SPSO decision report

Case: **201405861, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C, an advocacy worker, submitted a complaint on behalf of Ms A regarding the care and treatment received by her late brother (Mr A). Mr A had a history of mental and physical health problems and was an in-patient in the Royal Edinburgh Hospital for more than 15 years. He was discharged into supported accommodation. Daily support was provided by a voluntary sector organisation and his psychiatric care was overseen by the board's community rehabilitation team (CRT). Mr A's physical health deteriorated following discharge and he was diagnosed with renal cancer around five months later. Mr A died the following month. Ms A complained about the time taken to diagnose her brother's cancer and about a failure to involve her in his care and listen to her concerns about his deteriorating condition.

We obtained independent advice from a mental health professional. They noted that the primary responsibility for monitoring Mr A's health following his discharge lay with his GP practice. However, they noted that the CRT had a role in liaising with the GP practice and monitoring Mr A's engagement with them. The adviser considered that the discharge plan lacked clarity surrounding these roles and responsibilities and lacked focus on Mr A's physical health, despite his history of physical health problems and known difficulties engaging with healthcare providers. The plan did not set out a schedule for visits from Mr A's key worker and the adviser observed that there were long gaps between visits, despite Mr A's carers contacting the CRT to raise concerns about his wellbeing.

The adviser also considered that the discharge plan should have set out strategies for involving Ms A in her brother's care and observed that the key worker did not contact Ms A directly until five months after discharge. In light of the advice received, we concluded that the CRT could have been more proactive in overseeing Mr A's care following discharge and in engaging with his family. Arrangements for doing so should have been set out in the discharge plan and we considered that closer monitoring of Mr A's physical health and evident deterioration might have resulted in medical assessments being requested earlier. We therefore upheld the complaints. We could not say that closer monitoring would have led to an earlier diagnosis or altered the outcome for Mr A but we noted that it could have allayed some of the family's distress. We obtained additional independent advice from a GP who noted that, when Mr A was referred for investigation of his deteriorating condition, he was thoroughly assessed and managed appropriately.

Recommendations

We recommended that the board:

- ask relevant staff to reflect on the failings highlighted in this investigation and advise us of identified actions to improve future discharge planning, with a specific focus on monitoring physical health and engaging with family/carers; and
- apologise to Ms A and her family for the identified failure to monitor Mr A more closely following his discharge from hospital.