# Ombudsman's **Commentary**

**OCTOBER 2010 REPORTS**

The SPSO laid one investigation report before the Scottish Parliament today. It relates to the health sector.

## Ombudsman's Overview

As detailed in previous Commentaries, to use our resources as efficiently as possible and to maximise our impact, we have developed new criteria for deciding which cases should end with a report being laid before the Parliament. We only lay a report before the Parliament if we consider that the matter is in the public interest. This can include: significant personal injustice complaints; systemic failure cases; precedent and test cases; and cases where there has been significant failure in the local complaints procedure.

Our laid investigation reports form only one part of our work. A larger proportion of the complaints we receive are handled at the detailed consideration stage of our process. This usually ends with us sending our findings and conclusions to the complainant and the organisation complained about in what we call a decision letter. As with investigation reports, we may make recommendations in decision letters.

**In September, in addition to the investigation report laid before the Parliament:**

- **We determined 288 complaints**
- **Of these, 79 were suitable for us to look at**
- **We were able to resolve 63 of them quickly**
- **16 required detailed consideration**
- **We made a total of 27 recommendations in decision letters (some of these are listed below at the end of this Commentary).**

### Prisons Complaints

On October 1, the functions of the Scottish Prisons Complaints Commission (SPCC) were transferred to the SPSO. For the past several months, our staff have worked with the Government, the Scottish Prison Service (SPS), the SPCC and the Parliament to prepare for a smooth transition. This included ensuring IT system compatibility, communication with stakeholders (especially prisoners), knowledge transfer, setting up archive and retrieval systems and training our staff in handling enquiries and complaints in this new area of responsibility. We have been pleased with the way the SPS and prison governors have responded to the change and we will be reporting in due course on our findings from complaints about this sector. The transfer of prisons complaints to our office makes significant savings to the public purse and we are absorbing these complaints without increasing our headcount.

### Consultation

As we reported last month, we received over 90 responses to our Consultation on a Statement of Complaints Handling Principles and Guidance on a Model Complaints Handling Procedure (CHP). Our analysis report will be published on our Valuing Complaints website in the next few weeks. We intend to submit the revised Principles to the Parliament for approval at the end of this month. Following discussion by the Parliament (through committees and in the chamber) we hope to have Parliamentary approval by December.

Our work on establishing the Complaints Standards Authority (CSA) continues. The CSA is an integral part of the SPSO and not a stand alone body. It will work with each sector to develop model CHPs over the course of 2011 – 12.

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## case reports

### Health

#### Diagnosis; clinical treatment

Tayside NHS Board (200900692)

Mr C felt that, given his past medical history which meant that he regularly took Warfarin, the post-operative care provided to him after a wisdom tooth extraction in hospital was sub-standard. He complained to me that the Health Board failed to adequately diagnose and treat a haematoma. Although it was clear that this was a very distressing and painful experience for Mr C, I did not uphold his complaint. This was because there was insufficient evidence to allow me to establish whether, on balance, clinicians should have reached a diagnosis of haematoma earlier. I did, however, find that the Board did not provide adequate pre-operative planning or post-operative guidance, and that clinicians did not ensure adequate pain control. I, therefore, recommended that the Board review pre-operative planning for dental patients with pre-existing disease and/or drug history to ensure that effective treatment plans are available in the event of post-operative complications. This should include a review of post-operative information packs for patients, to ensure that they provide detailed instructions to patients on Warfarin therapy. I also recommended that they apologise to Mr C for failing to provide effective pain control.

## Recommendations made in decision letters in September 2010

### Recommendations to Health Boards

- that a GP Practice review their clinical practice with regard to the management and investigation of prostatic symptoms
- ensure a consultant follows guidelines on note keeping
- provide a full and meaningful apology to the complainant and copy to the Ombudsman
- a GP Practice apologise for failing to monitor a patient's low white blood count
- a Board apologise to a complainant for failing to provide accurate information in their complaint response
- a Board ensure relevant staff are made aware of the need to provide accurate information when responding to complaints
- a Board apologise for the additional pain a complainant suffered
- a Board reassure the Ombudsman that:
  - a procedure for offering appointments for quicker post-operative assessment in similar cases has been reviewed;
  - staff have been advised of the appropriate procedure for obtaining and documenting informed consent; and
  - they have taken action to avoid a recurrence.

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## Recommendations made in decision letters in September 2010

### Recommendations to Councils

- clearly identify individual complaint numbers in correspondence when replying to multiple complaints
- apologise to a complainant for the delay in carrying out loft insulation works
- emphasise to staff the importance of properly kept records
- consider whether an ex-gratia payment is appropriate
- remind relevant staff in a planning department
  - of the need to scrutinise plans adequately;
  - to seek clarity where there is any doubt regarding the applicant's intentions; and
  - to re-notify neighbours where required
- a Council department to apply for retrospective planning permission for a streetlight
- remind staff that action taken on non-material changes to a planning application should be documented satisfactorily to ensure that there is sufficient consistency, robustness and transparency in the consideration of these requests
- consider whether any lessons can be learned from the handling of a case
- apologise for the failings identified during the SPSO investigation

### Recommendations to colleges or universities

- apologise that facilities and technical support available were not in keeping with expectations in promotional materials, and review the materials to ensure that they accurately reflect both this and the availability of access
- apologise that complaint handling was not in keeping with good practice
- make a student complaints procedure explicit about how Stage 2 complaints will be dealt with, including the timescale for appeal

### Recommendations to a Scottish Government or devolved administration body

- the authority to apologise for their error and reconsider their decision not to investigate

### Compliance & Follow-up

In line with SPSO practice, my Office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

**Jim Martin, Ombudsman**
**20 October 2010**

The compendium of reports can be found on our website **www.spso.org.uk**

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# Ombudsman's **Commentary**

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**SPSO** Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: **www.spso.org.uk**

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