S.29/02-03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against
West Lothian Healthcare NHS Trust (the Trust)

Complaint as put by Mrs C

1. The account of the complaint provided by Mrs C was that her general practitioner (the GP) referred her to St John's Hospital (the Hospital) in July 1998 as she was having bowel problems. She saw a consultant (the first Consultant) in August and he thought that she had suffered a prolapse in the rectal area which would require surgery. The first Consultant arranged for Mrs C to attend the Royal Infirmary of Edinburgh (the Infirmary) for further tests before considering surgery. The tests took place in November 1998 and Mrs C expected that she would receive an appointment to see the first Consultant again so that he could inform her of the results. Mrs C heard nothing further and contacted the GP in early 2000. He referred her to another consultant at the Hospital (the second Consultant) to investigate her stomach problems and to the first Consultant for the results of the tests. Mrs C saw the second Consultant three times and he asked her on each occasion whether she had heard from the first Consultant. The second Consultant sent the first Consultant three memos. The first Consultant saw Mrs C in July 2000 and he told her that one of the test results had still not been received and as nearly two years had passed, he would arrange for the tests to be redone. After a further three months, Mrs C had heard nothing further from the first Consultant. She therefore requested a second opinion. Mrs C complained to the Trust about the length of time taken for the first Consultant to obtain the test results and that he did not take action to obtain the test results. She remained dissatisfied with the Trust's response and requested an independent review on 31 January 2002. The convener refused the request on 5 April. Mrs C remained dissatisfied with the convener's consideration of her request for independent review.

2. The complaints subject to investigation were that:

(a) there was an unreasonable delay in the issuing of the test results and the first Consultant failed to take action to obtain the results; and

(b) the convener exceeded her responsibilities by seeking to resolve the complaint through her own investigations and failed to take appropriate clinical advice from someone not associated with the complaint.

Investigation

3. The statement of complaint for the Ombudsman's investigation was issued on 14 June 2002. The Trust's comments were obtained, and relevant papers were examined. Oral evidence was taken from Mrs C and Trust staff. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Chronology

4. I set out below a summary of the main events:

21 July 1998 - The GP wrote to the first Consultant about Mrs C's bowel problems.

7 August - The first Consultant reviewed Mrs C at his clinic and referred her to the Infirmary for an anorectal manometry (a test to measure pressure in the anal canal) and an endo anal scan (an examination using imaging techniques).

11 November - Staff at the Infirmary wrote to the first Consultant with the anorectal manometry results.

1 December 1999 - The GP wrote to the second Consultant concerning problems Mrs C had with reflux (a backflow of stomach contents into the gullet).

12 January 2000 - The second Consultant reviewed Mrs C at his clinic. He wrote to the GP with a summary of the consultation and his treatment plan.

The second Consultant copied the letter to the first Consultant and highlighted that the result of the endo anal scan taken in 1998 did not appear to have been received.

19 May - The second Consultant reviewed Mrs C at his clinic. He wrote to the GP and told him that he had discussed the reflux problems with Mrs C and that there was no need for him to review her again. The second Consultant was also aware that Mrs C was still suffering from bowel problems and he had asked the first Consultant to review her once the results of the investigations were known. The letter was copied to the first Consultant.

14 July - The first Consultant reviewed Mrs C at his clinic. He wrote to the GP and told him that he had not received the results from the anorectal manometry and the endo anal scan and that he would telephone the Infirmary to see if the results could be sent. On receipt of the results he would consider whatever intervention was required and he would make arrangements to see Mrs C again.

31 October - The GP wrote to the first Consultant and asked if he was now in a position to offer further advice. [Note: This letter was annotated by the first Consultant to his secretary (the Secretary) asking her to telephone the Infirmary for the test results.]

19 November - A member of staff at the Infirmary wrote to the Secretary in response to a telephone conversation. She told the Secretary that the test results from 1998 were not filed in Mrs C's case notes but she would arrange for the laboratory to send a copy within two weeks.

November/December - A copy of the anorectal manometry and endo anal scan results were sent to the Hospital. [Note: It has not been possible to establish the exact date the copy results were received at the Trust].

12 January 2001 - The first Consultant wrote to the GP. He told the GP that he had still not received the endo anal scan result from the Infirmary. He had managed to procure an ultrasound machine for his own department and he

would arrange for Mrs C to have the scan completed at the Hospital. He would then be in a position to make a decision on her future treatment.

6 August - A member of staff from an Advocacy Project wrote to the first Consultant on behalf of Mrs C. Mrs C had requested a review of her case and also a second opinion. Mrs C was anxious to find out whether she would require surgery or alternative treatment to relieve her discomfort.

20 September - The first Consultant wrote to the Advocacy Project. He explained that Mrs C's scan had revealed no evidence of anatomical damage and that further scanning was not required. He thought the only possible intervention would be treatment of the anterior mucosal prolapse which could be arranged through a second opinion. The first Consultant suggested the name of another consultant who could be contacted and asked to provide a second opinion.

29 October - The Advocacy Project wrote to the Trust on behalf of Mrs C with a formal complaint about the lack of communication from the first Consultant. Mrs C felt that despite being sent for tests in 1998, matters had not progressed.

6 December - The Chief Executive of the Trust wrote to the Advocacy Project with the formal response to the complaint.

31 January 2002 - The Advocacy Project wrote to the Convener and requested an independent review.

5 April - The Convener wrote to the Advocacy Project and refused the independent review.

27 May - Mrs C wrote to the Ombudsman about her complaint against the Trust.

<u>Complaint (a) delay in the issuing of the test results and that the first Consultant failed to take action to obtain the results</u>
<u>Mrs C's evidence</u>

5. **Mrs C** said that she was referred to the first Consultant as she was having bowel problems such as constipation and the feeling that she was unable to fully empty her rectum. The first Consultant told her that he was sending her to the Infirmary for tests as they were not available at the Hospital. He did not say how long she would have to wait for the tests and she could not recall if he had said that he would see her again after the tests had been completed. Mrs C thought that the first Consultant would arrange a further clinic appointment after the tests had been completed. The tests took place in November 1998. The member of staff who carried out the tests told Mrs C that it would take a few weeks to gather all the results together and that they would be sent to the first Consultant who would then arrange a follow up appointment at the Hospital. Mrs C heard no more from the first Consultant during 1999 and her bowel condition continued to worsen. She did not contact the first Consultant because she has a fear of anaesthetics and he had previously mentioned that she would require an operation. However, in December 1999, Mrs C saw the GP about her reflux and bowel problems and he said he would refer her to the Hospital to see the second Consultant.

6. Mrs C saw the second Consultant on three occasions and he always asked her whether she had heard from the first Consultant. Mrs C told him that she had heard no more and the second Consultant sent the first Consultant memos. At the third appointment with the second Consultant, in May 2000, the second Consultant left the consulting room and personally spoke to the first Consultant. Mrs C then received an appointment with the first Consultant on 14 July. The first Consultant told her that he had only received some of the test results which had been taken at the Infirmary. The first Consultant examined Mrs C and said as it had been nearly two years since the tests had been taken, he would arrange for the Infirmary to take them again. The first Consultant gave no indication as to how long it would take for the tests to be retaken. Mrs C felt that the first Consultant was not too concerned that the test results had not been received. She felt that she was getting in his way and that he thought the cause of her bowel problems was laxatives which she had been taking. Mrs C had only taken laxatives in the past on medical advice. As Mrs C received no further contact from the first Consultant, she contacted the Advocacy Project in August 2001 and they wrote to the first Consultant to request a second opinion.

Evidence from Trust staff

7. The **Secretary** said that when the first Consultant referred a patient to another hospital for tests, she would retain the patient's clinical records in a filing cabinet until the results were received. Once the results had been received, they would be associated with the clinical records and passed to the first Consultant for consideration of further action. The patient was not discharged from the first Consultant's care at that time. The clinical records would remain with the Secretary unless the patient had to attend another consultant's clinic. If that was the case then the Secretary would release the records and mark on the cover that the records should be returned for her retention. Due to the large volume of clinical records that she held, the Secretary did not operate a brought forward system and would not know whether results were outstanding for a particular patient. If it appeared that results had been lost then she would either receive a telephone call or letter from the patient or their GP enquiring about the results. This would prompt a reminder to be sent for the results.

8. The Secretary did not recall the first Consultant dictating notes asking her to chase up the test results. The first time that she was aware of a problem was in October 2000, when the first Consultant annotated a letter from Mrs C's GP, that she should chase up the test results. The Secretary then telephoned the Infirmary and was told that copy test results would be sent. There was no indication when the copy results were received at the Hospital. The Secretary could give no explanation as to how the results came to be filed in Mrs C's clinical records but it appeared that neither she nor the first Consultant had seen them. She thought that a copy of the manometry result only was received in November 2000 and this was the result of her telephone call to the Infirmary.

9. The **first Consultant** said that it was appropriate to refer Mrs C to the Infirmary for endo anal scanning and anorectal manometry in order that he could reach a definitive diagnosis on her condition. The tests were not available at the Hospital and it would have been wrong for him to consider operating on Mrs C without the results of the tests. Once the first Consultant had made the referral to the Infirmary, he discharged Mrs C from his care.

The usual procedure which should have been followed was that once the results of the anorectal manometry and the endo anal scan were received, the Secretary would associate the results with Mrs C's clinical records and they would be passed to him. The first Consultant would then decide on the next course of action which could either be a review appointment with the patient or a letter to their GP with the results of the tests. The first Consultant would never arrange a follow up consultation without the test results.

10. The first Consultant did not keep a record of cases where he had referred patients for tests. If a patient was concerned that their results had been lost, the first Consultant would assume that they would contact their GP. The GP would then contact the first Consultant and the patient's clinical records would be retrieved and the case would be reviewed. The first Consultant accepted that a delay such as that experienced by Mrs C could happen with other patients who were suffering from similar conditions.

11. The first Consultant recalled receiving memos from the second Consultant about Mrs C. He thought that he had then dictated messages to the Secretary to chase up the results. The first Consultant was aware that there was correspondence between the Secretary and the Infirmary in November 2000 but he could not say when the scan results were actually received in his office. Mail received in the first Consultant's office was not date stamped. It was possible that the test results had been received in November/December 2000 and had been misfiled or were awaiting association with the clinical records. The first Consultant wrote to the GP on 12 January 2001 and told him that he was arranging for the scanning to be performed at the Hospital. The Trust had by then purchased a scanning probe but this was later deemed unsuitable as it had to be used with a machine which was held in the maternity unit. The first Consultant remembered that he received a letter in August 2001 from the Advocacy Project asking for a second opinion. The first Consultant must have had the scan results by that time as he knew that there was no operative intervention that would help Mrs C. However, he could offer no explanation as to why he had not advised Mrs C of this sooner. The first Consultant felt that clinically, Mrs C had had appropriate treatment for her condition but she had been let down by the system for reporting test results.

Mrs C should have been brought back into the system once the results had been received at the Hospital but this did not happen in her case.

Findings (a)

12. Mrs C is concerned about the way the first Consultant handled her treatment. The tests were carried out at the Infirmary in November 1998 but despite reminders to the first Consultant from the second Consultant and the GP, it was not until September 2001 that she was told that surgical intervention was not required. That was nearly three years after the tests had been taken, and during that time Mrs C continued to suffer bowel problems. The first Consultant has explained the procedures he follows when referring patients for tests outwith the Hospital. He would discharge the patient from his care until the test results were received. He would then contact the patient for a review appointment and decide on the next course of treatment. Both the first Consultant and the Secretary would expect that a patient who was concerned about lost results would contact their GP and the GP would send a further letter to the first Consultant. The first Consultant could offer no explanation as to how the delays had occurred in Mrs C's case. He thought that he had asked the Secretary numerous times to contact the Infirmary for the test results.

13. There is little evidence from Mrs C's clinical records to show that the first Consultant actively pursued the test results. There is nothing to indicate that contact was made with the Infirmary following the reminders from the second Consultant or Mrs C's clinic appointment in July 2000. The first Consultant annotated a note to the Secretary on the reminder letter from the GP in October 2000 to chase up the Infirmary for the test results. In the absence of evidence to the contrary, it is assumed that this led to the copy results being received at the Hospital in November or December 2000. However, the first Consultant did not think they were filed in Mrs C's clinical records when he wrote to the GP in January 2001. He then told the GP that he would arrange for the tests to be retaken at the Hospital. It would then appear that a further period of inaction affected the first Consultant's consideration of Mrs C's treatment. By this time, there had been a change of plan and Mrs C's scan would take place at the Hospital. However, the probe which the Hospital had obtained was not deemed to be suitable. Again, no action was taken to

contact Mrs C until the Advocacy Project wrote to the first Consultant in August 2001. The first Consultant was then able to refer to the copy scan reports and he told the Advocacy Project in September that further scanning was not required.

14. The fact that Mrs C had to wait from November 1998 to September 2001 to receive the test results is totally unacceptable. I am concerned that the first Consultant and the Secretary consider that it would be appropriate to leave it to a patient to contact their GP to report that their test results could be missing. However, this is what happened in Mrs C's case and despite reminders from the second Consultant and the GP, no action was taken to obtain Mrs C's test results and to advise her of the results until September 2001. There should be a system in place to alert the first Consultant or the Secretary that test results are overdue. The administration system used by the first Consultant in this regard is inadequate and requires to be reviewed in order that similar delays do not occur with other patients. I **recommend** that as a matter of urgency, that the Trust conduct a review of administration procedures followed by the first Consultant and the Secretary in order that follow up action is taken timeously which would prevent patients from effectively becoming lost in the system. I uphold this complaint.

Complaint (b) that the convener exceeded her responsibilities and failed to take appropriate clinical advice

National Guidance

15. Guidance on dealing with complaints issued by the Scottish Executive Health Department in May 1999 includes;

- The role of the convener is crucial in deciding whether there should be an independent review. It also provides complainants with an independent and informed view on whether any more can be done to resolve their complaint. The convener must decide whether to: refer the complaint back for further local resolution; or set up a panel to consider the complaint; or to take no further action. It is not the convener's role to seek a view on the merits or otherwise of the complaint or to investigate it. (2.4)

- The convener is responsible for ensuring that the complaint is dealt with impartially and that those handling the complaint maintain a distance from the complainant and the complained against. (2.7)

- In reaching a decision on a request for independent review, the convener must take appropriate clinical advice where the complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement. (2.8)

- Clinical advice should initially be sought from the medical or nursing director of the Trust, or the appropriate local professional head. Where these officers are the subject of the complaint, or where possible conflict of interest arises (for example, if this person has already been involved in the handling of the complaint) then the advice of an independent professional person should be sought. (2.10)

Documentary evidence

16. The Convener wrote to the Advocacy Project on 5 April 2002 refusing the independent review. She wrote:

> '...
>
> 'I consider that [Mrs C] had appropriate investigations for her symptoms. There were clearly failures of communications in reaching the diagnosis and the Trust has apologised for these.
>
> 'In the circumstances I think a second opinion from a Consultant in Edinburgh would be the best way to proceed and [Mrs C] should approach her GP to request this. [The Trust's Medical Director], would be happy to assist her GP in suggesting a suitable Consultant ...
>
> '...
>
> 'My decision is therefore that an Independent Review Panel is not to be convened and, as I have already said, I am happy to attempt to expedite

the process of obtaining a second opinion, with the assistance of the Trust's Medical Director.'

Mrs C's evidence

17. **Mrs C** did not feel that the Convener had looked at her complaint from an impartial point of view. The wording of the Convener's letter read as though the Convener had investigated the complaint. If the Convener had felt that the Trust could have taken further action by arranging a second opinion, she should have returned it for further local resolution. It also appeared that the Convener and the Medical Director had worked together in an effort to resolve the complaint by offering to arrange a second opinion. The Medical Director had previously been Mrs C's GP and it was he who had made the referral to the first Consultant in July 1998. Mrs C saw this as a conflict of interest and felt that the Convener had not acted in accordance with the guidance on the NHS complaints procedure.

Evidence of Trust staff

18. The **Convener** said she became involved in Mrs C's complaint when the previous convener resigned. The Convener was conscious that the request for independent review had been ongoing for some time and that the timescales in the complaints procedure were not going to be met. The Convener considered the papers and thought that although the Trust had apologised for the delays in obtaining the test results from November 1998, Mrs C required reassurance concerning her medical condition. The way forward was for Mrs C to have a second opinion which would take the form of further local resolution and was not a matter that would benefit from an independent review. It was the Convener's intention that the question of a second opinion be addressed as soon as possible which was why she told Mrs C that she or the Medical Director would be willing to assist in expediting matters. The Convener is aware that it is not her role to investigate or try to resolve the complaint but she was trying to offer assistance to Mrs C.

19. The Convener could see how her letter to Mrs C refusing the independent review could give the impression that she had investigated the complaint. The Convener usually drafts/writes her letters herself but on this occasion, she was about to go on holiday. Trust staff had drafted the letter for her which she

signed without fully reading it. She would have chosen her words more carefully and the letter would have made it clear to Mrs C that she was returning the complaint back to the Trust for further local resolution. If Mrs C was not satisfied with the further local resolution, she could again request an independent review. The letter did not make this clear. The Convener did not realise that the Medical Director had previously been Mrs C's GP and that he had referred Mrs C to the first Consultant. That was an oversight on her part and she could understand that the Medical Director's previous involvement as the referring GP and then to provide clinical advice could be viewed as a possible conflict of interest. If the Convener had realised that at the time, she would have sought clinical advice from another source.

Findings (b)

20. Mrs C has said that it appeared the Convener had investigated her complaint from the wording of the Convener's letter which said that she had had appropriate investigations and that the way forward was for Mrs C to have a second opinion. Additionally, Mrs C thought that there had been a conflict of interest as the Convener had sought clinical advice from the Medical Director. The Convener has said that she felt that Mrs C required reassurance about her medical condition and that could be addressed by obtaining a second opinion. She tried to be helpful and told Mrs C that she or the Medical Director would be willing to assist her. The Convener saw the offer to assist as a form of continued local resolution but her letter to Mrs C did not make that clear. The Convener had not noticed that the Medical Director had been Mrs C's GP.

21. The guidance at paragraph 15 is clear that it is not the convener's role to investigate the complaint and that the convener should maintain a distance from the complainant and the complained against. I am satisfied that the Convener did not investigate Mrs C's complaint but she did become involved by offering to help Mrs C obtain a second opinion. While I have no doubt that the Convener acted with the best of intentions, if she thought there was scope for further local resolution, then she should have returned the complaint back to the Trust to take further action. The guidance also says that initially, clinical advice should be sought from the medical director unless a possible conflict of interest arises. I take the view that as the Medical Director used to be Mrs C's GP then there was the possibility of a conflict of interest and as such the

Convener should have obtained clinical advice from another source. Accordingly, it is to the extent of the failings which have been identified that I uphold this complaint.

Conclusion

22. I have set out my findings in paragraphs 12-14, 20 and 21. The Trust have asked me to convey to Mrs C - as I do through this report - an apology for the shortcomings which have been identified. The Trust have agreed to act on my recommendation in paragraph 14.

Graham Pettie
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services Ombudsman Act 2002

November 2002