SPSO decision report

Case: **201906833, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received. A had Muir-Torre Syndrome (individuals with this diagnosis are more likely to develop certain types of cancers).

We took independent advice from a consultant colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus), a consultant dermatologist (a doctor specialising in the disease and treatment of the skin, hair and nails) and from a consultant haematologist (a doctor specialising in the disease and treatment of the blood and bone marrow). We found that A received appropriate monitoring and treatment in respect of their Muir-Torre Syndrome. We did not uphold this aspect of C's complaint.

C also complained about the care and treatment that A received for arm pain. We took independent advice from an orthopaedic surgeon (a surgeon specialising in the treatment of diseases and injuries of the musculoskeletal system). We found that a clinic letter was typed two weeks after an urgent appointment and that the time between a scan being performed and potentially receiving the results was unreasonable because it fell outside of the 18 weeks referral-to-treatment standard. We upheld this aspect of C's complaint.

Lastly, C complained about the care and treatment A received for cancer. We found that it was reasonable that no further investigations were arranged to try and identify the primary source of A's cancer, given that A was too unwell for treatment. It was reasonable that A did not receive chemotherapy in the circumstances, and the communication with A and A's family about the possibility of chemotherapy was also reasonable. We did not uphold this aspect of C's complaint.

During the course of our investigation we identified aspects of the board's complaint handling which could have been better; in particular that C was not provided with a written record of the complaint meeting with the board, contrary to the NHS Scotland Complaints Handling Procedure. Also, the board's complaint response did not address all of the concerns that C raised. We made recommendations to the board in respect of their complaint handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the length of time taken to type the clinic letter following A's appointment with the Trauma and Orthopaedics service; for the length of time A had to wait for a follow-up appointment with the Trauma and Orthopaedics service; for not providing a written record of the complaint meeting; and for not addressing all the concerns that C raised. The apology should meet the standards set out in the SPSO guidelines on apology available at or www.spso.org.uk/information-leaflets.

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

- In line with Scottish Government standards, where possible, no patient should wait longer than 18 weeks from referral to treatment.
- When a clinic appointment has taken place following an urgent GP referral, a letter setting out the clinic findings and the plan for any diagnostic investigations should be sent promptly to the patient's GP.

In relation to complaints handling, we recommended:

- Responses to complaints must address all areas that the board are responsible for.
- Written records of complaint meetings should be completed and provided to the person making the complaint.

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.