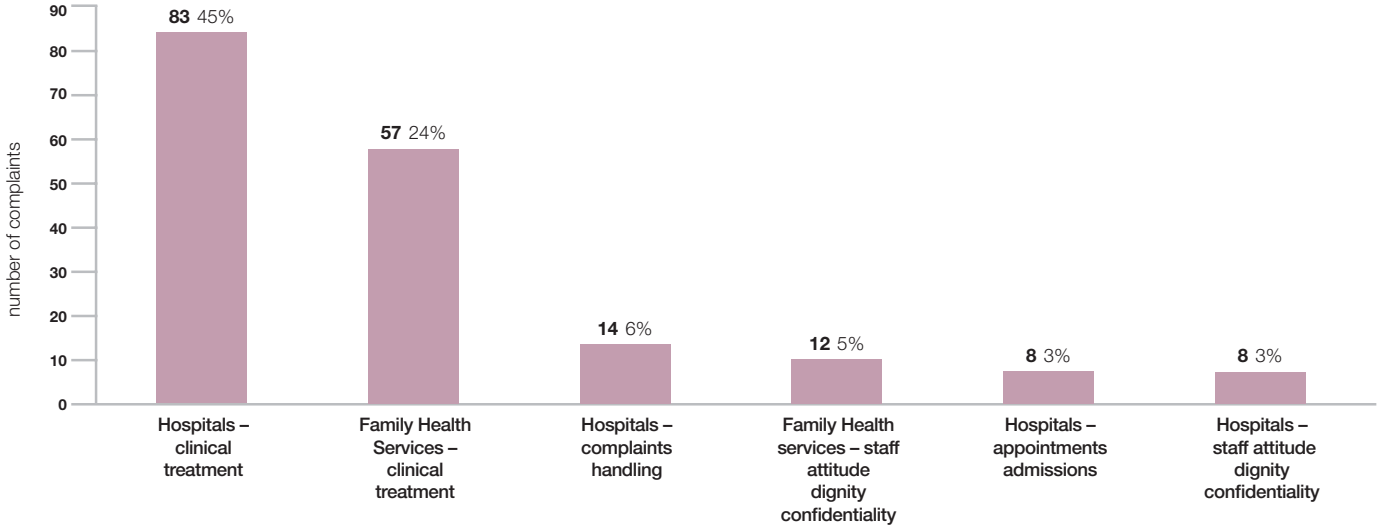
As part of their general responsibility of acting as 'the voice of patients' in their area, Local Health Councils have in the past provided support to people wishing to complain about NHS services. Local Health Councils ceased to exist on 31 March 2005 and although the new Scottish Health Council and its local offices will seek to ensure that information is systematically gathered about complaints it will not be their role to support individual complainants. The Scottish Executive have made it clear that NHS Boards should support individuals who have a concern about the quality of care provided to them and, where appropriate, provide assistance in understanding and using the NHS Complaints Procedure. At the time of writing it is not clear how those responsibilities will be met across Scotland. That lack of clarity is, in itself, a matter of concern. It would be still more worrying if there were gaps or inconsistencies in the assistance provided in different Board areas. We will monitor developments in this area.

Issues from cases coming to the Ombudsman

As *Figure 6* illustrates, the largest category of complaints about the NHS which the SPSO considered this year concerned clinical treatment in hospitals, followed by clinical treatment by family health service providers (GPs, dentists, pharmacists and opticians). The variety of issues covered by those broad categories, and also key recurring themes, are well illustrated by the four cases in which Investigation Reports were laid before the Scottish Parliament during the year. These are summarised below. The full Investigation Reports can be found on our website under the heading 'Cases & Reports' (www.scottishombudsman.org.uk).

It is a truism that most complaints are rooted in failures of communication – real or perceived. All of these cases illustrate that.

FIGURE 6 **'Top six' categories of health complaints**



Note: percentages relate to total number of complaints in this sector

In the first case (*Case 1*) an administrative failure meant that a vital piece of information was not communicated to the ophthalmologist – with potentially serious consequences. In the case of a young man with an ear condition (*Case 2*) the doctor who decided he needed an exploratory operation was not accurately informed about the length of the waiting list. Again, the failure in communication could have had serious consequences for the patient.

Learning lessons from complaints

Providing proper responses to individual complainants must be a key function of any complaints system. But it is equally important that lessons are spotted and acted on. Sometimes these will relate to an individual clinician's practice – as in the case involving 'GP 2' summarized above (*Case 4*). More commonly there are issues about systems and procedures which may have a much wider application.

Public bodies need to have systems in place to ensure that such issues are identified and addressed. In the NHS these systems must be integrated into clinical governance structures. Many NHS bodies have good systems in place but there is some way to go before all parts of the NHS are making the best possible use of the lessons to be learned from complaints.

Looking forward

The changes in the NHS complaints procedure mentioned earlier in this section took effect at the end of the period covered by this Annual Report. As expected, the changes have led to an increase in our caseload. A key challenge in the current year is to deal with that caseload efficiently and effectively.

To do so we will need to work professionally with complaints staff within the NHS. We have developed good working relationships with the NHS Complaints Association Scotland and will look to maintain and enhance those in the current year. Doing so does not compromise our independence or inhibit us from criticizing internal complaint handling if that is appropriate. But we see one of our roles as being to encourage good administration and complaint handling within bodies under our jurisdiction and working with organisations such as NHS Complaints Association Scotland helps to achieve that. Another key aim in the current year is to encourage greater learning from the cases we deal with. As has been mentioned earlier, later this year we will be moving to use the term investigation when we look further into all complaints that are under our jurisdiction. This will allow us to report on every such case and enable greater sharing of learning.

case studies

Case 1: **Delayed Diagnosis**

The complaint was that when a woman attended hospital with headache and vision problems doctors persisted with an incorrect diagnosis.

The woman had two serious medical conditions. Medical staff successfully treated her severe hypertension, but there was late diagnosis of a pituitary tumour. Ophthalmology staff took reasonable steps to identify the cause of vision problems, but a systems failure relating to clinic attendance contributed to a long delay before the patient sought treatment for her worsening eye condition which could have alerted staff to the existence of the pituitary tumour.

The Ombudsman recommended that the Health Board apologise for the distress caused in part by the administrative failure; and address the need to document patient records following a request that no further appointments be sent.

Case 2: **Delayed Treatment**

Parents complained that a delay in their son's treatment for an ear condition worsened his hearing loss. He attended a local hospital in August 2000, when he was 17 years old. As diagnosis was not possible, he was put on a waiting list for an exploratory operation. He was eventually invited to an outpatients clinic in February 2001. By then his condition could be diagnosised and an operation to treat it was performed in April 2001.

The Ombudsman found the exploratory operation should have been done within eight weeks. The patient was not given a priority marker because staff thought the waiting list was shorter than it actually was. The Ombudsman criticised the procedures, or lack of them, that allowed this to happen and recommended that the Health Board review practices. However, her clinical assessors advised that the delay was unlikely to have contributed to the young man's hearing loss.

Case 3: **Treatment of Hepatitis C**

This complaint was by a man who felt the explanations given to him about the lack of response to his enquiries about treatment were inadequate; and also that the alpha-interferon treatment he received was not followed according to the protocol indicated by a consultant.

The Ombudsman found that with regard to the main complaint the patient had received adequate explanations but that his alpha-interferon treatment was not monitored in accordance with the protocol. There had been significant changes to the system for interferon therapy since the events of this complaint which the Ombudsman was satisfied addressed the issues raised.

case studies

Case 4: **GPs' care of woman with kidney problems**

In November 2000 a woman underwent a test arranged by a GP (GP 1) which indicated a slight abnormality in kidney function. She was not followed up and did not see a GP again for about 20 months. A GP (GP 2) visited the woman at home on 17 July 2002, examined her and arranged for a blood sample to be taken the following day. The test results, which were grossly abnormal and indicated that the woman was in acute renal failure, were received by GP 2 the day after the sample was obtained. Before going on holiday on that day, GP 2 arranged for further blood tests to be taken in one week's time but did not make any arrangements to hand over the case to another GP. Four days later, on 23 July 2002, another home visit was requested and a third GP attended and arranged emergency admission to hospital for the patient. She died in hospital later that day.

Her son raised concerns with the Practice but was dissatisfied with the response from GP 2. He applied for his complaint to be considered by an independent review panel. A panel was held and recommended that new procedures should be introduced to ensure that appropriate hand-over protocols were in place and for the routine monitoring and reassessment of repeat prescriptions. The complainant considered these recommendations were acceptable but did not go far enough. He complained to the Ombudsman that the prescribing for and monitoring of his mother's condition between November 2000 and July 2002 was inadequate; and that GP 2's clinical management following the home visit in July 2002 was not of a reasonable standard.

The Ombudsman obtained advice from two clinical assessors who agreed that the prescribing for and monitoring of the woman's condition was inadequate. They also considered that GP 2's clinical management of the woman's condition was not appropriate; and that the patient should have been admitted to hospital following GP 2's home visit and that prompt hospital treatment might have prevented her sudden death. The Ombudsman upheld both aspects of the complaint. She welcomed the fact that the Practice had taken action to prevent a recurrence of shortcomings in prescribing and monitoring and that a computerised control system was introduced. But because she was concerned that GP 2 did not recognise that the management of the patient's condition was not appropriate she recommended that GP 2 should be dealt with under the arrangements for poorly performing doctors.

impartiality

accountability

reports from the deputies

Scottish Executive & agencies

Eric Drake & Carolyn Hirst

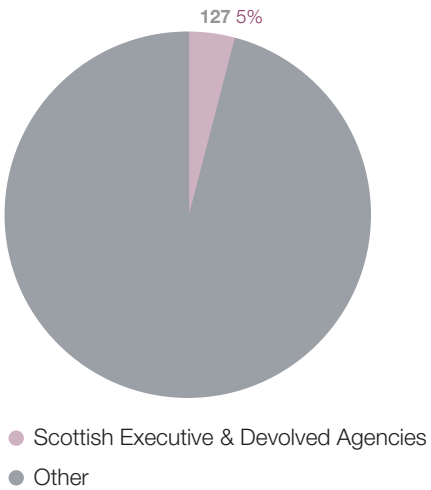
This heading covers a wide and varied group of bodies: the Scottish Executive itself; 'Scottish public authorities' listed in Part 2 of Schedule 2 to the Scottish Public Services Ombudsman Act 2002 as being within our jurisdiction (itself a diverse group – the 40 entries in Part 2 include Audit Scotland, 'any local enterprise company', the Scottish Arts Council and the Standards Commission for Scotland); 32 cross-border public authorities and eight categories of tribunals about whose administrative actions we can consider complaints.

As is explained below, the number of Scottish Executive and agency complaints we receive is relatively small. Many of the bodies under this heading have yet to be the subject of a complaint to us. Some may never be, given that they have very little direct dealing with individual members of the public.

We interact in different ways with a number of organisations in this category. The Scottish Executive is responsible for policies which can impact on all bodies within our jurisdiction while agencies such as Communities Scotland and the Care Commission have policy and regulatory responsibilities in specific sectors. It is important for us to keep abreast of policy developments which may affect our work and to make sure policy makers and others take account of relevant lessons to be drawn from our casework.

There are also agencies which have complaint handling responsibilities that can overlap with ours. Examples are the Scottish Information Commissioner and the Standards Commission for Scotland. It is particularly important, therefore, that we work in a joined-up way with such bodies.

FIGURE 7 **Scottish Executive & devolved agencies complaints & enquiries received**



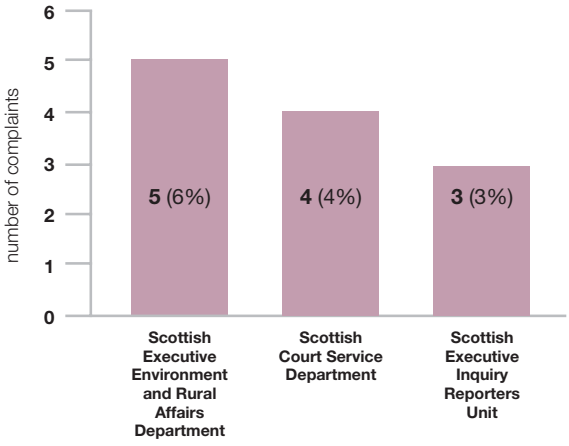
DEPUTY OMBUDSMEN CAROLYN HIRST AND ERIC DRAKE

Complaints about the Scottish Executive and agencies

Complaints and enquiries about the Scottish Executive and agencies together formed just over 5% of the cases received in 2004-2005 (*Figure 7*). At 127 the number is slightly lower than the 133 (7%) received last year, and includes two non-categorised enquiries. The total covers 12 enquiries and 29 complaints about the Scottish Executive and its departments – 1.7% of the total caseload. The 'top three' in terms of case numbers are illustrated below (*Figure 8*).

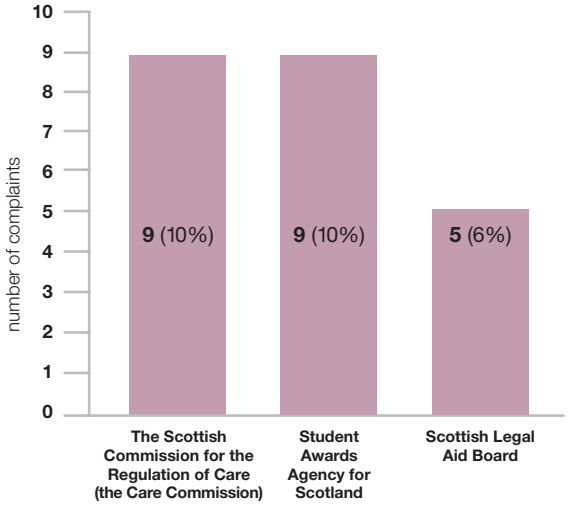
Complaints and enquiries about agencies account for 3.5% of the total received during 2004-2005, with 24 enquiries and 60 complaints. The 'top three' agencies in terms of case numbers (*Figure 9*) were the Scottish Commission for Regulation of Care (2 enquiries, 9 complaints), the Students Awards Agency for Scotland (2 enquiries, 9 complaints) and the Scottish Legal Aid Board (3 enquiries, 5 complaints).

FIGURE 8 **'Top three' categories of Scottish Executive department complaints**



Note: percentages relate to total number of complaints under this heading

FIGURE 9 **'Top three' categories of Scottish Executive agency complaints**



Note: percentages relate to total number of complaints under this heading

integrity

support

reports from the deputies
Scottish Executive and agencies

Most complaints about Scottish Executive departments and agencies are concerned with administrative actions and decision making. This is reflected in the top three categories of complaint during 2004-2005, which are policy/administration, the handling of applications and complaints handling (*Figure 10*).

FIGURE 10 **'Top three' categories of complaints and enquiries**

Category	Enquiry	Complaint	Total	% All Executive/ Agencies Cases
Policy/Administration	6	29	35	28%
Handling of Applications	3	22	25	20%
Complaints Handling	3	16	19	15%

Note: percentages relate to total number of complaints and enquiries under this heading

Complaints about the Scottish Executive and agencies are diverse, but are often characterised by complexity. There are frequently several strands to the complaint and the issues complained about may have been on-going for some time. As in other sectors, delay is a common cause of complaint and a significant number of cases (15%) are about the way in which the agency has dealt with a complaint.

Just one complaint about an agency was the subject of an investigation report during this year. This concerned how an agency with enforcement powers chose to exercise those powers. The full report of the investigation is available on our website (www.scottishombudsman.org.uk). The investigation pointed up lessons with application beyond the particular case and agency. In particular it highlighted the importance of written guidance for staff to ensure consistency in decision-making and the need to keep records of the basis and reasons for key decisions taken.

In *Box 1* we provide general advice for Executive Departments and agencies in handling complaints.

We see one of our roles as being to encourage good administration and complaint handling within bodies under our jurisdiction.

Box 1: **Advice on Handling Complaints & Enquiries**

- Be clear why information is being requested and how it will be used.
- Use face-to-face meetings and telephone calls to discuss complex issues, clarify understanding and agree future actions, rather than lengthy correspondence that often further confuses the issues.
- Have clear and up-to date guidance on how policies and procedures should be implemented and make sure that staff have relevant and current training on implementation.
- Keep full and accurate records about the basis on which decisions are made in order to ensure accountability and consistency.
- Be clear about time-scales for action and don't let things run on. Most complaints to the Ombudsman refer to delays.

Other interaction with the Scottish Executive and agencies

Scottish Executive

While the Scottish Executive is under our jurisdiction, we maintain contact with the Constitutional Policy Unit who sponsored the Scottish Public Services Ombudsman Act. This is helpful when questions arise about the policy intention behind the legislation. They also have a role in scrutinising proposed legislation to ensure that mention is made of the SPSO as appropriate and that any necessary consequential changes are made to the SPSO Act. It is also a suitable forum in which to raise the issue of potential revisions, as indicated by the Ombudsman in her Overview of the Year.

During the year we have had dealings with other parts of the Scottish Executive on a variety of issues, including a meeting with the Health Minister to provide feedback on lessons from complaints. Our involvement in reviews of complaint handling in the NHS and in social work is mentioned elsewhere in this report. We have also been involved in discussions about the Scottish Executive's own complaints procedures and have briefed staff in a number of Executive departments about the work of the Ombudsman. In addition, in anticipation of Further and Higher Education institutions coming within the Ombudsman's jurisdiction, we have had helpful discussions with Scottish Executive staff about the implications of these planned changes. We were also pleased to brief those considering new arrangements for handling complaints about the Police on the experience and the lessons from the work of our office.

Agencies

As noted already, several agencies in Scotland have a regulatory function and may also investigate complaints. As such, they have some overlap with the work of the SPSO. As was mentioned in last year's Annual Report, we have worked with a number of agencies to produce a Route Map that helps to explain the different routes to make complaints both in Scotland and the UK (see our website: www.scottishombudsman.org.uk).

More specifically, in order to simplify and clarify our respective roles, the SPSO intends to develop Memoranda of Understanding with key agencies. Memoranda[3] have already been signed with:

- **The Mental Welfare Commission for Scotland**
- **NHS Quality Improvement Scheme**
- **The Standards Commission for Scotland**

A specific area of interaction during the year has been with Highland and Islands Enterprise and local enterprise companies in their area to enhance their awareness of the Ombudsman and our understanding of their role and working practices. This has been particularly useful because the enterprise bodies first came within the Ombudsman's remit with the passing of the legislation setting up our office in 2002.

Looking forward

We are currently developing Memoranda with Audit Scotland, the Care Commission, Communities Scotland and the Scottish Information Commissioner. The Memorandum with Communities Scotland is intended to maintain and enhance the positive working relationship built during the days of the former Housing Association Ombudsman for Scotland.

A current frustration is the limit that our legislation places on the extent to which we can share both good and poor practice with the relevant regulators. Our change to reporting practice will allow greater openness, accountability and sharing of the learning.

[3] *Agreed Memoranda of Understanding are accessible through our Publication Scheme under the Freedom of Information (Scotland) Act – see "Freedom of Information" on our website www.scottishombudsman.org.uk.*

reports from the deputies

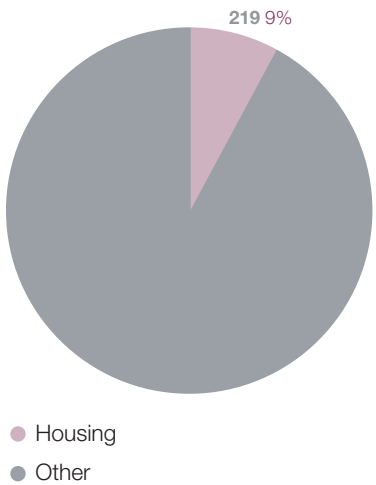
Housing Sector

Carolyn Hirst

Registered Social Landlords

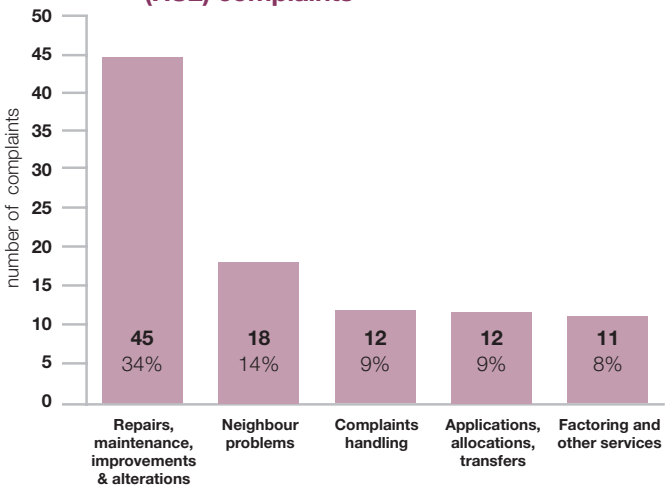
Complaints and enquiries about Registered Social Landlords account for 9.2% of the total received during 2004-2005 (131 complaints and 88 enquiries – *Figure 11*). This is an increase from the 97 cases (5.4% of caseload) received during 2003-2004. The increase can be explained in part by our first full year of recording all enquiries and by the higher number of properties in the Registered Social Landlord sector as a result of large scale stock transfers.

FIGURE 11 **RSL Housing complaints & enquiries received**



When considering complaints and enquiries together, the top categories for Registered Social Landlords during 2004-2005 are repairs, anti-social behaviour, complaints handling, applications and allocations and factoring (*Figure 12*). No investigative reports on housing complaints were laid before the Parliament during the year.

FIGURE 12 **'Top five' categories of housing (RSL) complaints**



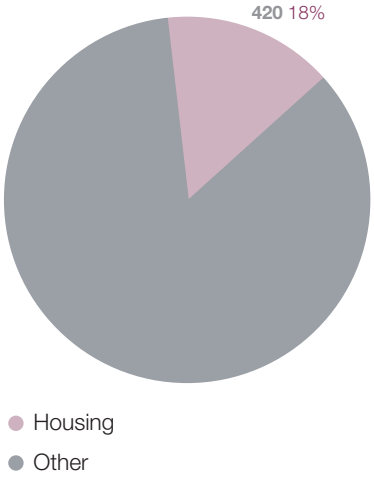
Note: percentages relate to total number of complaints under this heading

DEPUTY OMBUDSMAN CAROLYN HIRST

Local Authorities – housing cases

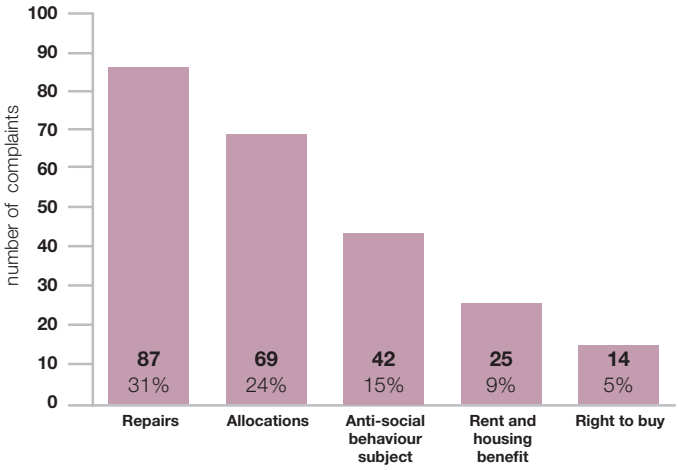
Complaints and enquiries about housing functions of Local Authorities account for 17.7% of the total complaints received by the SPSO during 2004-2005, with 136 enquiries and 284 complaints (*Figure 13*). Housing related issues account for 29% (420) of all cases received about Local Authorities.

FIGURE 13 **Local Authority housing complaints & enquiries received**



When considering complaints and enquiries together, the top three categories of complaint about the housing related functions of Local Authorities during 2004-2005 are repairs, then allocations and anti-social behaviour (*Figure 14*).

FIGURE 14 **'Top five' categories of Local Authority housing complaints**



Note: percentages relate to total number of complaints under this heading

Most housing complaints relate to service delivery and are not complex, although they often contain more than one issue. As the case studies illustrate, the subject of a complaint can vary from a delay in repair work to the funding of applications.

responsibility

clarity

reports from the deputies
Housing Sector

Case 5: **Funding Adaptations**

The complainant was aggrieved by a local authority's handling of her application for funding to assist with the adaptation of her house to meet her husband's medical needs. She complained that there had been undue delay in dealing with the matter.

Sadly, the complainant's husband died during our examination of the case. As he had died the application for funding could not be met. However the authority accepted that there had been delay on their part during the processing of the application, and they agreed to offer the complainant an apology for this; and to make her an appropriate financial payment for the trouble to which she had been put as a consequence of the authority's shortcoming.

They also confirmed that, as a consequence of the delay highlighted by the case, they had instructed a 'Best Value' service review of aids and adaptations which would look at the issues of service delivery across the authority and the interface between local authority departments and external agencies.

Case 6: **Delayed Repair Work**

The complainant transferred to a ground floor flat. The local authority indicated at the time of her acceptance of the tenancy that a number of minor repairs had been identified, which could be carried out after she took entry. There was a nine month delay in carrying out the repairs. Then the complainant was only given 1 hour's notice before repair work started, which did not give her sufficient time to protect her belongings. It became apparent that the repair work was more extensive than anticipated. The complainant was moved to a decant house, but only after she had experienced considerable inconvenience.

The local authority recognised and accepted shortcomings in its handling of the matter, in particular, an unacceptable delay in completing the repair work and a failure to provide a satisfactory service. There was a breakdown in communication between the contractor and the Local Housing Office. The local authority agreed to waive the rent charges and council tax for the period that the complainant had been decanted, to compensate her for damage to her belongings and to make her a 'time and trouble' payment of £500. The local authority also restructured the Housing Management service to improve co-ordination and communication.

Case 7: **Central Heating**

A complaint was made about the cost of running a new electric central heating system in a council house. The complainant claimed that he did not receive proper instructions on how to run the new system and that his bill for the first three months was £500. He alleged that the Council had told him that the central heating would only cost him £35 per month to run.

The local authority agreed that there had been problems with the installation of the heating systems, which resulted in them using more electricity to produce heat. They agreed to reimburse the complainant's additional heating bills and also made a goodwill payment of £100. The local authority also agreed to keep the complainant informed on progress on remedying the problem.

Case 8: **Premature Action**

A distressed tenant contacted our office with a complaint about a number of unresolved repairs that she considered could result in harm to her children. She had reported the repairs to her Housing Association landlord, but had not made a complaint. The Complaints Investigator was concerned about the well-being of the tenant and agreed to contact the landlord to find out what was happening.

The Housing Association confirmed that they already knew about the repairs and that a Repairs Inspector had visited the tenant the day before and considered the repairs to be non-urgent. However, he had reported back that the tenant appeared to be unwell. The Association advised that they would contact the complainant that day to let her know when the repairs would be done and would also arrange for a Housing Officer to carry out a home visit. By the time our Complaints Investigator phoned the complainant later in the day to let her know what was happening, the Housing Association had already been in touch.

Case 9: **Provision of Carpets**

An organisation that provides support to people with mental health problems made a complaint on behalf of a client. The client had been allocated a local authority property and the local authority had agreed that the carpets belonging to the previous tenant would remain in the property. The client made arrangements to move into his new home, but found that there were no carpets in the property when he came to move in.

The local authority apologised for the inconvenience caused as a result of an internal misunderstanding and agreed to compensate the new tenant with vouchers towards the cost of new carpets.

A common subject for repairs complaints is poor communication, both between landlord and tenant and, on occasion, between different parts of the landlord organisation. It is important that landlords provide tenants with clear and easily understandable written information, particularly during times of change and when introducing new systems. Wherever possible, it is recommended that a verbal agreement should be followed up in writing to avoid misunderstandings (or at least, to sort them out at an earlier stage).

Combined Registered Social Landlord and Local Authority complaints about allocations are fifth in the total number of cases received by the SPSO during 2004-2005 (*Figure 3*).

The SPSO is likely to determine that maladministration has taken place if a listed authority fails to do something when a policy document says that it will do it. However, a landlord must take care not to be inflexible in its approach, for example by having a blanket policy that does not consider individual needs because these needs do not fit neatly into a pre-determined category.

justice

accessibility

reports from the deputies
Housing Sector

Case 10: **Inflexible Approach**

A complaint was made that a local authority had failed to rehouse an applicant, despite severe overcrowding in their current home. One of the children in the household was autistic and had been assessed as needing a quiet place in the home. However, medical priority could not be awarded in this case, as the rehousing policy only took account of physical disability. As this was a premature complaint, our Complaints Investigator advised the complainant to contact the local authority to arrange an appointment to discuss her housing application, with a view to making a complaint if she remained dissatisfied after this approach. However, the complainant phoned again to say that she had contacted the authority, but had been distressed with how her approach had been received.

The Complaints Investigator exercised discretion in taking the complaint and made initial enquiries to the Council, receiving a very positive response from the Service Manager. The Manager proposed contacting the complainant to discuss the possibility of obtaining medical reports so that additional priority could be awarded under the category of 'special needs'. The Service Manager also advised that she would look into the complaint of poor treatment when the complainant had contacted the listed authority and would ensure that all staff had proper training in the areas of concern highlighted. When this response was communicated to the complainant, she advised that she was satisfied with the action proposed and decided not to pursue her complaint.

A notable development in both repairs and allocations complaints is an increasing incidence of the landlord using a third party to carry out its functions. Examples include private repairs contractors and Common Housing Registers. In most situations, it is the responsibility of the landlord to ensure that a good service is provided by their contractor and there is often the need for more clarity about which party is responsible for handling complaints.

Spotlight on Anti-Social Behaviour

Anti-social behaviour is a hot topic and the sixth highest reason for complaints to the SPSO in 2004-2005 (*Figure 3*). Recent national and local government initiatives have highlighted concerns about anti-social behaviour and increased the tools that Registered Social Landlords and Local Authorities can use to prevent and manage the problem. There has been a corresponding increase in public expectations that landlords will now deal effectively with reported anti-social behaviour. However, common factors in complaints about anti-social behaviour that come to us include unrealistic expectations by the complainant, a lack of understanding about what the landlord is able to do and administrative failures in actions taken by the landlord.

In *Box 2* we offer lessons that can be learned in handling complaints about anti-social behaviour.

Box 2: Advice on Handling Complaints about Anti-Social Behaviour

- Be careful not to raise expectations unduly. Tenancy agreements may contain strong statements about action that you will take in response to anti-social behaviour, which you may not be prepared to take in reality.
- Be seen to be doing something quickly about the complaint. Recognise the importance of early intervention.
- Be clear what you can and cannot do. Explain the role of other departments and agencies, such as Environmental Health and the Police in tackling noise nuisance complaints.
- Be clear about the purpose of diary sheets for recording anti-social behaviour and only use them for a set period.
- Be clear about time-scales for action and don't let things run on. Most complaints to the Ombudsman refer to delays in response by the landlord.
- Be clear when you have found no evidence of anti-social behaviour and cannot do anything more about the complaint.
- Recognise when a complaint about anti-social behaviour turns into a complaint about how you are dealing with the complaint.

Complaints Handling

Relatively few Registered Social Landlord cases are about the way in which a complaint has been handled. This can be attributed in part to the requirement on social landlords in the Housing [Scotland) Act 2001 (Section 23(6)] that 'the landlord under a Scottish secure tenancy must provide the tenant with information about its complaints procedure'. It may also be the result of a good practice guide for Registered Social Landlords currently published by the Scottish Federation of Housing Associations in the document 'Raising Standards'.

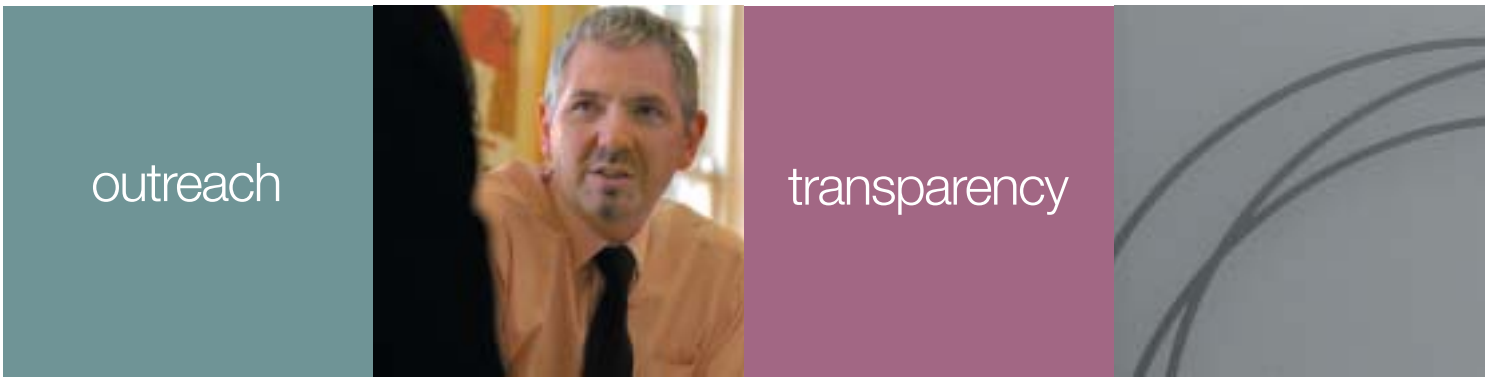
Outreach

Our outreach work this year in relation to housing has concentrated on bodies regulating and representing the sector. We meet regularly with Communities Scotland and have had initial meetings with the Chartered Institute of Housing Scotland and the Scottish Federation of Housing Associations. The aim of these meetings has been to update each other on current issues, concerns and trends, and to ensure that the SPSO is providing information, advice and assistance to complainants and housing providers that is both relevant and useful.

Looking forward

Our work this year has identified a concern relating to 'premature' complaints relating to housing as well as other subject areas. These are complaints that have been brought to our office too early. A requirement of our legislation is that the listed authority complained about is given the opportunity, wherever reasonable, to deal with a complaint before it comes to the SPSO. We let complainants know when we consider their complaint to be premature and invite them to come back to us if they are dissatisfied after the authority has dealt with the complaint. However, our concern is that very few complainants return to the SPSO. It may be that their complaint has been resolved by the authority, but our intention next year is to actively follow up premature complaints in order to find out what has happened.

A further piece of work for next year is to formalise our actions relating to compliance. Where we have recommended that a listed authority take action to put things right, we will be more active in following up to ensure that the action has taken place. By doing this, the SPSO will be better able to demonstrate its effectiveness in obtaining redress. Compliance is particularly important in housing complaints, where the complainant is likely to have an on-going relationship with the landlord.



reports from the deputies

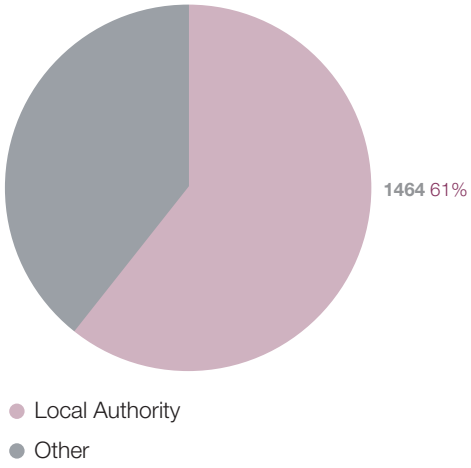
Local Government Sector

Lewis Shand Smith

Local government has an impact on each one of us every day of our lives. Local authorities, directly or indirectly, provide essential services to us from the cradle to the grave. They employ the Registrar who records our coming into the world and look after the graveyards that may be our last resting place. They have responsibility for education, housing, roads, the environment, for police and fire services, waste management, planning, social work, care of the elderly and so on. Councils also have the power to raise and collect taxes. Further, they have a duty to initiate, facilitate and maintain the community planning process, and they have wide powers to enable them to advance the well-being of their communities. Through the Joint Future Agenda they participate in joint working with health and housing to provide for the care needs of individuals and communities. Given their key role in the delivery of public services it is perhaps unsurprising that complaints about local authorities accounted for over sixty per cent of complaints to the Ombudsman in 2004-2005.

In 2004-2005 the SPSO received 1464 complaints and enquiries about local authorities, 61% of the overall total received throughout the year (*Figure 15*). As is the case in most other areas this is very small

FIGURE 15 **Local Authority complaints & enquiries received**



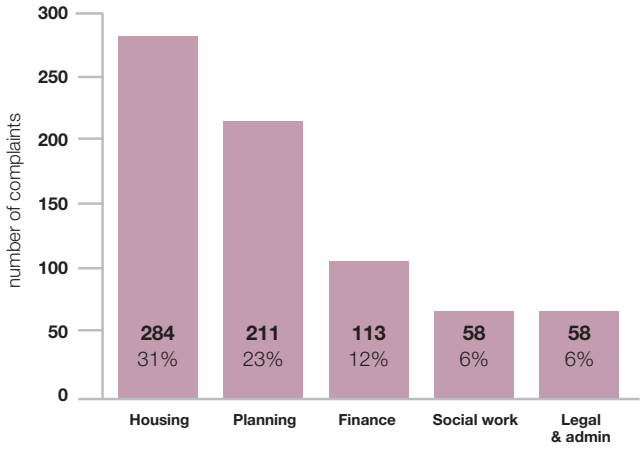
when compared to the extent of council operations. It may be that most people are satisfied by the service they receive most of the time. When they do raise an official complaint it is more than likely that this will be dealt with quickly and effectively by the council concerned. Of course things can go wrong, and sometimes the council does not sort it out to the satisfaction of the complainant and that is when they can come to the Ombudsman.

DEPUTY OMBUDSMAN LEWIS SHAND SMITH

Cases

As *Figure 16* illustrates, of the cases brought to the SPSO, the largest single group was to do with housing, with 284 complaints. These are dealt with in more detail in the section on Housing. The next largest group was about planning, with 211 cases.

FIGURE 16 **'Top five' categories of Local Authority complaints**



Note: percentages relate to total number of complaints in this sector

Reports on three local authority cases were laid before the Scottish Parliament during the year. All of these were planning complaints. In two cases the complaint was upheld and in the third it was partially upheld.

In the first case (*Case 11*) the payment recommended represented a percentage of the complainant's costs (as well as a sum in recognition of time and trouble), because we took the view that the complainant and his agents should have been prepared to undertake greater preliminary research.

We were concerned that the Council was intending to restrict the range of pre-application enquiries to which they will respond. Discussion with a planning department is one of the ways someone intending to apply for planning permission learns what is expected in terms of local plans and council policy. As councils struggle to resource planning departments it is tempting to withdraw this service. We would caution against doing so. Sound advice and clarification at this informal stage will lead to smoother consideration of the formal application when it is submitted. We regard it as best practice and a key part of the planning process.

Sound advice and clarification at an informal stage will lead to smoother consideration of the formal application when it is submitted.

consistency

effectiveness

reports from the deputies
Local Government

Case 11: **Pre-application Advice**

This complaint concerned the Council's handling of a pre-application enquiry from the complainant's architect, in which he sought specific information on relevant Local Plan issues. The complaint made was that salient information was omitted in a written response from the Council to the enquiry and that the complainant incurred substantial abortive costs.

The complaint was upheld. However, it was not considered that the remedy should extend to full reimbursement of the design costs and associated fees.

It was recommended that, in addition to an apology already given, the Council should make a payment of £2,500 to the complainant. It was recommended also that the Council should review their recently introduced policy of restricting the range of pre-application enquiries to which they will respond.

Case 12: **Pre-application Advice**

The Council's response to an enquiry from the complainants' architectural agents failed to disclose a condition attached to an amended planning consent of twenty years earlier. The response was that the proposals to extend a terraced house were permitted development and planning consent was not required. When worked started, a neighbour objected and an enforcement officer who visited requested the submission of a planning application. When the application was considered at Committee retrospective consent was refused along with the following appeals and the complainants were required to demolish the extension.

The complaint was upheld. It was considered that, given the response to their agents' letter and having obtained a building warrant, the complainants were entitled to proceed. The costs would not have been incurred had the complainants been advised at the outset that they required prior written approval of their proposal.

It was recommended that the Council apologise to the complainants, meet the substantial costs they incurred in constructing and demolishing the extension, all the fees paid and additional financial redress of £2,000 in recognition of their time and trouble in submitting a complaint and the stress they had experienced.

Case 13: **Mandatory Aspects of the Planning Process**

The complaint related to the Council's handling of representations about unauthorised timber decking erected by the complainant's neighbours. The investigation established what was mandatory or a matter of discretion in the planning process.

Two aspects of the complaint were upheld: that the Council failed to advise the complainant that she could apply to speak at the Committee meeting when the decision on the planning application was being considered; and there was a failure to record fully the reasons for the decision reached at that meeting. Taken as a whole the circumstances of the case did not represent good practice and the planning system failed the complainant.

It was recommended that the Council should make an unreserved apology to the complainant for the failings identified and further redress in the sum of £2,500 in recognition of her time and trouble in pursuing the complaint. It was recommended also that the Council should review the content of their standard letter and specify the circumstances where an objector may have the opportunity to be heard at a meeting of the Committee.

The second case also concerned a pre-application enquiry (*Case 12*). The third case related to mandatory aspects of the planning process (*Case 13)*.

Planning decisions are made either by officials with delegated authority to act within council policy, or by council members in a planning committee. If there is a departure from policy the reasons for doing so must be clearly stated. In this case (*Case 13*) it was not and so we found that there had been maladministration. We can also look behind a decision to discern whether the information given to councillors was sufficient and accurate.

The Scottish Public Services Ombudsman Act (2002) states that:

'The Ombudsman is not entitled to question the merits of a decision taken without maladministration by or on behalf of a listed authority in the exercise of a discretion vested in that authority'

This does not mean that the Ombudsman cannot look at discretionary decisions. If there is an allegation of injustice or hardship resulting from maladministration or service failure in reaching that decision then we can investigate. If we find no evidence of either then we cannot query the decision.

After a period of consultation, planning law is about to change. New responsibilities will be given to councils, for example neighbour notification, and the procedure for dealing with planning applications will be amended. We will continue to participate in the consultation exercise by providing lessons learned from the complaints we have received.

As discussed by the Ombudsman in her Overview, we have been restricted in the way we have been able to report on the cases we have examined during the year. This will change in the current year.

All complaints that are accepted as within jurisdiction will be defined as investigations and this will allow us to report more fully in the future. Councils will therefore see the number of investigations rise, but reports will cover details of decisions where the complaint has not been upheld or where resolution has been achieved during the investigative process. This will enable us to share what has been learned from complaints received as well as examples of best practice.

'Model' complaints process

Of the thirty-two local authorities in Scotland, each has its own way of handling complaints. That can lead to confusion. Also some complaints processes are excellent while others need to be improved. We are encouraging council chief officials and COSLA to consider producing a single 'model' complaints process that can be adopted and adapted by each council. An effective internal complaints system needs to be:

Easy to Access

Fair

Flexible

Ensure confidentiality

Clear and

Timely

Integrated with other systems to provide

Valuable feedback and

Engender trust from service users and staff

accountability

justice

reports from the deputies
Local Government

An additional complication is that local authorities have to take a different route when they receive a complaint about services received from social work. This direction was introduced by the Secretary of State for Scotland at a time when only a few councils had complaints procedures, and it mirrored the NHS complaints process of the time. There have been many changes since then, including those to the NHS process itself. It is no longer so easy to define social work as a discrete element of local authority services. For example provision of care for the young, the elderly or the vulnerable can cut across what in the past would have been supplied by a number of separate council departments, such as education, leisure and recreation, social work and housing.

The Joint Future Agenda means that the care provided to an individual may not come solely from a council's own resources, but is increasingly likely to be a package that could involve a number of other bodies including the NHS, housing associations and the private sector.

The goal of inter-departmental and cross-sector working is to supply the best possible support to an individual in the most efficient and effective manner. When that person believes something has gone wrong, he or she should have any complaint addressed in a quick and simple way. At present they could be faced with several complaints processes, including the possibility of two within the council alone. It is important to find ways of dealing with such grievances so that the complainant does not face an unfathomable maze and has a straightforward route to speedy resolution; preferably one way in and one person dealing with the complaint on behalf of all the sectors involved. It is essential that such a person has the co-operation of all the agencies, including access to records and officers. This can be achieved locally through Memoranda of Understanding and we recommend that these be agreed wherever possible.

I am involved with a Scottish Executive Committee looking at social work complaints procedures. The group includes representatives of local authorities, the NHS and the Care Commission. We are considering whether the social work directions and guidance should be changed to bring them into line with the new NHS complaints procedure, whether it is now time for councils to have a single complaints system that will cover all the services for which they have responsibility, and ways in which a complaint against a number of providers can best be handled to minimise any stress caused to the complainant and so that lessons learned can be applied across the board.

Outreach

As part of our outreach work with local authorities we have re-established links with council liaison officers and held three workshops for them in our office. This gave us the opportunity to tell them more about SPSO and the services we can provide to both complainants and listed authorities. We were able to discuss a number of issues and representatives from the councils had a forum in which to share experiences, best practice and developments. The feedback we have had from these events is positive, and we have agreed that they should be repeated annually. We value the links we have with liaison officers and the role they play in facilitating responses to our enquiries. Equally important is the way in which they ensure officers throughout the councils know about the SPSO and our procedures.

Looking forward

Together with the Ombudsman I will be visiting each council during 2005 to meet with the Chief Executive and the Leader. The purpose is to make and maintain links, to give information, to learn more about the issues the council is facing and to discuss matters arising from particular complaints we have received against the council. Councils face a number of inspection and regulation regimes. We welcome moves to consider and map these regimes with a view to streamlining them and reducing duplication.

We also welcome the establishment of the Improvement Service and look forward to working with it. We will be working more closely too with COSLA and SOLACE in our move towards establishing a single complaints process.

We shall also be considering the implications of the e-government policy for our office and finding ways in which we can conduct more of our business with authorities and complainants electronically.

fairness

support

the year ahead
Alice Brown

As discussed in this report the SPSO will be pursuing a range of new activities during the year ahead as well as the extension of our remit to include Further and Higher Education. The consultation on the provision of an independent reviewer for Further and Higher Education institutions continued throughout this year, culminating in the Scottish Further and Higher Education Act 2005. The result is that these institutions, funded by the new Scottish Further and Higher Education Funding Council, will become listed bodies subject to the Scottish Public Services Ombudsman Act 2002. This will bring an additional 77 bodies under our jurisdiction. In preparation for this change we have been working with the colleges and universities and their representative bodies as well as the National Union of Students and the Coalition of Higher Education Students in Scotland. We look forward to taking forward this work and establishing the new scheme.

Another important area of work will be to develop our approach to equality, diversity and human rights issues, especially in relation to older people and black and minority ethnic communities. We will explore these issues with relevance to our work, identifying under-represented complainants and implementing actions to increase the awareness of under-represented groups about the functions of the SPSO.

A further key aim will be to implement our Business Plan for 2005-2006 around the areas of Development, Service, People and Assurance (*Box 3*).

The Business Plan will be delivered within the context of the SPSO's Strategic Objectives for 2005-2007 (*Box 4*).

These objectives are challenging – we believe that they are essential components of the high-quality service we are committed to delivering to the people of Scotland.

the year ahead
Alice Brown

Box 3: The SPSO Business Plan 2005 – 2006

Development

To manage the changes in the NHS complaints procedure

To successfully take responsibility for HE/FE complaints

To clarify 'grey areas' of jurisdiction

To ensure SPSO influence over policy and legislative changes

To build a more effective outreach capacity

To increase co-operation with other Ombudsman offices

To take a leading role in the development of good public administration and 'administrative justice'

Service

To promote and measure public awareness of the SPSO

To raise awareness among under-represented groups

To review how best to serve all sections of Scottish society

To create a culture of continuous service improvement

To review and improve how we communicate our findings

To review how we currently manage premature cases

People

To better plan and measure resource utilisation

To establish a performance culture based on assessment against objectives and competencies

To develop our leadership skills and management capability

To better leverage our collective knowledge and expertise

To develop a comprehensive workforce plan

To attract, develop, retain and reward a staff team that can deliver the objectives of the SPSO

Assurance

To implement and maintain a proper management information system

To demonstrate value for money for the public purse

To set transparent targets for dealing with complaints work

To develop measures to assure quality and consistency

To implement the internal scheme of control

To ensure that delegated authorities are clear

Box 4: Strategic Objectives 2005 – 2007

8 challenges:

1 centre of excellence

2 service targets

3 process development

4 pro-active advisory service

5 real strategic influence

6 people development

7 excellence in functional performance

8 the 21st century office

If you have any comments on this Annual Report and any suggestions for inclusion in our next report, please do not hesitate to contact us.

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