SPSO decision report

Case: **201401536, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about his wife (Mrs A)'s neurological consultation which they both attended, the correspondence following this consultation, and the way the board handled his complaints. Mr C said that the way the consultation at Crosshouse Hospital had been conducted failed to meet Mrs A's specific needs and requirements arising from the fact that she was autistic and had dyslexia, Asperger's syndrome and anxiety. Mrs A was subsequently diagnosed with a disc protrusion (a common form of spinal disc deterioration that causes neck and back pain) by another consultant and Mr C said that the failure to meet Mrs A's needs meant that the first consultant missed the diagnosis.

We took independent advice from a medical adviser and an equalities adviser. We found that it was not reasonable to expect the first consultant to have diagnosed a disc protrusion and the findings from a later investigation were not evidence that the diagnostic process had been hindered. In relation to the equalities aspect of the complaint, however, it was not clear that the consultation booking process and the consultation procedure would meet the needs of people with disabilities generally. While we found that the consultant was aware Mrs A had specific needs and requirements and had made adjustments in line with their understanding of them, the current process (whereby information about the consultation was normally read by the consultant just before the patient was seen) did not enable the board to plan ahead and make reasonable adjustments once a patient's needs were known. It was also not clear if staff had received appropriate training about making reasonable adjustments. We therefore upheld the complaint in light of the evidence in relation to the equalities aspect of the consultation booking process and consultation procedure.

With regard to the other aspects of Mr C's complaint, we found that the subsequent correspondence about the consultation was reasonable and that the board handled Mr C's second complaint in a reasonable way. However, we were concerned about the way that the board had handled Mr C's first complaint in that there was an unreasonable delay and staff were not as proactive as they should have been in keeping Mr C informed about the delay and the reasons for it. Moreover, the complaint was only resolved when the board revisited it after their substantive response to the complaint and it was not clear why this did not happen when they first investigated it.

Recommendations

We recommended that the board:

- carry out an equality impact assessment on the board's consultation booking process and consultation procedure;
- confirm the provision of training and guidance to ensure that clinical and booking staff make reasonable adjustments for patients with additional needs for consultations or, if this has already been delivered, provide us with evidence of the training and guidance;
- bring our decision, including the equalities adviser's comments, to the attention of relevant staff;
- bring our findings about complaints handling to the attention of relevant staff; and
- apologise for the failures this investigation identified.