SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case ref: 201401011, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals: clinical treatment/diagnosis

Summary

Mrs C complained on behalf of her grandmother (Mrs A) about the time it took to provide Mrs A with treatment. Mrs A had a long history of incontinence problems, and her GP referred her to the board in August 2012. In November 2012, Mrs A had her first appointment at Wishaw General Hospital. In May 2013, tests at a second appointment identified the problem as stress incontinence. At a third appointment in October 2013 a doctor suggested that surgery might address this, and said that Mrs A would be referred to a specialist consultant. This, however, did not happen and when by January 2014 nothing had been heard, Mrs A, her GP and Mrs C all contacted the hospital. Mrs A was eventually referred to a consultant in February 2014, and was placed on a waiting list for surgery.

Meanwhile, in September 2013 new national guidelines had been produced for managing incontinence in women and subsequently the board formed a group to discuss the best way to treat patients like Mrs A. The group discussed Mrs A's case at their first meeting in March 2014. They decided that, per the guidelines, rather than her being on the waiting list, they should instead refer her to a specialist centre at another board (Hospital 2) to consider her treatment. She eventually had surgery in February 2015, some two and a half years after her initial referral.

In February 2014, Mrs C had complained to the board about the delays. They explained why these happened, acknowledged that they were unacceptable and apologised for this and for the distress caused. Mrs C was unhappy with their response as it did not say whether anything had been done to stop this happening again.

I took independent advice from two advisers, a consultant physician and a consultant gynaecologist. The consultant physician said that the delays after the first appointment were unacceptable, and that there was a failure of care when Mrs A was not referred to the specialist consultant in October 2013. Both advisers found the delay in referring Mrs A to the specialist centre

unacceptable, although the consultant gynaecologist confirmed that in Mrs A's case it was entirely correct to follow the guidelines and refer her there for consideration.

I found that there was a general lack of urgency in Mrs A's care, that there were unreasonable delays in investigating and assessing her condition, and that the board did not address these effectively when responding to Mrs C's complaint. I was particularly concerned that Mrs A was not referred to a consultant in October 2013, and that when handling the complaint the board did not try to find out why this happened. I upheld Mrs C's complaint and made four recommendations.

Redress and recommendations

I recommended that the Board:		*Completion date*
(i)	conduct a detailed review of the failings around the out-patient appointment of 28 October 2013, particularly treatment time targets and the lack of referral/clinic letter;	22 June 2015
(ii)	conduct a review of appointment allocation and waiting times for patients within the uro-gynaecology speciality;	22 June 2015
(iii)	apologise and provide an explanation for the delay in referring Mrs A to Hospital 2; and	20 May 2015
(iv)	apologise to Mrs C for failing to provide a reasonable response to her complaint.	20 May 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002. Under the Act, the Ombudsman can publish a public report and lay this before the Parliament where he considers that there is a public interest in the matter and it is appropriate to do so. The Act says that, generally, reports of investigations should not name or identify individuals, so in the draft report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. The complainant (Mrs C) has raised this complaint on behalf of her grandmother (Mrs A). Mrs A was referred to Lanarkshire NHS Board (the Board) by her GP on 13 August 2012 as she was experiencing problems with incontinence. Mrs A had a history of problems with this issue and had pelvic floor surgery carried out in 1982, with further treatment in the form of macroplastique (a stress incontinence treatment) and colposuspension (surgery to change the position of the bladder) in 2001.

2. Following the referral, Mrs A was seen as an out-patient on 5 November 2012 by a gynaecology consultant (Consultant 1) at Wishaw General Hospital (Hospital 1). Consultant 1 referred Mrs A for a urodynamic assessment to provide more information of the type of incontinence she was suffering from. Mrs A was seen in a urodynamics clinic on 2 May 2013 by a gynaecology consultant (Consultant 2). The urodynamics test results showed stress incontinence only and a urinary tract infection (UTI).

3. Mrs A was referred to her GP for treatment for the UTI and was subsequently seen by a gynaecology registrar (Doctor 1) at Consultant 1's out-patient clinic on 28 October 2013; however, no clinic letter was generated following this appointment. Doctor 1 discussed a tension free vaginal tape obturator (TVTO) procedure to address Mrs A's stress incontinence and a referral was to be made to a consultant gynaecologist with a special interest in this area (Consultant 3) for an opinion on the procedure. There is no evidence that this referral was made.

4. In January and February 2014, Mrs A, her GP and Mrs C all contacted Consultant 1's secretary about the lack of action. On 14 February 2014, Consultant 1 referred Mrs A to a consultant in obstetrics and gynaecology (Consultant 4) and then discussed the case with the Gynaecology Lead (Consultant 5) on 19 February 2014. Consultant 5 advised that Mrs A would require a TVTO procedure and agreed to carry out the procedure if the patient was happy to go ahead. Consultant 1 then arranged to see Mrs A at an out-patient clinic appointment on 24 February 2014. Mrs A agreed to be placed on the waiting list for the TVTO procedure and Consultant 1 apologised for the delay.

5. Some months earlier, in September 2013, the National Institute for Health and Care Excellence (NICE) published new guidelines for the management of urinary incontinence in women. The Board formed a new uro-gynaecology group within Hospital 1's gynaecology department, which held its initial meeting in the first week of March 2014. Mrs A's case was discussed by the group and Consultant 5 advised that, in line with the new NICE guidelines, Mrs A would have to be referred to a tertiary centre at a hospital in another NHS board area (Hospital 2) to consider her ongoing care and treatment. This referral was prepared on 26 March 2014.

6. Mrs C complained to the Board on 21 February 2014 about the length of time Mrs A had had to wait for treatment and received a final response dated 27 March 2014. This correspondence apologised for the unacceptable delay and outlined the sequence of events.

7. Mrs A finally had surgery to address her stress incontinence problems at Hospital 2 in February 2015, approximately two and a half years after her GP referred her to the Board.

8. The complaint from Mrs that I have investigated is that the time taken for the Board to provide treatment to Mrs A following a referral in August 2012 was unreasonable *(upheld)*.

Investigation

9. Investigation of Mrs C's complaint involved reviewing the information received from Mrs C and the Board. This included Mrs A's medical records and relevant guidance. My complaints reviewer also obtained independent advice from two medical advisers. The first of these is a consultant physician (Adviser 1) and the second is a consultant gynaecologist (Adviser 2).

10. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The time taken for the Board to provide treatment to Mrs A following a referral in August 2012 was unreasonable

11. Mrs A was referred to the Board regarding her incontinence difficulties by her GP in August 2012. Her first out-patient clinic appointment took place on 5 November 2012 with Consultant 1. Her next appointment was with

Consultant 2 at the urodynamics clinic on 2 May 2013, to investigate the type of incontinence she was suffering with. Mrs A was diagnosed with stress incontinence and seen again by Doctor 1 on 28 October 2013; however, the Board took no action to progress Mrs A's care at that time. This lack of action prompted Mrs A, her GP and Mrs C to contact the Board. Mrs A was offered a TVTO procedure and placed on the waiting list on 24 February 2014.

12. The Board formed a new uro-gynaecology group, which met for the first time in March 2014. Following discussion, Consultant 5 advised that Mrs A's care and treatment would be referred to Hospital 2 and she was removed from the waiting list for the TVTO.

The Board's response

13. In their response to Mrs C's complaint, the Board apologised for the delays Mrs A had experienced and for the distress caused. They acknowledged that her wait for surgery was unacceptable. The Board outlined the sequence of events and apologised for the failure to refer Mrs A to Consultant 3 following the 28 October 2013 clinic appointment. They acknowledged that Consultant 1 became aware the referral had not been made after Mrs C and Mrs A contacted the Board and explained that Consultant 5 had become involved thereafter. After agreeing on 24 February 2014 that surgery would go ahead under Consultant 5's care, the Board explained that Mrs A's plan for treatment was changed by new NICE guidelines published in November 2013. A referral to Hospital 2 was arranged, which the Board advised was best practice for complex uro-gynaecology cases like Mrs A's. The Board referred Mrs C to this office if she remained dissatisfied but also offered a meeting with senior staff to discuss any concerns if she wished.

14. Mrs C has explained that she was unhappy with the Board's response as, although an apology had been offered for the delays, they had not explained how they would prevent problems like these occurring for other patients who do not have family available to support them. Mrs C made particular reference to the failure to refer Mrs A to Consultant 3 following the 28 October 2013 out-patient appointment and the lack of urgency in provision of treatment.

Advice received

15. My complaints reviewer asked Adviser 1 whether Mrs A was seen within a reasonable time by the Board, following the referral by her GP. Adviser 1 said that Mrs A was referred by her GP on 13 August 2012 and was seen by

Consultant 1 on 5 November 2012, giving a time of 84 days or 12 weeks. He advised that the target time for patients to be seen is within 12 weeks, so Mrs A was within the target and that her care in this regard was considered to be reasonable.

16. Adviser 1 was also asked to comment on Mrs A's wait to be seen at the urodynamics clinic. He calculated that from 5 November 2012, when Mrs A was seen by Consultant 1, to 2 May 2013 when she attended at Consultant 2's clinic, was 179 days or 25 weeks (rounded down). Adviser 1 noted that the Board had not identified any particular reason for this delay. He advised that this is an unacceptable delay for what is a relatively simple diagnostic test which has a monthly clinic. Adviser 1 referred to Information Services Division (ISD) Scotland (ISD Scotland is part of NHS National Services Scotland) guidance on diagnostic waiting times which states:

> 'Better Health Better Care published in December 2007, set out a commitment: "the 18 week Referral to Treatment (RTT) standard will address the whole patient care pathway, from receipt of a GP referral, up to the point at which each patient is actually admitted to hospital for treatment".
>
> Diagnostic waiting times are an important component in the delivery of the 18 Weeks RTT commitment as the test or procedure is used to identify a person's condition, disease or injury to enable a medical diagnosis to be made.'

17. In relation to the time that elapsed before Mrs A's next out-patient appointment, Adviser 1 noted that the urodynamics report was completed on 14 May 2013 and sent to Consultant 1. He found the delay between the urodynamics assessment and the clinic visit to be 180 days or 25 weeks (rounded down). Adviser 1 considered this to be an unreasonable length of time and noted that Mrs A experienced longer delays within the NHS system than she had waited to enter it following her GP referral. He commented that there was no sense of urgency from the medical staff that this was an unduly slow process or that it was unfair for Mrs A to have to wait this long.

18. Adviser 1 noted that no formal clinic letter from Hospital 1 to Mrs A's GP was created following the appointment of 28 October 2013. He advised that this was a failure of care and commented that professional standards in the

General Medical Council (GMC)'s Good Medical Practice state that doctors should:

> 'share all relevant information with colleagues involved in your patients' care within and outside the team, including … when you delegate care or refer patients to other health or social care providers.'

19. Adviser 1 considered that this failing resulted in the error in referring Mrs A to Consultant 3. He was critical of this and the Board's response to the failure.

20. Adviser 1 noted that although Consultant 1 made a referral to Consultant 4 on 14 February 2014, after the error came to light, she did not highlight the fact that this had not been done on 28 October 2013 and appeared to have treated it as a routine referral. He commented that in the referral to Consultant 4, Consultant 1 showed no anxiety about the delay for Mrs A. Adviser 1 was critical that no additional urgency was added to the process at this stage and that no additional concern for Mrs A was demonstrated. He considered that better care for Mrs A would have been an urgent referral highlighting the delays which had already occurred and asking the specialist to try and reduce any further impact by minimising any future delays.

21. Adviser 1 said that, without any action from Mrs A or her GP, the failings around the clinic appointment of 28 October 2013 would not have come to light. He considered the failure in this system to be so profound that nothing would have happened without action from Mrs A and her GP.

22. My complaints reviewer asked Adviser 1 if it was reasonable to delay Mrs A's operation further by referring her to the tertiary centre at Hospital 2. He advised that this may have been the correct decision clinically for Mrs A, but that it represented very poor care that the Board changed their mind about her treatment between 24 February 2014, when she was placed on the waiting list for surgery, and 5 March 2014 when it was decided that a referral to Hospital 2 was needed. Adviser 1 was particularly critical as the NICE guidelines had been available for several months before this and the Board were already considering changing their treatment pathway for women like Mrs A by forming a specialist group, yet she was still put on the waiting list.

23. Further advice on the issue of onward referral to Hospital 2 was sought from Adviser 2. My complaints reviewer asked Adviser 2 if the decision to refer Mrs A to Hospital 2 was in line with the relevant NICE guidance. He advised

that the updated NICE clinical guidelines on the management of urinary incontinence in women were published in September 2013. Adviser 2 explained that the guidelines clearly state that invasive therapy for stress urinary incontinence should only be made after a multi-disciplinary team (MDT) review. He advised that the guidelines also state 'women whose primary surgical procedure for SUI [stress urinary incontinence] has failed should be referred to tertiary care for assessment and discussion of treatment options by the MDT'. Adviser 2 said that if the patient does not want further surgery, conservative measures should be offered.

24. Adviser 2 said that, consequently, it was entirely appropriate that Mrs A was referred to a tertiary centre at Hospital 2, with a functional MDT and clinical experience in cases of recurrent incontinence. He advised that in this particular case, whilst suggestive of stress incontinence, the urodynamic studies also illustrated a reduced bladder capacity and intermittent void. Adviser 2 explained that both of these factors may be associated with a poor outcome when considering repeat surgery and hence he agreed that a specialist opinion was justified. Whilst he found that an appropriate tertiary opinion was sought, he considered the delay in referral to be unacceptable.

25. Adviser 2 considered that, given Mrs A's age, physical health, failed previous continence surgery and urodynamics findings, referral to a tertiary centre was entirely appropriate. He acknowledged that this had caused a further delay in management; however, Adviser 2 took the view that it was preferable to delay and take the correct management action rather than performing the wrong procedure in the interests of reducing waiting time. He concluded that whilst the delay was unacceptable, on balance, the right decision was made in referring Mrs A to the tertiary centre.

Decision

26. Following referral from her GP, Mrs A waited around 12 weeks to be seen by the Board as an out-patient. Whilst this was reasonable, the subsequent delays in investigating and assessing her condition were not. Mrs A waited approximately 25 weeks between her initial out-patient appointment on 5 November 2012 and her urodynamics assessment on 2 May 2013; then a further 25 weeks to be seen at another clinic appointment on 28 October 2013. The advice received highlights that these timeframes are well outside the RTT standard of 18 weeks and represent poor service for Mrs A. I acknowledge that the Board have apologised for the unacceptable length of time that Mrs A

waited for surgery; however, I am not satisfied that a reasonable explanation for these delays has been provided or that any assurance has been given that other patients will not experience the same problems.

27. I am particularly concerned by the advice received in relation to the out-patient appointment of 28 October 2013. Although brief handwritten notes do exist for this consultation, a clinic letter was not dictated until 24 February 2014. Despite the fact that a referral to Consultant 3 had been agreed at the appointment, the Board have confirmed that the referral was not made. Although the Board apologised for this failing, there is no evidence in the information provided to suggest that this prompted further action by the Board. The advice highlighted that the failure to issue a clinic letter to Mrs A's GP was a failure in care, in terms of the GMC's Good Medical Practice guidance, and Adviser 1 commented that this error resulted in no referral being made for Mrs A. I am concerned that the Board did not instigate further investigation of how the omissions occurred, once they became aware of these errors.

28. There has been a marked lack of urgency on the part of the Board throughout this episode of care. The advice I have received commented on this and Adviser 1 highlighted that, even after the referral error of the 28 October 2013 clinic appointment came to light, Consultant 1 completed a routine referral rather than attempting to expedite the process for Mrs A.

29. Although Adviser 2 has been clear that the decision to refer Mrs A to Hospital 2 was appropriate and in line with NICE guidelines, both he and Adviser 1 were critical of the delay in making this referral, given that the guidelines were published some five months earlier in September 2013. The advice received is that whilst the referral decision was correct, the Board provided very poor care by changing Mrs A's treatment plan just nine days after it was agreed. The Board should have been aware of the NICE guidelines and the changes they would introduce when treating women such as Mrs A.

30. Overall, there were unreasonable delays in the time taken to investigate Mrs A's symptoms and a failure to enact the clinical plans for her treatment. Even after her treatment was discussed and agreed on 24 February 2014, it was changed soon after without any prior warning that this could occur. The lack of urgency in her care continued even after staff became aware of delays, such as the failed referral in October 2013. I note that at no point did the Board

acknowledge Mrs A's right to treatment within the 18 week target and that none of the clinicians involved in this case demonstrated any concern about this.

31. The Board's response to Mrs C's complaint does not provide sufficient explanation of the delays she experienced; how the errors after the 28 October 2013 appointment occurred; or how they propose to prevent a recurrence of similar problems in future. I agree that the failings should have been fully addressed during the complaints process. I do not consider the Board's response to be reasonable in this regard and, in light of the findings detailed in this report, I uphold the complaint.

Recommendations

32.	I recommend that the Board:	*Completion date*
(i)	conduct a detailed review of the failings around the out-patient appointment of 28 October 2013, particularly treatment time targets and the lack of referral/clinic letter;	22 June 2015
(ii)	conduct a review of appointment allocation and waiting times for patients within the uro-gynaecology speciality;	22 June 2015
(iii)	apologise and provide an explanation for the delay in referring Mrs A to Hospital 2; and	20 May 2015
(iv)	apologise to Mrs C for failing to provide a reasonable response to her complaint.	20 May 2015

33. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mrs A	the aggrieved
the Board	Lanarkshire NHS Board
GP	general practitioner
Consultant 1	consultant gynaecologist
Hospital 1	Wishaw General Hospital
Consultant 2	consultant gynaecologist
UTI	urinary tract infection
Doctor 1	gynaecology registrar
TVTO	tension free vaginal tape obturator
Consultant 3	consultant gynaecologist
Consultant 4	consultant in obstetrics and gynaecology
Consultant 5	Gynaecology Lead
NICE	National Institute for Health and Care Excellence
Hospital 2	tertiary centre
Adviser 1	consultant physician
Adviser 2	consultant gynaecologist

ISD Scotland	Information Services Division Scotland
RTT	referral to treatment
GMC	General Medical Council
MDT	multi-disciplinary team
SUI	stress urinary incontinence

Annex 2

Glossary of terms

colposuspension	surgery to change the position of the bladder
General Medical Council (GMC)	the body which registers doctors, allowing them to practice in the United Kingdom. Promotes and upholds standards for the medical profession
gynaecology	medicine of the female genital tract and its disorders
macroplastique	a stress incontinence treatment
National Institute for Health and Care Excellence (NICE)	an independent organisation responsible for developing national guidance, standards and information on providing high-quality health and social care, and preventing and treating ill health
tension free vaginal tape obturator (TVTO) procedure	a type of urinary incontinence surgery
tertiary centre	specialist care centre
urodynamics	a group of tests used to check the function of the bladder and urethra

Annex 3

List of legislation and policies considered

National Institute for Health and Care Excellence – NICE clinical guideline 171 – Urinary incontinence – The management of urinary incontinence in women – September 2013

General Medical Council, Guidance for Doctors, *Good Medical Practice*