SPSO decision report

Case: **201406474, Borders NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C, a patient with long standing heart problems, complained that he was not provided with a cardiology service at Borders General Hospital for a period of nearly 18 months. We found that Mr C was not recalled for his routine six-monthly cardiology review appointment. The board said this was because, after Mr C declined surgery for an unrelated medical condition, surgeons did not let the cardiology department know that the surgery did not go ahead. We found that even after Mr C's GP referred him again it took too long, and considerable effort on his part, to get another cardiology appointment. We asked the board to review the process by which patients are discharged from one service to another and back again. We asked them to build in safeguards to ensure the system was robust and, following review, that the process was shared and understood across specialist areas as well as within administration teams.

Mr C told us there was an unreasonable delay when a letter from the board took 49 days to reach him. The board acknowledged that there were problems with workload within the administration team and apologised for their failing. They acknowledged the delay was unacceptable. They also took steps to monitor workflow within the administration team. We found that these were reasonable actions.

We found some shortcomings in the handling of Mr C's complaint. The initial response to Mr C's complaint made no reference to key points he had raised. Nor did it refer to the difficulties he experienced when he contacted the board by phone. We found the board had apologised for the fact that a room used for the meeting caused Mr C distress in that it was very small and full of people when he arrived. The board acknowledged the agenda could have been better arranged. We found that the cumulative effect of these errors made Mr C feel that his complaints were not being taken seriously.

Recommendations

We recommended that the board:

- review the process by which patients are discharged from one service to another and back again and ensure, following this review, that the process is shared and understood across specialist areas as well as within administration teams.