SPSO decision report

Case: **201302021, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C suffered from ongoing problems urinating and tried to treat these himself, but this caused him further problems. He went to A&E at St John's Hospital and the urology department at the Western General Hospital several times. He was prescribed antibiotics for infection and given an appointment for a cystoscopy (an operation using a special telescope to examine the urethra - the tube that allows urine to pass out of the body - and bladder).

Mr C did not attend the appointment, as he said he did not receive the letter and did not know where to go. Another appointment was arranged, but Mr C developed another infection before this. He was prescribed more antibiotics, and although the operation could not be carried out, the surgeon met Mr C to discuss his condition and treatment. Another appointment was made for the cystoscopy, but Mr C was worried about the operation. He wrote to the surgeon about it, and they met again to discuss his concerns and his treatment plan, after which the operation went ahead with a different surgeon. Follow-up tests, however, showed that it was not successful and the new surgeon arranged for Mr C to have an urethrogram (an x-ray examination of the urethra). He planned to follow this up in his clinic, but Mr C was not given a follow-up appointment.

During this time, Mr C made several complaints about his treatment, in particular about medical staff being reluctant to give him ongoing antibiotics, which he thought he needed. He emailed the board's complaints team regularly about his complaints and ongoing health problems. While the board investigated and responded to several complaints, they eventually told him that the complaints team was not able to influence his medical treatment. They said that they would not respond to further complaints about antibiotics, but would investigate any new matters. However, when Mr C wrote to complain that he had not heard back since his urethrogram, the board told him that his complaint was closed and would not be investigated. Mr C asked his MSP to complain on his behalf, but the board told the MSP that the complaint was too old, as the events had happened over six months before. Mr C then complained to us about his medical treatment and the board's handling of his complaints.

We investigated Mr C's complaints and took independent medical advice on his case. As a result of our enquiries, the board acknowledged that he had not been given a follow-up appointment, and they arranged this as a matter of urgency. We upheld Mr C's complaint about treatment, as it was unreasonable that the board had at first failed to arrange this. We also found no evidence that Mr C was sent an appointment letter for his first surgery date, and we were critical of this. Finally we noted a lack of continuity in Mr C's care (with nine doctors involved over a six-month period). Although the first surgeon showed particular care in meeting twice with Mr C to explain his treatment, the lack of continuity meant that Mr C did not fully understand the treatment plan, or the importance of treating his underlying problems as well as taking antibiotics.

We also upheld Mr C's complaints about the board's complaints handling, as they did not correctly follow their complaints handling policy or their unacceptable actions policy. In particular, the board should have tried to clarify Mr C's complaints earlier, and should have told him as soon as they had concerns about the amount of contact he was having with them. We also found that they should have investigated his last complaint about the lack of

follow-up appointment, as it raised a new issue that had occurred within the last six months and had not previously been investigated.

Recommendations

We recommended that the board:

- issue a written apology to Mr C for the failings our investigation found, and provide a reassurance that his future requests for medical care will be treated with respect;
- review the processes for arranging urology appointments at the Western General Hospital, to ensure there are clear records of when an appointment is required and when an appointment letter (or replacement letter) has been sent;
- consider identifying a single clinician to maintain continuity of care in cases where the patient may benefit from this;
- remind complaints handling staff of the requirements of the complaints policy in relation to clarifying complaints at the outset and the time-frames for acknowledging and responding to complaints;
- identify and address any training needs for complaints handling staff in relation to supporting vulnerable complainants (including responding appropriately to comments relating to self-harm); and
- review complaints handling processes and procedures to ensure they comply with the unacceptable actions policy.