HEALTH COMMITTEE

Tuesday 30 November 2004

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

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HEALTH COMMITTEE
28th Meeting 2004, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Rhona Brankin (Deputy Minister for Health and Community Care)

THE FOLLOWING GAVE EVIDENCE:

Professor Alice Brown (Scottish Public Services Ombudsman)
Eric Drake (Scottish Public Services Ombudsman)
Chester Woods (Food Standards Agency Scotland)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 6

Scottish Parliament

Health Committee

Tuesday 30 November 2004

[THE CONVENER *opened the meeting at 14:00*]

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No 2) (Scotland) Order 2004 (SSI 2004/500)

The Convener (Roseanna Cunningham): Item 1 is subordinate legislation. The committee is asked to consider the affirmative order, the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No 2) (Scotland) Order 2004 (SS1 2004/500). I welcome to the meeting the Deputy Minister for Health and Community Care and Chester Woods from the Food Standards Agency Scotland. The Subordinate Legislation Committee considered the instrument at its meeting this morning and made no comment on it.

The Deputy Minister for Health and Community Care (Rhona Brankin): I intended only to move motion S2M-2074. I do not know whether anyone wants to ask questions.

The Convener: That is almost certain. I am sure that David Davidson seeks clarification on aspects of the order.

Mr David Davidson (North East Scotland) (Con): It is kind of you to acknowledge that, convener. I want to ask the minister a couple of questions that I think are relevant to what is going on. First, from which agencies, individuals and organisations have she and the Executive taken advice in the formulation of the new and welcome policy to move to end-product testing? Secondly, what discussions has the minister had—or what discussions will she have—with the industry?

Rhona Brankin: I am happy to ask Ms Woods to answer those questions. As you know, the move to end-product testing is a result of European Union legislation. I will ask Ms Woods to answer your question about contact with the industry, because there have been recent meetings.

Chester Woods (Food Standards Agency Scotland): As recently as this morning we had meetings with representatives of the Scallop Association and Mallaig and North West Fishermen's Association. As far as the entire shellfish communities goes, we have also had close liaison with the Association of Scottish Shellfish Growers and other industry bodies.

Mr Davidson: I have not had an answer about from where you are taking technical advice. Will there be further meetings with the industry?

Chester Woods: Yes. As far as end-product testing is concerned, we will take technical advice from the Fisheries Research Services marine laboratory in Aberdeen.

The Convener: Given that no member wishes to debate the instrument, I invite the minister to move motion S2M-2074.

Rhona Brankin: I move,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No.2) (Scotland) Order 2004 (SSI 2004/500) be approved.

The Convener: The question is, that motion S2M-2074 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 5, Against 1, Abstentions 0.

Motion agreed to.

The Convener: I thank the minister for coming.

Items in Private

14:03

The Convener: Item 2 is to consider whether to take items in private. I ask the committee to consider whether items 4 and 5 should be taken in private for a number of reasons. Item 4 relates to ministerial correspondence. The committee is to consider alternative proposals for action in response to correspondence received from the Minister for Health and Community Care. Item 5 is consideration of our draft report on our workforce planning inquiry. We are asked to consider taking in private consideration of the draft report at subsequent meetings.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I am pleased to see that agenda item 3 is in public. That is a good compromise between taking items in public and in private.

The Convener: Does anyone want to say anything against the recommendation that items 4 and 5 be taken in private?

Members: No.

The Convener: I will then take it as agreed that both those items will be taken in private and that future consideration of the workforce planning inquiry draft report will also be in private.

Scottish Public Services Ombudsman

14:05

The Convener: Agenda item 3 is a briefing from the Scottish public services ombudsman. I welcome Professor Alice Brown to the committee. I also welcome Eric Drake, the deputy public services ombudsman. The session was originally going to be informal but we asked Professor Brown if she would agree to go on the record and she kindly did so.

Members will be aware that the decision to invite Professor Brown and her colleague arose from the committee's consideration of petition PE537 from Alexander Mitchell. That petition raised several issues relating to procedures for pursuing mental health complaints under the former mental welfare commission and subsequently under the Scottish public services ombudsman.

We are grateful to Alexander Mitchell for bringing his concerns to the committee. We concluded consideration of the petition and, before Professor Brown begins her brief, I remind members that although the ombudsman is able to provide information about the new complaints procedures, she is unable to comment on specific cases. Members should therefore not raise specific cases with her.

Professor Alice Brown (Scottish Public Services Ombudsman): Eric Drake and I welcome the opportunity to speak to the committee today. We offered to do so because I thought that it would be helpful if we were able to explain the processes, and if we were able to get feedback from the members about other things that they think that we might want to do. I see this as the beginning of a continuing dialogue between my office and the committee and, indeed, other committees in the Scottish Parliament. We want to play a constructive role in contributing to the work of the Scottish Parliament because our brief covers a range of areas that reflect some of the committees' work. We have already given a presentation to the committee clerks. The head of clerking has also given a presentation to our staff, so there is a two-way understanding of our different roles.

We also thought that this would be a good opportunity to tell the committee about some of the roadshow events that we completed in September and October. We visited all 15 health regions in Scotland to raise people's awareness of our role and, crucially, to discuss some of the imminent changes to the internal processes for dealing with complaints in the health sector and our role in that.

We have quite a lot of slides to show you. Members have a copy of our presentation, which we intend to go through fairly quickly, but you will have the papers for future reference. We are happy to answer questions as we go through the briefing as well as at the end.

First, I should introduce Eric Drake in a little more detail. He is one of the deputy ombudsmen. We cover several different areas of policy but Eric has particular experience of health, and of parliamentary procedures; he worked in the Millbank office of the ombudsman before becoming the manager of complaints for the Scottish end of that office in Edinburgh. He has also been on secondment to the Irish ombudsman's office so he has spent some time in Dublin. It is useful to have such a range of expertise. Eric is going to be my lovely assistant for this afternoon and he will press some of the buttons for the slide show so that we can divide the presentation between us.

I will start with a brief introduction because the first question that we get asked whenever we do anything is, "What is an ombudsman?" There is a simple answer to that; the definition in "The Chambers Dictionary" is:

"an official who is appointed to investigate complaints".

Indeed, that is what my staff and I do with complaints about the delivery of public services in Scotland.

The next slide says a little bit about the British and Irish Ombudsman Association. I know that the committee has previously discussed that organisation. The Scottish public services ombudsman is a member of the association, as are our counterparts in England, Wales, Northern Ireland and beyond. It allows ombudsmen to come together to discuss areas of policy and best practice. One of the first things that the office in Scotland did in the spring, just after we were appointed, was to give a presentation to the association's conference on Scotland's aspirations to develop a one-stop shop for handling complaints. The association very much looks to Scotland as leading the way in some matters. We contribute a lot to its discussions and, indeed, learn from it. We meet on various occasions and our staff are involved in subgroups in which we talk about complaint-handling processes and key principles. We have been able to feed into that discussion. One of the packs that we will leave for members is from our roadshow events and contains the key principles of good complaint handling that we drew up and are sharing with our colleagues in other parts of the United Kingdom and beyond.

The first key principle and the foundation for what ombudsmen do is the independence of the ombudsman from those whom the ombudsman has the power to investigate. That is an important principle. Members of the public should be able to bring complaints to us knowing that we are an independent voice and have an independent way of looking at things.

Obviously, we want effectiveness and to add value to the system. Fairness is another key principle. We must be seen to be fair to both sides. We are not on anyone's side. We will hear a complaint, but we will also ask the body that is complained about for its perspective. There is also our public accountability. We are concerned about considering ways in which we can be more accountable, and this evidence is part of that process.

It is worth reminding colleagues and members that Scotland had ombudsmen before devolution. The UK was rather late in coming to the concept of having an ombudsman. In 1809, the Swedes invented the concept and had the first ombudsman, but the UK did not have an ombudsman until 1967. In Scotland, we had parliamentary and health service ombudsmen. There was the office to which I have referred in which Eric Drake worked. There was a main office down in London and an office in Scotland that dealt with complaints about the health service in Scotland, but mainly with complaints about the work of the Scottish Office at the time. One office had two functions. There was also a separate local government ombudsman to reflect the fact that Scotland has a separate local government system, and a housing association ombudsman. That was the pre-devolution position.

It is clear that there were many pluses in that system, not the least of which was the high regard in which the ombudsmen and the work that they carried out were held. However, in the parliamentary debate preceding the Scottish Public Services Ombudsman Act 2002—in which many committee members would have been involved—concerns were expressed that there were things that Scotland wanted to do to create a new and modern complaints-handling process that was more open and accessible and simpler for the average member of the public to understand. Such debates informed the legislation that was passed.

The new system that we have tried to develop is very much in tune with the Parliament's aspirations for running its own affairs. It is based on the ideas behind devolution and the key principles of power sharing, accountability, access and participation, and equal opportunities. Two consultation exercises were held on the kind of system that Scotland wanted. One was called "Modernising the Complaints System—Consultation on Public Sector Ombudsmen in Scotland" and the other was called "A Modern

Complaints System—Consultation on Proposals for Public Sector Ombudsmen in Scotland", both of which very much informed the new legislation—the Scottish Public Services Ombudsman Act 2002. The aspiration was to create a one-stop shop to make things much simpler for members of the public who have a complaint. Having one door is much simpler. Members of the public would know which door to go through, even if there were a number of different aspects to their complaint. Long-term care for the elderly is a classic example. A person might have a complaint involving the local authority, the health service and a housing association. Previously, the complaint would have been handled by three different ombudsmen, but they can now be handled by one person in my office.

We brought together under our jurisdiction the Scottish Executive and its agencies, the Scottish Parliamentary Corporate Body and all the work of local authorities, the national health service and housing associations. We also brought under our umbrella the enterprise bodies that previously had their own separate adjudicator system. The new jurisdiction brought in mental health complaints to the NHS.

There have also been developments since we were set up two years ago. As I said in my introduction, major changes are proposed for health service complaints. There will be one step in the internal process. In the next few months the independent review panel will no longer exist and complaints will come straight to the ombudsman. I hope that that change will make the timescale shorter and simpler for members of the public. We have already budgeted for that and we are ready for it to happen.

14:15

A big question mark surrounds further and higher education. A bill is currently going through Parliament and part of the legislation on further and higher education is that the ombudsman should also have jurisdiction in complaints about those sectors. Lots of change is on-going from when we were set up.

We thought that we would highlight the main differences between the previous process and the current one, which is where Scotland has very much led the way.

The first point is that in Scotland the legislation means that there is no MSP filter. Members of the public can come straight to our office. Previously, under different jurisdictions and in particular sectors, people had to go via an MP and latterly via an MSP. They do not have to do that now. Many MSPs and MPs are involved in some complaints and we do not discourage that, but a member of the public does not have to involve them if they do not want to do so.

The next point is about accessibility, personal and oral complaints and so on. The legislation is innovative because it tries to reduce the barriers that face people who want to make a complaint. In the past complaints had to be made in writing. It was acknowledged that some people would find that difficult if English were not their first language or if they did not find it easy to articulate their ideas on paper. People can make complaints to us in person and via e-mail. We have not got as far as text messaging yet, but you never know—we might get to that. The idea is to try to open the process up.

The consideration of service failure across all sectors is a very important aspect of our new powers. Previously that power applied only in the health sector. I think that it was Iain Smith MSP who raised the question in the Scottish Parliament why, if the power applies to health, it does not apply elsewhere. The legislation now allows us to look not only at maladministration, but at service failure across the different sectors under our jurisdiction.

The next point refers to a complaint by listed authority. That should more accurately be referred to as a request by a listed authority. Although we mainly take complaints from members of the public or their representatives we can also take a request from a listed authority that is under our jurisdiction. If the listed authority has been dealing with a complaint from a member of the public and it feels that it has met the complaint, responded and done everything that it can, but the member of the public remains dissatisfied, it might want to ask us to look at the complaint in order that an independent eye can be cast over it. We are beginning to see a number of listed authorities approach us to ask us to take those issues.

Informal resolution is another important aspect of the process. If a complaint can be resolved as early in the process as possible that is the best way of resolving it. The matter should be resolved with the body involved at the point at which the problem arises and if that is not the case and it comes to us, we will look at ways to resolve the problem rather than have a lengthy investigation that is stressful for the complainant.

Something else that we very much welcome being asked to do—we would welcome the committee's view on the matter—is to increase public awareness about the role of the ombudsman. We receive various letters that are addressed to all sorts of interesting people. Eric Drake recently got one that was addressed to "the deputy omnibus". We might find that amusing, but nonetheless there is an important issue if people do not understand what we do. We have a big role

to play in addressing that. The other aspect of the matter is that we give advice to bodies under our jurisdiction on best practice and guidance. That is part of an outreach strategy, which we are happy to tell the committee more about as we go on.

We are about the promotion of good administrative practices. An important point is that we can report to Parliament and we do so. We are required to do that if we carry out an investigation and if an injustice has not been remedied after we have recommended in our report to Parliament that it should be. We also have the power to lay a special report. We are often asked about our enforcement powers: that is an indirect way of doing that.

It is important to remember that there are many similarities with the previous process. As I acknowledged at the beginning, there are good aspects to what happened previously and we should not leave them aside.

The first clear point is that our role is to be independent. The second point is that we look at maladministration—poor administration, simply put—where it has caused an injustice to the complainant. We were asked to come up with a new definition of maladministration because it is one of those words that is tricky for people to understand exactly. Our stress will be on laying down principles of good administration and asking people to ask themselves whether they have met those principles.

Thirdly, we do not exist to challenge proper decision making. Bodies under our jurisdiction have decision-making processes and we cannot overturn a decision. That can disappoint members of the public who often come to us wanting a decision overturned. We cannot do that if the decision has been properly made, but we can look at the process that leads to the making of that decision.

Fourthly, we are the last resort in more senses than one. We are required to ask people to pursue and exhaust the complaint-handling process of the body they are complaining about before they come to us. We should be there at the end of such a process to try to settle it.

We have an important power to require evidence and, last but not least, the work that we do is done in confidence—we protect the confidence of the parties involved. When we lay a report before the Parliament, the names of the individual complainants are not published, but the name of the body that is complained about is.

We will have a handover now and Eric Drake will speak briefly about what we can consider.

Eric Drake (Scottish Public Services Ombudsman): As Alice Brown said, there are a number of issues that we can consider and some that we cannot. The essential definition of our jurisdiction is that we look at complaints from people who say that there has been some maladministration, administrative failure or failure in service, which is defined as either failure to provide a service that it is a function of a public body to provide—that is an interesting concept—or failure in a service that has been provided. Those elements have to be present and the person making the complaint has to have suffered some hardship or injustice. It is not enough that they simply do not like what has happened; there has to be something that can be defined as hardship or injustice.

As Alice Brown said, we cannot look at decisions that are properly made. According to the legislation, if a discretionary decision is made without maladministration, the ombudsman cannot look at it. We cannot look at personnel issues—we exist to look at complaints from users of public services, not people working within them. Similarly, we cannot generally look at commercial and contractual matters. If somebody has a commercial relationship with a public body, the ombudsman does not look at that sort of thing.

We cannot look at issues of academic judgment. That will become increasingly important if we take over complaints about higher education and further education

We can look only at services provided by or on behalf of the national health service. We cannot look at private care, but if the NHS has bought in services from the private sector, we can look at complaints about that.

We cannot look at complaints about UK Government departments; we look only at devolved matters. The parliamentary ombudsman in London still looks at complaints about matters that are reserved.

As Alice Brown said, we are the last port of call for complainants. The legislation states that internal complaints procedures have to have been "invoked and exhausted" before we can look at a complaint. People often say to us, "I am exhausted by these procedures, I don't know about having exhausted them." However, unless we think that there is a good reason for people not to pursue their complaint with the body first, we expect them to have done so before they come to us.

People have to go through a two-stage process at the moment before we could consider a complaint about the NHS. The first stage is referred to as "local resolution," when people try to sort out the complaint with the doctor, dentist, hospital or wherever the complaint has arisen. At the moment there is a second step, where people have the option to ask for an independent review

of their complaint. There is no automatic right to be granted it, but they can ask for it. Only after that second stage can we consider a complaint about the health service. The process has been under review for some time, and the Scottish Executive has announced that there will be changes. As far as we are concerned, the key change is that the second stage of the process will be abolished so, essentially, the NHS will have one bite at sorting out a complaint, and if that does not do the trick the next stop is the ombudsman.

When we set up our office just over two years ago, we thought carefully about what should characterise our processes. There are obviously some key issues. We had to start with the Scottish Public Services Ombudsman Act 2002, which is the key basis for our work. From the discussions in Parliament on the legislation, there were clear pointers about what MSPs wanted to characterise this new office. Among other things, it should be modern and open.

We have taken the view that, as a matter of principle, we should screen complaints in, not out. In other words, we should be looking at reasons why we can deal with a complaint, not looking for reasons why we cannot. Wherever possible, rather than get into a long winded, expensive, formal investigation process, we want to sort out complaints informally because that is better for everybody concerned. We have tried to build flexibility into our processes so that we can do that, and have given quite a lot of discretion to our staff to bring about informal resolutions.

We have created a process in which there are five possible steps through which a complaint can go. The vast majority of complaints will not go through all processes. The first step is the initial contact with our office. Often, that is as far as a complaint goes because, unfortunately, people misunderstand what the ombudsman can and cannot do. As Alice Brown said, I have had letters addressed to me as a deputy omnibus. People have a notion that we are something to do with the buses. If they phone up to complain that the number 36 is late, sadly we have to say that we cannot sort that out. We would point them to Lothian Buses plc, if it was the 36 in Edinburgh. A lot of first contacts with us get no further.

Steps 2 and 3 look at complaints in more detail to determine whether they are matters for us and, if they are, whether we might be able to sort them out. Step 4 is what we refer to as formal investigation. The Scottish Public Services Ombudsman Act 2002 says a number of things about what we must do if we get into that process, including producing a report of the investigation, which has to be laid before the Parliament. In every case where we have gone to formal investigation, a report of the investigation has been laid before the Parliament.

The fifth step is an option if we find hardship or injustice resulting from maladministration or service failure that has not been remedied. If we have investigated a complaint, found that something has gone wrong, and made a recommendation for it to be put right, and that recommendation has not been implemented, we can report that to Parliament. We have not yet had to do that, but it is an option if we ever find ourselves in a situation where our recommendations are not acted on.

Using our internal processes, each case is looked at in considerable detail. If we are looking at a health case, one question that we ask ourselves is, are there clinical issues? If there are, we seek professional advice to consider them, because the ombudsman and her investigative staff are all lay people. We take an intelligent layperson's view of cases, but if there are clinical issues we take clinical advice.

14:30

In each case, we will reach a decision as to whether there is anything that we can usefully do, whether we can bring about an informal resolution or take the matter to a formal investigation. Again, if we took a clinical issue to a formal investigation, we would take appropriate clinical advice.

Having investigated the complaint, we would produce a draft report setting out the evidence that we had found and would share that report with both parties, so that they would have the chance to correct any mistakes that we might have made and point out whether they think that we have omitted anything. The final stage will be when a report is laid before the Parliament.

It might be useful if I give you a few figures so that you get a better sense of the cases that we are dealing with. In the previous full year, we dealt with 307 complaints about the national health service, which represented a 17 per cent increase on the year before. In itself, that was a 16 per cent increase on the year before that. There seems to be a fairly steady upwards trend in complaints about the health service.

A large proportion of those cases we could not take any further. Some of those that we could not deal with were not within our jurisdiction—for example, those concerning people complaining about private health care. Others were, in our terms, premature, which is to say that they had not been raised with the NHS. We simply told those people that they had to pursue their complaint with the NHS first, before we could consider it.

Of the remainder, having considered the cases in detail, we decided that there was nothing further that we could achieve in the majority of cases. There were a variety of reasons for that. For

example, we might take the view that the matter had already been fully investigated and responded to by the NHS or that there was simply nothing more that could be done for that person.

We were able to resolve a small number of cases informally and, as time goes by, we would hope to be able to do that more often.

A small number of cases proceeded to a formal investigation. In the first two years in which our office has existed, we have formally investigated 22 complaints about the NHS. We have given the committee summaries of each of those investigations. We have pulled together basic information on what those complaints were about and how they were spread across the country. I do not think that there is any huge significance in the geographical spread, which pretty much matches the spread of population.

The issues that come up tend to follow a pattern. Delay—in getting treatments, appointments at clinics and so on—is an issue that worries people a lot. Sadly, we get a lot of complaints from people who have been struck off their doctor's list of patients, sometimes with little justification. That is something that we are concerned about. Quite a range of issues come up in the complaints, however.

Professor Brown: It is worth stressing that, in relation to most cases that come to us, we spend a lot of time at the beginning giving people advice about what they need to do rather than examining papers in depth. In other cases, we need to examine the papers in depth before we are able to say that there is nothing else that we can do. A lot of work can be involved in that preliminary stage, even if all we do is provide an explanation for people and talk them through the paperwork that they have but which they do not understand. Our approach involves education—I do not mean that in a patronising sense. We seek to raise awareness among bodies that are under our jurisdiction and among the public about what we can and cannot do.

The second aspect of our approach is prevention, which is very much in tune with the health debate. It is better to prevent problems from happening in the first place. Much of our work is at the beginning of processes. We work with the sectors that are under our jurisdiction and encourage them to get their processes right. Evidence shows that the first reaction when something goes wrong is most important. If a problem can be resolved early, matters should not grow out of proportion.

The third aspect of our approach is to work on prevention in partnership with the bodies that are under our jurisdiction, and with other ombudsmen, regulators and so on. Last but not least, we seek to contribute to wider governance. We regard our role as being part of the process of delivering better public services for the people of Scotland so that the kind of services to which we all aspire are provided.

One of the key aspects that arise from our work is learning of lessons. For the benefit of members of the public who are present, I will read out the information on slide 20, which they might not be able to see on the screen. This is the sad story of a man who presented at a clinic with earache, but who was given a vasectomy. Lest you fear, I hasten to add that the case did not happen in Scotland. The story is this:

"A farmer who went to the doctor suffering from ear ache ended up having more radical treatment than he expected - he was given a vasectomy. Brazilian Valdemar Lupes de Moraes, 39, was suffering from muffled hearing and thought his name had been called out in the waiting room at a clinic in Montes Clacos."

I will not go into the detail of the calling out of his name, but the name that was called out was Aldemar, rather than his first name of Valdemar. However, a vasectomy was carried out on the man. The story continues:

"Asked why he had not complained Mr de Moraes told staff he thought his ear inflammation must have reached his testicles."—*[Laughter.]*

Members may laugh, but people do not always understand what is going on when they are at the doctor. The story continues:

"The father of two, who had the vasectomy last week, turned up at the same clinic again on Wednesday for the ear examination he failed to get the first time—but made no request for a reversal of the operation."

There are obviously lessons to be learned from that example. First, there was a lack of clarity in calling out the patient's name. It must be clear that the patient who presents is the correct patient on whom a procedure is performed. Secondly, there was a lack of informed consent. The man had clearly not consented to a vasectomy. Thirdly, there was a lack of information concerning his understanding of his condition and the possible treatments.

One of the ways in which our office can be a useful learning resource is through consideration of the most common complaints that we receive, a crucial one being about the attitude of health service staff to people when they first come through the door. Other common areas of complaint are the clinical care and treatment that people receive, delays in the process, handling of a patient's discharge from hospital and the relationship with other services at that point, removal from a general practitioner's patient list—we have seen a number of such cases—and complaint handling itself. Crucially, the common factor in all complaints is poor communication at

all stages of the process. There is a lack of proper explanations about what has or has not happened.

Clearly, we were set up as a one-stop shop for complaints and we deal with individual cases. However, there are other potential players in the field and we make links with that wider group. For example, if there are issues of serious service failure or fitness-to-practice issues, we work with other agencies, such as the General Medical Council, to talk about the issues more generally rather than about specific cases.

There must be clarity in interaction between audit and regulatory bodies. We have created a one-stop shop for complaints, but there are many other such offices in Scotland, which causes confusion among the public. To reduce confusion and to make the system work more effectively, we are working on memoranda of agreement with other bodies—we have one such memorandum in place with the Mental Welfare Commission for Scotland. We are drafting another for the NHS quality improvement service and the Scottish Commission for the Regulation of Care. We are also in initial discussions with the GMC to try to clarify issues and the boundaries between our roles.

We have produced a route map, which we will leave copies of, to direct members of the public through the right door, whether to the Auditor General for Scotland, to the Scottish information commissioner, to our office or to another office. We also raise a question with the committee: do we need something specific, such as the route map, for the NHS? It is difficult for people to know, with reorganisation and the other proposals that are under way, to whom they should go with specific issues. We would like to play a part with the committee and others in creating a mechanism to make the process simpler.

The Convener: Thank you. We have about 10 minutes to deal with members' questions. I ask members to keep them as brief as possible. If the answers are brief, too, we will get in as many as possible.

Kate Maclean (Dundee West) (Lab): I think that Eric Drake spoke about failure to provide a service as opposed to failure in the service that is provided. Can you please give an example of what you mean? I am quite puzzled.

Eric Drake: As I said, the legislation talks about the

"failure of the authority to provide a service which it was a function of the authority to provide."

The example that I always give—it is barn-door obvious, and it has never happened—is that of the Scottish Ambulance Service deciding not to provide emergency ambulances, which would be a clear failure to provide a service that is a function of that body. Where the matter gets more difficult is in deciding to what extent the ambulance service has to provide patient-transfer services, as opposed to emergency services. There will be interesting debates about where boundaries lie.

Kate Maclean: So, it would be up to an individual's interpretation of what is meant by a statutory service. You also said that you could not consider properly made decisions so, if a public body decides not to provide a service that is not a statutory service, that does not count. It would be a matter of somebody's interpretation of whether they should receive a service and whether it was a statutory duty of a public body to provide that service.

Eric Drake: Yes. For example, some years ago, the English health ombudsman examined a case in which a chap who had serious brain injuries did not need hospital care any more, but still needed considerable nursing care, which he got at home. The local health authority decided that it would not fund that, but the ombudsman said that it was obvious that that was the sort of service that the NHS should provide. The complaint was upheld. Such issues are likely to come up.

Kate Maclean: So, the matter is about the service that is provided, not about where or how it is provided.

Eric Drake: Yes. It is about whether a service should be provided at all.

Mr Davidson: I agree that there is a need for a route map of the NHS for the public to use. We all probably have queries about what that would do. However, health boards tend to have complaints systems in place. Is there a risk that, at an early stage, they will pass matters across to you? You mentioned their referring a case to you. Sometimes, because of the threat of litigation and other issues that come up—as well as the amount of care-staff time that is involved—health boards will tend to do that at an early stage. If that is the case, how will you deal with that? I presume that you require the process to be dealt with fully within the health boards. Do you have a relationship with them? Have you explained to them what you expect of them?

Professor Brown: Yes—that was the purpose of the roadshow events. We have been round all 15 health board regions and have talked through many such matters. My impression is that emphasis is being placed more on trying to get internal processes right and on putting proper investment and resources in place. We are happy to help the health service to do that with advice and support from our staff. Staff shadowing arrangements have also been undertaken to develop common understanding, and we have had

visits to our office from staff who deal with complaints in different parts of Scotland. Quite a lot of preparation work has been done, with the emphasis on encouraging boards to get the process right. We have not, as yet, seen that we will have to monitor the extent to which cases are being fast-tracked to us rather than being handled effectively at the first port of call.

Mr Davidson: Will you set a timescale in which people can expect the NHS to deal with the process?

Professor Brown: Setting the timescale for the NHS is less clear cut; we tend instead to issue good practice guidance on the process. That said, it is perhaps more defined in the health service than it is in other areas.

14:45

Janis Hughes (Glasgow Rutherglen) (Lab): People often come to MSPs after they have complained to a consultant and received a reply, after which the matter has not been taken further. What would you to say to someone who came to you claiming that the correct procedure had not been followed in their case?

Professor Brown: Members of the public can get very confused about whether they have exhausted a body's complaints process. Before I answer the question, I point out that we are trying to raise awareness about simplifying complaints processes across public services. For example, there are 32 complaints processes in local government; indeed, there are sometimes different processes within the same local authority, which becomes very confusing for people, who tell us that they have already made a complaint or have exhausted the process. As a result, we spend a lot of time giving advice to people and clarifying whether they have indeed made a complaint and whether it has been made to the right person and through the right process. We can pull most of the systems up on to our computer screens and tell the person who is in front of us or at the end of the phone to whom they should write and what they should expect will happen. We also recommend that they come back to us if nothing happens. Much of our work is explaining internal complaints processes and how to go through them properly.

Janis Hughes: You said that you cannot overturn a properly made decision. However, if such a decision has not been properly made and you are upholding a complaint, what power do you have to overturn that decision?

Professor Brown: We can recommend that the body in question offer some form of redress. I point out that some areas are easier than others in that respect. Health is the most difficult area. After all, things might have gone terribly wrong—we cannot bring people back from the dead. Complaints in local government and other areas might involve planning or housing issues and we can usually do something very practical to help in such situations. As a result, what we are able to do depends very much on the case in question. We have a range of redress options that we can choose. People sometimes seek an apology, but they certainly want lessons to be learned and procedures and processes to be changed if they have led to a faulty decision in the first place.

We work from the basic premise that we try to put people back where they would have been had maladministration or service failure not happened. However, as I said, it is easier to do that in some contexts than in others.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I want to pursue an example of that. The 19th report in your submission centres on the removal of a patient from a GP list, and you say in your recommended remedy:

"I recommended that the GPs apologise to the man and review their procedures … Regretfully I have to report that the GPs refused to accept my recommendations or make an apology."

What happens then?

Eric Drake: A special report might be made to Parliament but, in this case, the local health board has had further discussions with the GPs concerned, who have now apologised and reviewed their processes. The report sets out the stand that the GPs were making when we issued our report. We are now waiting for confirmation that they have since modified their position.

Mike Rumbles: So you have teeth.

David Davidson asked about reasonable time for a health board to complete its investigations, including the independent review. I am not referring to individual complaints, but would it be reasonable for a complaint to be subject to independent review for six to eight months?

Professor Brown: The independent review stage is being removed. However, if we feel that there has been undue delay, we might intervene earlier.

When someone has not exhausted a body's complaints process, I can use discretion if problems have arisen; for example, if they have not received a reasonable response or if the response or process has been delayed. Whether we can be involved earlier—if we think that that is necessary—must be considered in every case.

Mike Rumbles: I will be in touch.

Professor Brown: I am sure that you will.

Shona Robison (Dundee East) (SNP): Having sat with a lady who had followed an exhausting

complaints process in the health service, I think that it is good that the complaints procedure will be shorter. How will you inform the public about the new procedure? Further to Kate Maclean's point, if a body says that its failure to provide a service was due to financial restrictions, what can happen? Is that just accepted?

Professor Brown: Eric Drake can supplement any points that I make. Informing the public is a big challenge for us, because we need to inform them about a lot. We will have informed the sector and the public via other agencies in the first instance, given that we must be careful about resources. We have worked a bit with pilots through citizens advice bureaux, which people tend to approach first when they have problems, and with other advocacy agencies.

From January next year, we will have a programme of more direct ways of conveying messages. We would be interested to hear what MSPs and others consider to be the most effective ways of reaching the constituents who are the least likely to use our service. All the evidence shows that those who depend most on public services are least likely to approach an ombudsman. One aspiration of the Scottish Public Services Ombudsman Act 2002 was to reverse that inequality, which is not direct but indirect. We will target organisations, too, because the exercise is big.

Shona Robison asked at what point we can intervene in service failure. We appreciate that bodies under our jurisdiction have many demands on their resources. If they have several objectives to achieve with those resources, we will examine how they have reached decisions and why they might prioritise one matter over another.

We return to whether supplying a service is a function of the body that is involved. Kate Maclean pressed that point because she recognises that legislative interpretation is often involved. The question is whether supplying a service is a function of a body or something that it could provide with other services but which it chose not to prioritise because it gave other matters higher priority. We will consider how such decisions are reached.

I will give a silly example. If a body had a meeting at which it said, "We quite fancy doing X rather than Y," that would not be good logic for a decision. However, if it had evidence and papers on why X was a priority and why it would use its resources that way, we would consider that because it might show that the decision was properly made.

Eric Drake: In examining the NHS internal complaints procedure, the Scottish Executive has sensibly obtained outside help to draft leaflets in plain English, so that the public can understand what happens in the NHS. All public bodies are required to make their service users aware of the right to approach the ombudsman. All NHS bodies should explain how people can pursue complaints with them and should say that if they are dissatisfied after that, they can come to us. We are careful to ensure that that is done properly. A few bodies have still not caught up with the establishment of the Scottish public services ombudsman, so whenever we spot that, we ensure that those bodies get the description right.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): How can you help people who make a complaint while having treatment but who do not want to take it too far? Having highlighted their need or asserted themselves in asking for treatment, they begin to feel that they are in a them-and-us situation and to feel intimidated. One of my constituents had the liaison nurse or complaints person sitting in during consultations. Many people do not want to complain—what they want is a better service. I do not know how much you can do to improve the complaints system in the NHS. Can people contact your office for advice? What do you think about people sitting in during consultations and making people feel intimidated?

The Convener: That probably comes under the heading "specific". You might not want to comment on that, in case that particular case comes up.

Professor Brown: I will not talk about that case. We encourage people to phone us and ask for advice about what they can expect when they pursue a complaint. One of the things that was fed back to us when we did the roadshows—which were attended by a good range of people, including many people who represent patients—is that there is great reluctance to complain about the NHS, for obvious reasons. That is particularly true in small communities, such as islands, where people might not have a choice of GP or hospital.

One of our objectives is to talk to people on the other side and tell them that complaints are good if they are seen as feedback on a service. We are trying to change the culture and people's attitudes about complaining so that it is seen not as negative but as a way to establish what works, what doesn't work and what can be done. That involves bodies' dealing with issues properly and not being defensive when people complain. All the studies show that people's trust and confidence in the system is determined when something goes wrong, they raise the matter, and a member of staff reacts. By the time people get to us, their level of confidence and trust is sometimes so low that it is difficult for us to help to put things right, because they are suspicious of everybody.

The general answer is that a culture shift is required in the delivery of all public services. We are putting that message across to chief executives and chairs because they must set the tone. We must move away from an adversarial blame culture towards a joint responsibility for delivering good services.

Helen Eadie (Dunfermline East) (Lab): First, I complement you on your excellent website, which I have used. It is first class. My question is this: How do you plan to develop the interaction between the Scottish Public Services Ombudsman and parliamentary committees to take forward critical issues?

Professor Brown: That is a good question. As I said at the beginning, we are keen to play a part in feeding back what we learn from our work to the parliamentary committees. We have met clerks on three occasions. We gave a presentation and we brought our staff to Parliament in two separate groups and we have had meetings with clerks to explain the work that we do in sectors such as education, planning, local government and health. We addressed how the things that we learn might be useful to the committees, particularly in relation to amendments to legislation, future legislation and general feedback on how services work in reality.

We have a particular role to play in the forthcoming planning bill because complaints about planning in Scotland account for our largest proportion of complaints. We want to play a constructive role, so if you have suggestions about how we can do that more effectively, we will be happy to examine them.

The Convener: I thank Professor Brown and Mr Drake—we are grateful for their comments. I suspect that there will be follow-up requests from members when they have had time to assimilate the information.

The next two items on the agenda will be held in private.

14:59

Meeting continued in private until 17.13.

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