

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid four investigation reports before the Scottish Parliament today, three about health boards and one about a local authority. We also laid a report on 72 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in February 2013), we received a record number of complaints – 438. In addition to the three investigation reports we laid before Parliament, we determined 426 complaints and handled 47 enquiries. Taking complaints alone, we:

- gave advice on 264 complaints
- resolved 114 in our early resolution team
- resolved 45 by detailed consideration
- made a total of 95 recommendations in decision letters.

Ombudsman's Overview



Health and equalities matters

Three of this month's investigation reports are about different aspects of care – delayed diagnosis of breast cancer in a young mother; a failure to provide appropriate surgical and cosmetic treatment; and a failure to provide British Sign Language interpretation for a deaf patient during her hospital admission.

The investigation into the lack of provision of interpreting services is an unusual one for us. While we are clear that we are not the appropriate body for determining equalities and human rights (that is the job of the courts) we are equally clear that we have a role to play in ensuring that public bodies reflect the obligations placed upon them by the Equality Act 2010 in their policies and practices.

We articulate this role in our five equalities commitments, which are contained in our 2012 – 16 Strategic Plan. One of those commitments is that we 'identify common equality issues (explicit and implicit) within complaints brought to our office and feed back learning from such complaints to all stakeholders'. Each year in my annual report I highlight such cases in a dedicated Equalities and Diversity chapter, where I also outline what we have done to live up to our commitments. In publishing this investigation report about a failing by one organisation, I expect all organisations to whom the Equality Act 2010 applies to examine their policies and procedures to ensure that in similar circumstances they would be ready to obtain suitable support, in line with their legal duty to do so under section 20 of the Equality Act 2010.

The role of advisers

Two of the health complaints published today were brought to us by people supporting the complainants. As I have put on the record recently, I particularly value the work of Citizens Advice Bureaux (CABx), for a number of reasons. One reason is that we are a small organisation with staff operating from a single office. CABx located across Scotland provide a welcome signposting service to members of the public who have problems with public services. In our experience, the support provided to clients by bureau advisers is of a high quality. Similarly, we value the work of Patient Advice and Support Service (PASS) workers in NHS settings, and are keen to continue our links with them as we did this month, when we participated in their regional meetings.

Scottish Welfare Fund

Advocates and support workers also play a key role in helping people who apply for emergency welfare assistance. We have written a leaflet for advisers and others about our new role in relation to the Scottish Welfare Fund, and we will make this available very soon. On 1 April 2013, the Scottish Government are introducing the Scottish Welfare Fund to replace community care grants and crisis loans. The Fund will be administered by local authorities and, as the final stage for complaints about local authorities, the SPSO will be able to look at complaints about this new function.

Our role is, however, different from the Independent Review of the Social Fund (IRS), which was abolished by the UK government. This is because our legislation means that, unlike the IRS, we cannot normally look at whether a decision is correct. Our leaflet explains that there are two local authority processes that can be used to raise concerns about the Fund. The review process allows the local authority to reconsider the decision. The complaints process deals with customer service complaints and some issues that cannot be raised through the review process.

The Scottish Government has issued detailed guidance and documentation about the Fund, which can be found on their website. Local authorities will be able to provide information about how to apply to the Fund for support. The new leaflet and further information about our role will shortly be available on our website.

Complaints Standards Authority Update

Local authority complaints handling procedures (CHPs)

In March 2012, we published the model CHP for the local government sector in Scotland. At that time we asked all 32 local authorities to implement the model as soon as possible, and by no later than 31 March 2013.

Significant work has been undertaken by the sector since then to plan for and introduce the model CHP across all appropriate council services. This included staff awareness sessions, staff training, developing products and redesigning systems to ensure that the infrastructure to support the model CHP was in place in good time. This is a significant achievement by the sector and one that will drive up the standards of complaints handling and deliver an improved and more efficient service to customers.

Local authority complaints handlers network

The local authority network will next meet on 26th April 2013 when the main topics of consideration will be the Performance Reporting Framework and performance indicators for the sector.

Housing CHPs

In April 2012, we published the model CHP for the housing sector in Scotland. Excellent progress has been made across the sector as organisations planned for the development and full implementation of the model CHP. From April 2013 all Registered Social Landlords (RSLs) and Housing Associations are required to have a CHP in place which is compliant with the model CHP for the sector. We are grateful to those that have sent us confirmation of their current position. If your organisation has not yet advised the CSA of its current position, or needs advice or guidance about the introduction of the model CHP, please contact the CSA directly to discuss this.

Further education

Following publication of the model CHP in December 2012 the sector has set up a steering group to develop a consistent approach to developing systems to accommodate the requirements of the model CHP. Positive progress is reported, with the sector confident that all colleges will introduce the CHP by 30 August 2013.

Higher education

Positive progress is also being made by individual institutions in this sector to develop the CHP for their university. In April 2013 we will host a stakeholder event where we will consider issues such as the challenges of implementing the CHP, including systems and recording, training and awareness, performance indicators and reporting, and CSA training and support.

Scottish Government, Scottish Parliament, agencies, NDPBs & associated bodies

The model CHP for this sector which includes all agencies, NDPBs and associated bodies under the SPSO's jurisdiction, as well as the Scottish Parliament and Scottish Government departments, has now been developed and will be published on 29 March 2013.

The model, together with the implementation guide that explains the requirement to implement this during 2013/14, can be found on our valuing complaints website (www.valuingcomplaints.org.uk). Any enquiries relating to this CHP should be directed to CSA@spsa.org.uk.

The CSA is always available to provide specific advice or support to complaints handlers across the public sector. Please address any questions about model CHPs, or the requirement to implement, to the CSA at csa@spsa.org.uk.

Investigation Reports



Investigation report ref: 201104213

Communication; equalities; policy/administration; consent

Tayside NHS Board

Summary

Mrs C, an advocate, complained on behalf of a patient (Ms A) that the board failed to provide a British Sign Language (BSL) interpreter during her 12-day in-patient admission to hospital for surgery to remove her appendix. Mrs C said that Ms A was a BSL user with very limited lip-reading ability. She did not use verbal communication and did not have a good understanding of written English. Although hospital staff took steps to try to communicate with Ms A, at no point did they provide an interpreter. This was despite Ms A repeatedly pointing to a poster on the wall, which was for interpreter services, and handing staff a BSL interpreter's card on two separate occasions. Mrs C also said that the poster was out of date and contained incorrect contact details for interpreter services.

In the course of my investigation I took independent advice from my equality and diversity adviser and a medical adviser. The equality adviser said that staff had not taken reasonable and appropriate steps to obtain a BSL interpreter for Ms A in line with their legal duty to do so under section 20 of the Equality Act 2010. She said that once they had been alerted to Ms A's need for a BSL interpreter, a clear plan should have been drawn up to try to coordinate the availability of doctors and others communicating with Ms A and a BSL interpreter, sufficiently trained to be able to communicate complex medical issues. She said that staff should have begun this plan as early as possible to maximise opportunities to book an interpreter, especially to capitalise on the admission taking place during the working week. She commented that it appeared that two calls were eventually made to the interpretation service but these were both made at the weekend and were unsuccessful.

I asked the medical adviser about the issue of consent. He said that it was impossible to say for sure if Ms A gave informed consent for the operation, but the failure to obtain an interpreter certainly cast doubt on this. It is clear to me, however, that that by failing to obtain an interpreter, the board did not adhere to their Informed Consent Policy.

In their response to our enquiries, the board said that there is both a national and local shortage of registered BSL interpreters. I recognise that this is the position. However, I do not consider that hospital staff made sufficient attempts to try to obtain a BSL interpreter for Ms A, despite the fact that it had clearly been noted that that Ms A needed an interpreter and that her method of communication was sign language.

It was clear from the records that that Ms A felt isolated due to being deaf and not being able to communicate. Ms A's notes stated that that an interpreter was to be contacted at the family's request. Mrs C said that Ms A's family know very little BSL and would not have been able to communicate the information received from medical staff to her. I consider that it was unacceptable for the board not to obtain BSL interpretation for Ms A during her admission and I therefore upheld the complaint.

I made a number of recommendations, including that the board consider amending their Interpretation and Translation Policy to highlight the legal duties staff have, and to explain that using families, lip-reading and pen and paper is not likely to be an adequate or reasonable response to the needs of a BSL user. The policy should make clear that BSL is a registered language and not simply signed English. I also recommended that they produce further guidance for staff on what the protocol is once a patient makes staff aware that they need a BSL interpreter and that they consider providing training to staff on deaf culture, language and legal rights. I asked the board to consider seeking input from deaf people to review the effectiveness of the implementation of the Interpretation and Translation Policy. Finally, I recommended that they offer to meet with Ms A and a BSL interpreter to answer any questions she has about her treatment and to apologise, explain and feed back how her complaint has helped them to develop their service.

Investigation report ref: 201200733

Delay in diagnosis

Western Isles NHS Board

Summary

An advocate brought a complaint on behalf of Mr A about the board's delay in treating his late wife (Mrs A) for breast cancer. Mrs A had been referred urgently by her GP for the investigation of symptoms suggestive of breast cancer on three occasions within a period of seven months. When she was eventually referred on to a more specialised breast centre, Mrs A was diagnosed with cancer, from which she died two and half years later.

Mrs A was 30 years old when, in May 2008, she first reported her symptoms of discomfort and small lumps in her breast to her GP. The GP urgently referred her to the breast clinic at the local hospital. As her symptoms persisted and the lump grew larger, she was referred twice more to the clinic. After her third review there in November 2008 she was referred to a breast centre which has a multi-disciplinary team that can provide triple assessment as recommended by national guidance. In January 2009 Mrs A was diagnosed with breast cancer. At this time, she was some 12 weeks pregnant with her second child. The baby was safely delivered, and Mrs A was treated for her cancer, but it later returned and she died in June 2011.

My investigation, which took into account independent advice from a consultant general surgeon with experience in the management of breast cancer and a consultant radiologist, found that in the case of the first referral the care provided was reasonable. However, I found that the results of a second ultrasound scan should have prompted further investigation and follow-up. By the third referral and ultrasound scan there were clear signs of cancer and these should have been followed up urgently. In total, there was a delay of some six weeks from the third referral by the GP until Mrs A was seen at the breast centre. In my conclusion I note that it is not possible to say what the outcome might have been for this young mother, had she been referred to the multi-disciplinary team sooner.

The advice I received also looked at the facilities for managing the diagnosis of breast cancer in the Western Isles at the time. The board said that national guidance (SIGN 84, which deals with the management of breast cancer in women) was circulated to relevant clinicians in the board in January 2006. However, they had no record of any governance or surgical management team meetings explaining why this guidance was not implemented. In my conclusion I say that 'it is incumbent on health boards to ensure that national guidance is not only disseminated but also taken cognisance of by their clinicians.' The board have explained that, since these events, though not as a consequence of them, there have been changes in the referral system. In September 2009, they introduced a system whereby any woman being referred by a GP for symptoms suggestive of breast cancer is referred directly to the breast centre.

Given that the board have already implemented SIGN 84, I made a single recommendation in this case, that they issue an apology to Mr A for the failings identified.

Investigation report ref: 201201006

Clinical treatment

Tayside NHS Board

Summary

Mr C was a body builder who injured his chest whilst bench pressing. His GP referred him to a consultant orthopaedic surgeon who told him there was no surgical treatment that would improve his injury. The surgeon suggested that if Mr C was worried about the look of his injury, his GP should refer him to plastic surgery services. The GP did so, but a consultant plastic surgeon declined the referral before seeing Mr C, on the grounds that cosmetic augmentation of the pectoral muscle was not a procedure offered by plastic surgery services.

Mr C complained that the board refused to provide appropriate treatment for his injury. He said that he had suffered a loss of confidence in his appearance, which had a significantly detrimental impact on his career. He complained about the thoroughness of his orthopaedic examination and disputed the decision that no surgical treatment was required. He also complained that it was unreasonable for the plastic surgery services not to offer him cosmetic augmentation.

I upheld the complaint. My investigation criticised the orthopaedic surgeon, since in determining the course of treatment for Mr C he should have considered the importance to Mr C of strength and the restoration of physical appearance. The independent advice I received was that there was a significant body of evidence that early effective surgical treatment could result in normal recovery of shoulder strength. The adviser also said that surgery could in fact have improved the appearance of Mr C's chest, with the scar being camouflaged. I concluded that the orthopaedic surgeon had based his decision on inadequate awareness of up to date medical knowledge about treatment of this injury, and had failed to follow GMC guidelines in his consultation with Mr C by not listening and responding reasonably to his concerns, circumstances and preferences or respecting his right to make decisions about his care.

I also found that the board were remiss in how they handled Mr C's referral for plastic surgery. My adviser noted that Mr C had only one opinion from the orthopaedic surgeon and what was effectively a statement of the board's healthcare policy from the plastic surgeon. I concluded that the board had failed in not upholding Mr C's right to seek a second opinion, as set out in GMC guidelines. The denial of a second opinion has had significant consequences for Mr C, given that a surgical option is now less reliable.

I made several recommendations in this case, including that the board ensure that Mr C is referred for a second consultation with an orthopaedic surgeon and that they apologise fully for the failings identified. I also asked them to ensure that this case and the failings are discussed with the consultant orthopaedic surgeon at his next appraisal and that the medical director is made aware of the failure to facilitate the request for a second opinion.

Investigation report ref: 201103415

Planning: handling of application; enforcement; communication

Aberdeenshire Council

Summary

Mr C lives next to land that had been sold for development. The design specification said that the developer of the site could fell trees on the land, but should plant new ones in the next growing season. In 2004, the developer felled all the trees next to Mr C's home, and dumped stone and rubble on the site. Over the following years, more houses were built but no trees were planted. Mr C raised his concerns about this with the council. He said that the developer had not met the design brief and that the council were not ensuring that the developer complied with the conditions of the planning consent that had been granted. In 2010 the council told Mr C that the developer had severe financial constraints, and this was why the trees had not been replanted. Having pursued his concerns with the council over a number of years, Mr C brought his complaint to me.

After taking independent advice from one of my planning advisers, I upheld Mr C's complaints that the council unreasonably delayed in ensuring compliance with planning conditions and failed to take appropriate enforcement action. The council accepted the proposal for a formal replanting scheme in mid-2004, and replanting should have taken place in 2005. The adviser said that he would have expected them to follow this up. The council were aware that the trees had been felled, but there was no evidence that they monitored progress on the replanting between mid-2004 and early 2007. From 2009, as provided for in Scottish Government guidance, the council tried to negotiate with the developer to resolve the problem, as an alternative to taking legal action. However, the adviser said that there were unjustifiable further delays in progressing this, and there was no evidence that the council took individual circumstances into account. They had overall responsibility to ensure that the developer complied with the condition of the planning consent in good time.

They also had discretion to decide whether to enforce the condition, as long as they could demonstrate that their decision was reasonable in planning terms. The council said that they saw only one option open to them, and thought no breach of conditions had occurred. However, my investigation could not find evidence of the criteria they used and the checks they made in reaching these decisions. Although, after my investigation started, the council acknowledged that there had been a breach of conditions, I consider it unacceptable that, over an eight-year period, the matter remained unresolved and planning compliance unenforced. I made several recommendations for redress, including that the council provide details of how they are taking matters forward with the developer, with a specified timeline, now that they have acknowledged that a breach of condition has occurred; that they ensure learning from this complaint is fed back to all staff and that they issue Mr C with a full apology for the failings identified in this complaint.

Compliance and 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, 27 March 2013

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

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The 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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

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

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 complaints handling in bodies under our jurisdiction.



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