SPSO decision report

Case: **201700461, Fife NHS Board**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Decision: upheld, recommendations

Summary

Mrs C complained that the board failed to process an autism spectrum disorder (ASD) assessment for her child (child A). Mrs C said there were a range of administrative errors in the process, which led to significant delays. Mrs C also said that the board unreasonably tried to transfer child A's care to a different health board, based on child A attending a new school outwith the board area.

The board upheld Mrs C's complaint and apologised for some administrative errors in the process. They acknowledged that they were responsible for the assessment (rather than the other health board) and that their current wait times for assessment were unacceptable. The board said that they were introducing a new assessment pathway to improve this, including a new central point of contact for processing referrals. Mrs C remained dissatisfied and brought her complaint to us.

We took independent paediatric and nursing advice. We found that the board failed to process child A's referral in line with their own guidance, including failing to follow-up the paperwork sent to Mrs C. The board also failed to arrange a planned follow-up appointment with a paediatrician. We also found that it was unreasonable that the board tried to transfer child A outwith the board area, as staff should have been aware that they were responsible for all children resident in the board area, regardless of schooling. We upheld Mrs C's complaint.

While the board had acknowledged some failings, we found that their response to Mrs C did not give a clear and full apology for all the failings we identified. We considered that the action taken by the board to improve waiting times and communication was appropriate. However, we were concerned that, in 2014, we made similar findings about a delay in an ASD assessment (case 201401014) and, while the board took action following that case to reduce waiting times, these appeared to have extended again significantly. The board said that they had implemented a new pathway for ASD assessments, and we asked to see evidence of this and other actions the board is taking to reduce waiting times. We also made a number of recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C's family for the unreasonable delay in the ASD assessment, their error in attempting to refer child A outwith the board area, the administrative failings in their handling of the assessment pathway, and the failure to provide a follow-up paediatric review. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Information about patients within the board's area of responsibility should be easily accessible to all staff.
- Requests for consent to ASD assessment should be followed up, in line with the relevant guidance, when there is no response.

- Planned follow-up reviews should take place. If this is subsequently considered not necessary, clear explanations should be provided to the patient.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.