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: **Glasgow**

Case ref: 201605960, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Appointments / Admissions (delay / cancellation / waiting lists)

Summary

Ms C complained on behalf of her nephew (Mr A) about the care and treatment Mr A received from the Greater Glasgow and Clyde NHS Board (Board 1). Ms C's complaint concerned the delays in treatment for Mr A's dural arteriovenous fistula (DAVF – where there are rarer, abnormal connections between arteries and veins in a protective membrane on the outer layer of the brain and spine, called the dura. Symptoms can include an unusual ringing or humming in the ears, particularly when the DAVF is near the ear, and some patients can hear a pulsating noise caused by the blood flow through the fistula) and the poor communication with him about this. The original complaint we received concerned the treatment of Mr A's arteriovenous malformation in the brain (AVM - where a tangle of blood vessels in the brain or on its surface bypasses normal brain tissue and directly diverts blood from the arteries to the veins). During the course of our investigation, it was identified that there were different types of AVM and that Mr A had one type, known as DAVF.

We obtained independent advice on the case from a consultant neurosurgeon, a consultant interventional neuroradiologist and a consultant in public health medicine.

We found that that Board 1 unreasonably failed to provide Mr A with treatment for his DAVF and we upheld this part of the complaint. We also found that, having advised Mr A that a hospital in another board's area was willing to provide treatment for his condition, Board 1 then failed to make arrangements for this within a reasonable time and we upheld this part of the complaint. We found that Board 1 failed to keep Mr A updated on his proposed treatment and that Mr A and his family had to contact Board 1 repeatedly to find out what was happening and that Board 1 also failed to respond to Mr A's email detailing his concerns about Board 1's response to his complaint. We, therefore, upheld this part of the complaint. We made a number of recommendations to address the failings in this case.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking Board 1 to do for Ms C and Mr A:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b) and (c)	Board 1 failed to: 1. provide Mr A with appropriate treatment for his dural arteriovenous fistula; 2. make arrangements for Mr A to receive treatment for his condition at Hospital 2 within in a reasonable time; and 3. communicate with Mr A about treatment for his condition	Apologise to Mr A and his family for the failings identified in Mr A's care and treatment and the communication with him about this The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the record of apology By: 21 September 2018

We are asking Board 1 to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Mr A's angiogram in December 2015 was incomplete, the image quality was poor and the technical report for the imaging was inadequate to inform MDT discussion and treatment planning Consultant 2 did not have a clear treatment plan for Mr A and it took eight months before Board 1 decided what Mr A's treatment would be and advised him of this There was a lack of documentation of the MDT process and a poor standard of out-patient clinic discussions between Consultant 2 and Mr A, including discussion of risks of the embolisation procedure	Angiogram images should be complete and the image quality of a reasonable standard. The technical report for the imaging should be adequate to inform MDT discussion and treatment planning Consultants should ensure patients have a clear treatment plan, setting out the treatment required. Patients should be made aware of the plan within a reasonable time MDT process documentation and out-patient clinic discussions, including between a consultant and a patient, should be of a standard that provides a reasonable record of the discussion. Clinic discussions should include discussion of risks of procedures	Evidence that this case has been used as a learning tool for radiology and interventional neuroradiology staff This should demonstrate how, in a supportive way, the Board has learned to ensure that angiograms and technical reports are completed appropriately; that staff understand the risks involved in having to repeat angiograms; and that the MDT process documentation and out-patient clinic discussions should be of a reasonable standard By: 22 November 2018

(a)	It was unreasonable of the Board to cancel and reschedule Mr A's surgery repeatedly	Patients should receive appropriate treatment in a reasonable time from the appropriate organisation, in line with adequate contingency arrangements	Evidence that this case has been used in a supportive way as a learning tool for interventional neuroradiology staff, to ensure that in future patients receive treatment in a reasonable time, in line with adequate contingency arrangements By: 22 November 2018
(b)	Board 1 did not make sufficient arrangements for Mr A to receive cross border treatment in a reasonable time Board 1 failed to follow their own Policy and Scottish Government Guidance when dealing with Mr A's referral to Hospital 2 There was a lack of clear documentation or audit trail of the decision making process and the communication with the parties involved, including a lack of documentary evidence of Board 1's contact with Board 2 on Mr A's case	Board 1 should follow their own Policy and Scottish Government Guidance when making or considering cross border referrals. Treatment should be arranged within a reasonable time. Decisions should be clearly documented and communicated promptly to all parties involved	Evidence that all Board staff involved in cross border referrals are aware of Board 1's Policy and Scottish Government Guidance and the need for clear documentation and communication of the decision making process By: 22 November 2018

(c)	Board 1 failed to take reasonable steps to keep Mr A updated on his referral to/treatment at Hospital 2	Patients should be kept updated on their referrals to/treatment at other boards	Evidence that this matter has been discussed with the staff involved in a supportive way that encourages learning By: 22 November 2018
(c)	Board 1 failed to provide Mr A with a response to his email of 19 October 2016, either directly or via his MSP	Staff should respond to patients' complaints in a reasonable time	Evidence that this matter has been discussed with the staff involved in a supportive way that encourages learning By: 22 November 2018

Feedback

Response to SPSO investigation

Broad 1 failed to respond to my enquiries by the deadlines set and failed to provide full and complete responses, which delayed our investigation of Ms C's complaint.

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, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman on behalf of her nephew (Mr A) about the care and treatment Mr A received from the Greater Glasgow and Clyde NHS Board (Board 1) from August 2015 to April 2017. Ms C's complaint concerned the delays in treatment for Mr A's dural arteriovenous fistula (DAVF) and the poor communication with him about this. The original complaint we received concerned the treatment of Mr A's arteriovenous malformation in the brain (AVM) During the course of our investigation, it was identified that there were different types of AVM and that Mr A had one type, known as dural arteriovenous fistula (DAVF). A DAVF is where there are rare, abnormal connections between arteries and veins in a protective membrane on the outer layer of the brain and spine, called the dura. Symptoms can include an unusual ringing or humming in the ears, particularly when the DAVF is near the ear, and some patients can hear a pulsating noise caused by blood flow through the fistula.

2. Ms C complained to my office because she was dissatisfied with Board 1's response to the concerns she raised with them.

3. The complaints from Ms C I have investigated are that:

(a) From August 2015 to November 2016, Board 1 unreasonably failed to provide Mr A with treatment at Queen Elizabeth University Hospital for his dural arteriovenous fistula (upheld);

(b) From January to April 2017, Board 1 failed to make arrangements for Mr A to receive treatment for his condition at another board within in a reasonable time (upheld); and

(c) From August 2015 to April 2017, Board 1 unreasonably failed to communicate with Mr A about treatment for his condition (upheld).

Investigation

4. My complaints reviewer and I considered all the information provided by Ms C and Board 1, including Mr A's relevant medical records and Board 1's complaint file. We also obtained independent medical advice on the case from a consultant neurosurgeon (Adviser 1), a consultant interventional neuroradiologist (Adviser 2) and a consultant in public health medicine (Adviser 3).

5. I have decided to issue a public report on Ms C's complaint. The reasons for this are:

- there were failings by Board 1 at almost every stage of Mr A's care and treatment;
- there was a general lack of acceptance and learning by Board 1 regarding these failings; and
- there is wider learning for other boards in publishing this report.

6. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked. Ms C and Board 1 were given an opportunity to comment on a draft of this report.

Background

7. Mr A was diagnosed, aged 13, as having a DAVF. Mr A received treatment for this and Board 1 reviewed him annually for this condition until 2011.

8. On 8 August 2015, Mr A attended A&E at the Queen Elizabeth University Hospital (Hospital 1) with a two month history of 'whooshing' noise in his left ear and was concerned that he was having a brain bleed. Following examination and discussion with neurosurgery, he was discharged and a referral was made to a Consultant Neurosurgeon (Consultant 1) who was, and still is, involved in his care.

9. On 5 November 2015, Mr A attended an appointment with Consultant 1 and was advised that he would need an angiogram (a type of x-ray used to check blood vessels) of his brain.

10. On 3 December 2015, a Consultant Interventional Neuroradiologist (Consultant 2) carried out an angiogram on Mr A's brain. The report from this suggested that Mr A might have a recurrence of his DAVF, which had previously been treated in 2009.

11. On 4 February 2016, Mr A's case was discussed at the neurovascular multi-disciplinary team (MDT) meeting at Board 1. It was decided that Consultant 2 would arrange to see Mr A to discuss treatment. Consultant 1 wrote to Mr A the next day to advise him that Consultant 2 would make an appointment for him to discuss further management and embolisation (a procedure to block abnormal blood vessels) of Mr A's DAVF.

12. On 18 February 2016, Mr A's follow-up appointment with Consultant 2 was cancelled on the day due to an emergency.

13. On 21 April 2016, Mr A was seen by Consultant 2, who advised Mr A that he would need to talk to colleagues about Mr A's case.

14. On 30 June 2016, Mr A's case was again discussed at the neurovascular MDT meeting.

15. On 14 July 2016, Mr A was seen by Consultant 2, who advised Mr A that he would need an embolisation operation, which Consultant 2 would perform. Consultant 2 arranged for Mr A to be admitted to Hospital 1 in the first week of August 2016. The operation was scheduled for 2 August 2016, but was cancelled on the day due to staff absence.

16. On 8 August 2016, Mr A emailed a formal complaint to Board 1 raising concerns about the delay in his treatment and the lack of communication about this from Board 1. Board 1 responded on 13 September 2016. They said the service Mr A required was only provided by a small number of speciality interventional neuroradiologists. One of their consultants had left, leaving only one consultant and one locum providing the service. They said the service provided was impacted when either of them were absent.

17. Board 1 said Mr A's procedure on 2 August 2016 had to be cancelled due to sickness absence and apologised for the distress and inconvenience caused. Board 1 explained that they had been trying to recruit another consultant but this had proved challenging given the specialist nature of the post. They advised Mr A that his procedure would be rescheduled for 20 September 2016.

18. In August and September 2016, Mr A's MSP wrote to Board 1 on Mr A's behalf raising concerns about the delay in his treatment.

19. Mr A's surgery on 20 September 2016 was cancelled on the day due to emergencies taking priority. His surgery was again rescheduled, this time for 23 September 2016. For a third time, the surgery was cancelled, again due to emergencies.

20. On 19 October 2016, Mr A emailed Board 1 again, advising that he was not satisfied with Board 1's response to his complaint, as it did not address all of the issues he had raised.

21. Mr A's surgery was rescheduled for a third time, for 25 October 2016. For a fourth time it was cancelled; on this occasion due to staff absence.

22. Board 1 then took steps to try to source treatment for Mr A in hospitals in England and it would appear that Consultant 1 sent a referral for Mr A to a Consultant Neuroradiologist (Consultant 3) at a hospital in England (Hospital 2).

23. Mr A's MSP met with the Chief Executive at Board 1 on 7 November 2016 regarding Mr A's case. Board 1 drafted a letter from their Chief Executive to Mr A's MSP, which appeared to have been in final draft around 9 November 2016. There was no indication that this letter was ever sent.

24. On 4 November 2016, Mr A underwent another angiogram of his brain at Hospital 1, at the request of Consultant 3.

25. On 18 November 2016, Consultant 3 wrote to Consultant 1, acknowledging the referral. They indicated that after reviewing the most recent imaging for Mr A, they would not be able to offer a cure for Mr A but would be able to offer an endovascular treatment (a procedure to treat problem blood vessels) to alleviate the noises in his left ear.

26. On 21 November 2016, Ms C contacted Board 1 on behalf of Mr A, asking for a response to Mr A's outstanding concerns about his delayed treatment. Ms C said Mr A did not receive a response.

27. In December 2016 and January 2017, funding was agreed for a pre- assessment appointment for Mr A at Hospital 2 on 19 January 2017 and initial treatment on 27 January 2017.

28. On 19 January 2017, Mr A's pre-assessment took place at Hospital 2. On 27 January 2017, treatment was attempted but could not be carried out due to the size of Mr A's blood vessels - which were too large. Alternative treatment was suggested, which was subsequently discussed at a MDT meeting at Hospital 2.

29. On 17 February 2017, Consultant 3 wrote to Consultant 1 and advised them of the clinical decision by the MDT regarding Mr A's proposed treatment, which was an embolisation procedure.

30. On 6 March 2017, Consultant 1 acknowledged receipt of the letter and said they supported Consultant 3's management plan for Mr A at Hospital 2.

31. On 11 July 2017, Mr A attended Hospital 2 for a pre-operation assessment and on 21 July 2017, he attended for his embolisation procedure. The procedure could not be performed due to the twisted nature of an artery in Mr A's brain.

32. Throughout the period August 2015 to July 2017, Ms C and Mr A made regular contact with Board 1 enquiring about Mr A's treatment.

(a) From August 2015 to November 2016, Board 1 unreasonably failed to provide Mr A with treatment at Queen Elizabeth University Hospital for his dural arteriovenous fistula; and
(b) From January to April 2017, Board 1 failed to make arrangements for Mr A to receive treatment for his condition at another board within in a reasonable time.

33. Ms C said Board 1 failed to appropriately carry out Mr A's angiogram in December 2015, which she said they were later advised was incomplete. Ms C questioned whether embolisation was the correct procedure for Mr A's condition, as they were later advised that his condition might be untreatable. Ms C also complained that Board 1 repeatedly cancelled Mr A's embolisation procedure.

34. Ms C said that, having advised Mr A that Hospital 2 was willing to provide treatment for his condition, Board 1 then failed to make arrangements for this within a reasonable time.

Board 1's responses to my office
Angiogram/embolisation
35. In their responses to my office, Board 1 said:
- The imaging report for Mr A's angiogram in December 2015 did not indicate that the angiogram was incomplete or unsatisfactorily performed.
- The report advised 'Further multi-disciplinary discussion regarding this case is indicated which should be discussed with [another consultant]'.

- Mr A’s further management was discussed at the neurovascular MDT meeting on 4 February 2016, with his case being presented by Consultant 1.
- The meeting was attended by neurosurgical and interventional neuroradiology consultants who discussed the optimal management plan for Mr A. Board 1 referred to copies of the MDT meeting outcome form and letters from Consultant 1 to Mr A and his GP. They said these advised that Mr A would be reviewed by Consultant 2 in clinic to discuss his ‘further management and embolisation’.
- Mr A’s case was also discussed at an MDT on 30 June 2016.

Cancellations

36. Board 1 said that due to lack of specialist interventional neuroradiologists to provide the service, Mr A’s treatment was cancelled four times between referral in July 2016 and October 2016.

37. They explained that the service had more recently been supported by one substantive consultant and one locum, but the consultant left the service in January 2016, leaving a single locum consultant to provide the service. The locum endeavoured to become familiar with all cases on the waiting list as well as managing new referrals. They said that with a single practitioner, in the event of emergency cases requiring treatment, elective procedures, such as Mr A’s, were cancelled and rescheduled.

38. Board 1 said that unfortunately, on two of the four occasions, Mr A’s procedure was cancelled due to sickness absence of the locum. They said all efforts to recruit either substantive consultants or locums during this period were unsuccessful, despite efforts at an international level.

39. Board 1 set out events on Mr A’s case as follows:

- Mr A was referred on 5 November 2015 for an angiogram, which was required before a decision to proceed to treatment. This was performed on 3 December 2015.
- An interventional neuroradiologist left the employment of Board 1 in January 2016.
- Mr A’s case was discussed at an MDT meeting on 4 February 2016.
- Mr A attended the clinic with Consultant 2 on 21 April 2016.
- Mr A’s case was discussed again at an MDT meeting on 30 June 2016.

- A referral for Mr A's embolisation procedure was generated on 6 July 2016.
- Mr A attended the clinic with Consultant 2 on 14 July 2016 with a view to the embolisation procedure taking place in early August.
- Mr A's admission and procedure were scheduled for 2 August 2016, 20 September 2016, 23 September 2016 and 25 October 2016, but were cancelled due to emergencies or sickness absence. Discussions then began around referring Mr A to another centre for treatment.

40. Board 1 said Mr A was then scheduled for further treatment at Hospital 2 on 21 July 2017, with pre-assessment scheduled for 11 July 2017.

Referral to Hospital 2

41. Board 1 said Mr A was referred to Consultant 3 at Hospital 2. No copy of the referral was provided to us.

42. They said Consultant 3 advised Board 1 on 27 October 2016 that Mr A would require an updated angiogram, to take account of any potential changes in his condition before proceeding with any treatment. Board 1 said this was arranged at Hospital 1, was carried out on 4 November 2016 and images were sent to Consultant 3 for review, before going to an MDT meeting at Hospital 2 on 17 November 2016 for discussion on the preferred treatment options.

43. Board 1 said that whilst funding had been confirmed at the time of referral, formal written confirmation was requested by Hospital 2 on 6 January 2017 and this was confirmed on 9 January 2017. It was agreed to allow Mr A to be seen at the pre-assessment clinic at Hospital 2 on 19 January 2017, with treatment thereafter on 27 January 2017. Board 1 said Consultant 3's already committed workload and planned leave would not allow earlier dates for these.

44. When asked to comment on Mr A's treatment from February to April 2017, Board 1 said they advised that they would pay for Mr A's treatment at the outset, but it was sometime before they were asked to confirm this officially in writing, once the cost had been provided. They said they were, therefore, unaware that this was creating any delay.

Relevant policies, procedures, legislation, etc.

45. The relevant guidance in this case is:

- The Scottish Government CEL 06 (2013) 'Establishing the Responsible Commissioner: Guidance and Directions for Health Board', March 2013 (The Scottish Government Guidance)
- Board 1's Exceptional Treatment Requests Policy - December 2011 (Board 1's Policy)

Medical advice

Adviser 1

46. Adviser 1 said there was no established guideline for Mr A's complex case and said such cases were usually managed by a neurovascular team: an interventional neuroradiologist and a neurosurgeon with a special interest in neurovascular surgery (which happened in this case).

Adviser 2

47. Adviser 2 agreed with Adviser 1 that there was no relevant UK guidance document for the management of DAVF. They said the condition was rare and treatment was carried out in only two centres in Scotland as part of a MDT.

48. Adviser 2 said some forms of DAVF were life threatening and emergency or urgent treatment was needed. They said Mr A's DAVF had been known about for many years and previous attempts to treat it had been unsuccessful. They said Mr A's angiogram did not suggest any life threatening features and it would be usual practice in the UK to treat Mr A's DAVF as a 'routine' condition.

Angiogram

49. When asked if Board 1 failed to appropriately carry out Mr A's angiogram in December 2015, Adviser 2 said the angiogram was incomplete. They said:

- The angiogram confirmed the presence of DAVF but this diagnosis was already known.
- The angiogram did not fully evaluate Mr A's DAVF, the image quality was poor and the images did not include all of the abnormal blood vessels.
- The technical report for the imaging was inadequate to inform MDT discussion and treatment planning.

50. Adviser 2 said radiology reports should be structured, should include a description of the clinical indication for a procedure, a technical description of the

procedure, an interpretation of the imaging findings and an opinion about the clinical relevance of the procedure outcome / imaging findings. Adviser 1 noted that in this case, the report merely recommended onward referral of Mr A.

51. Adviser 2 said the poor quality of the December 2015 angiogram and the delays in Mr A's treatment necessitated the second angiogram in November 2016. They said this additional procedure subjected Mr A to an avoidable risk of stroke.

Embolisation

Adviser 1

52. When asked if embolisation was the correct procedure for Mr A's condition, Adviser 1 said it appeared that Mr A's case was discussed at an MDT meeting and a decision to offer embolisation was made. They said this was the correct thing to do.

Adviser 2

53. Adviser 2 agreed it was correct to consider embolisation in light of the new symptoms that Mr A was suffering. Adviser 2 said treatment for symptom control was often possible, even when the DAVF could not be cured. They said they could not see any documentation of a treatment plan for Mr A or of Consultant 2's treatment intentions. Adviser 2 said that from the available documentation, Consultant 2 did not have a clear treatment plan for Mr A.

54. Adviser 2 said they were concerned about the lack of documentation of the MDT process and said the MDT meeting record in this case was cursory. They said there was no list of attendees, no record of the discussion about options for treatment, treatment plan and treatment risks and no record of the expected natural history, if continued conservative management was undertaken. Adviser 2 said this fell below an acceptable standard of care.

55. In addition, Adviser 2 said the documentation of the out-patient clinic discussion between Consultant 2 and Mr A was cursory and noted from Mr A's account, that the discussion was 'less than five minutes'. Adviser 2 said an out-patient clinical review should describe the patient's presenting complaints, summarise the background clinical history and examination findings, describe the nature of any discussion with the patient and detail the management plan agreed with the patient. They said that all embolisation procedures for DAVF carried appreciable risks of serious complications, including stroke and brain

haemorrhage, and said there was a small risk of death or permanent disability. Adviser 2 said they did not think that these factors were discussed with Mr A and said this was well below an acceptable standard of care.

Cancellations

56. When asked about the repeated cancellation of Mr A's embolisation procedure, Adviser 2 said it was not reasonable for a plan for treatment to have been made and for that treatment to have been cancelled on four separate occasions. They said that, although it was unfortunately unavoidable to cancel treatments at the last moment, most centres would have a policy of prioritisation to ensure that no individual's procedure was subject to more than one cancellation, if at all possible. Adviser 2 said four cancellations was unacceptable and if the service was unable to offer treatment, then alternatives should have been sought much earlier.

Referral to Hospital 2

Adviser 2

57. Adviser 2 was asked if Board 1 failed to make arrangements within a reasonable time, having been advised that Hospital 2 were willing to provide treatment for Mr A's condition.

58. Adviser 2 said Mr A's condition was unpleasant for him but was also complex and not immediately dangerous to his health. Adviser 2 said that the delays for Mr A were regrettable but, to some extent, unavoidable. They said it was necessary for a clinical consideration of the case to be requested and then for a funding stream for cross border treatment to be identified. Adviser 2 said this process was not straightforward and suggested my office obtain advice from an adviser with specialist knowledge in this area, to assess whether any unnecessary delays occurred. We, therefore, obtained advice from Adviser 3 – see below.

59. Adviser 2 said the delay in treating Mr A's DAVF did not expose him to significant risks of more serious health issues such as brain haemorrhage, stroke, etc and noted that there did not appear to be a significant deterioration in Mr A's DAVF between the angiograms of December 2015 and November 2016. However, Adviser 2 said the delay in Mr A's treatment exposed him to a persistent loud noise in his head, which prevented normal sleep and was harmful to Mr A.

Adviser 3

60. When asked about delays in Mr A's cross border treatment, Adviser 3 said Mr A received treatment at Hospital 2 on 27 January 2017 and this treatment was funded by Board 1. They said the treatment was unsuccessful and following this, a clinical decision was made at an MDT meeting at Hospital 2 that further treatment was required and would need further funding approval. Adviser 3 said there was a gap of over four months between this decision, communicated to Board 1 on 18 February 2017, and the date of Mr A's treatment (21 July 2017).

61. Adviser 3 noted that Consultant 1 agreed to the suggested clinical management plan from Consultant 3 in a letter to the clinical team at Hospital 2 on 6 March 2017, but said there was no explicit mention of funding approval in the letter. Adviser 3 noted that Board 1 suggested in their response to my office that there was a clinical reason for the delay in scheduling Mr A's procedure. However, Adviser 3 said there was no available correspondence or notes from Board 1 to demonstrate an audit trail for funding authorisation for Mr A up to the end of April 2017 (the period being considered in this case).

62. Adviser 3 said Board 1 did not make sufficient arrangements for Mr A to receive treatment in a reasonable time and a lack of communication and coordination were underlying contributory factors for this unnecessary delay. Adviser 3 said the Scottish Government Guidance states:

> 'The underlying principle is that there should be no gap in responsibility for the provision of health care, and no treatment should be refused or delayed due to uncertainty or ambiguity over which NHS body is responsible for funding an individual's health care provision.'

63. Adviser 3 said the safety and wellbeing of patients was paramount and the process of seeking prior approval of funding should not delay patient access to clinical care.

64. Adviser 3 also said Mr A should have, as far as possible, remained in Scotland if the treatment was available. They noted that from the date of Board 1's decision to provide embolisation treatment for Mr A (the MDT meeting on 30 June 2016), Board 1 cancelled Mr A's operation four times and then referred him to Hospital 2.

65. Adviser 3 said that prior to referring a patient to NHS England it would be expected that, where there was a relevant specialist service in NHS Scotland, this was used or at least consulted. Adviser 3 said there was an equivalent specialist service in another NHS Scotland board (Board 2) and there was no evidence to demonstrate that Board 1 contacted this service for either a consultation or an opinion. Adviser 3 noted that the draft letter from Board 1 to Mr A's MSP in November 2016, indicated that Board 2 did not have the expertise to perform Mr A's surgery. Adviser 3 said they did not understand this to be the case.

Board 1's comments

66. My office asked Board 1 to comment on the availability of treatment for Mr A at Board 2 and Board's 1's statement on this in their letter to Mr A's MSP. In their response, Board 1 said the transfer of patients was based on a number of factors, but was predominately based on the clinical ability of the doctor to perform the procedure. They said clinical areas where there was a very specialist subset (as was the case here) was usually well known to that group of clinicians.

67. Board 1 said they had an agreed contingency plan in place for the transfer of radiology patients between Board's 1 and 2 for emergency procedures in the event of equipment failure or staff issues (i.e. sickness). Board 1 provided a copy of the plan. This appeared to cover the situation where if either of the boards did not have the appropriate staff to deliver the radiology service (due to staff not being available), they could transfer the patient to the other board for treatment.

68. Board 1 said that in Mr A's case, where no one at Board 1 could perform the complex procedure, they would automatically look to Board 2 in the first instance and said transfer needed to be agreed on a clinician to clinician basis to ensure that there was ongoing care of the patient. When asked for evidence of their contact with Board 2 about Mr A's case, Board 1 provided a copy of an internal email dated 24 October 2016, which stated

> 'Following on from the emails about sending a patient to [Board 2] and the process for funding approval, …. we are trying to find out if we can send [Mr A] … to [Hospital 2] to have their procedure done. We know that [Board 2] cannot do [Mr A] … .'

69. Board 1 also provided a copy of an email they received from Ms C on 25 October 2016, in which Ms C said

> '[Mr A] was told that [Board 1] were going to contact hospitals in [two cities in England] (as last time [Board 2] refused to take him because his case was too complex) …'

70. There was no evidence of Board 1's contact with Board 2 by email, letter or telephone about Mr A's procedure.

Ms C's comments

71. When my office asked Ms C about her email of 25 October 2016 to Board 1, Ms C said that when Consultant 2 was absent on 2 August 2016, they were advised that patients were being referred to Board 2 for treatment. She said Consultant 1 suggested that Mr A could be taken by ambulance to Board 2 for his surgery. Ms C said Mr A panicked and said he did not want to go to Board 2 as he had been treated by Board 1 for 20 years and he was concerned about how his mother would find him, if he was moved to a hospital in another board's area. Ms C said it was agreed that Mr A would remain in hospital overnight for surgery the following day, as Consultant 2 might be back then. Ms C said that the surgery did not go ahead the following day as Consultant 2 was dealing with another patient. Ms C said Consultant 1 said he had been in touch with Board 2 and they had indicated that Mr A's case was too complex for them to take.

72. Adviser 3 said Board 1's Policy states

> 'At all stages in this process, the staff grade in public health who manages the out of area referral arrangements, will provide advice on referral routes, on contracted and non-contracted services, National Services Division (NSD) arrangements and related matters. Where a non-contractual referral is approved, the staff grade makes all the necessary service and financial arrangements, including ensuring there is feedback to the referrer'

73. Adviser 3 said there was no evidence that the responsible officer for this process was contacted or informed of this referral or that Board 1's Policy was fulfilled.

74. Adviser 3 said there was no evidence that the NSD were contacted to discuss funding Mr A's case, even though an internal email sent to the staff

involved in this case on 25 October 2016, advised staff to contact NSD and set up the process for Mr A's procedure to be undertaken in England as soon as possible. The email went on to say

> 'We are collectively failing to assist this patient with his treatment and need to [set up the process] as a matter of urgency'.

75. Adviser 3 said Board 1 did not follow their Policy, which stated

> 'the aim should be [for the Board's decision making panel] to inform the requesting consultant and patient of a decision within 20 days or sooner, if there is a clinical need for urgency'

76. Adviser 3 said a decision on funding should be received within 20 working days in routine cases (such as Mr A's).

77. Adviser 3 said that Board 1's Policy and Scottish Government Guidance were in place to provide a transparent and efficient way of managing out of area referrals. Adviser 3 said these were not followed in Mr A's case, dating back to October 2016 - when Board 1 decided to source treatment for Mr A elsewhere, and this contributed to the avoidable delay Mr A experienced. Adviser 3 said there was a lack of clear documentation or audit trail both of the decision making process (from application stage to approval stage, including funding approval) and the communication with the requesting consultant, patient and healthcare providers.

(a) Decision

78. In her complaint to my office, Ms C said Board 1 failed to appropriately carry out Mr A's angiogram in December 2015, which she said they were later advised was incomplete. Ms C also questioned whether embolisation was the correct procedure for Mr A's condition, as they were later advised that his condition might be untreatable.

79. Adviser 2 said that the angiogram was incomplete as the images did not include all of Mr A's abnormal blood vessels, the image quality was poor and the technical report for the imaging was inadequate to inform MDT discussion and treatment planning. Adviser 2 also indicated that the poor quality of the December 2015 angiogram and the delays in treatment meant that a second

angiogram was required. This procedure subjected Mr A to an avoidable risk of stroke.

80. Advisers 1 and 2 both indicated that embolisation was the correct procedure for Mr A’s condition. Adviser 2 said that Consultant 2 did not have a clear treatment plan for Mr A and it is concerning that, having attended Consultant 1’s clinic on 5 November 2015 to decide on treatment for his condition, it took a further eight months before Board 1 decided what Mr A’s treatment would be and advised him of this. Adviser 2 also raised concerns about the lack of documentation of the MDT process and the poor standard of the out-patient clinic discussions between Consultant 2 and Mr A, including discussion of risks of the embolisation procedure, which they said fell below an acceptable standard of care.

81. Ms C complained that Board 1 repeatedly cancelled Mr A’s embolisation procedure. Adviser 2 said that it was not reasonable for Board 1 to have scheduled Mr A’s surgery and then cancelled it on four separate occasions. It would appear that consideration was given to referring Mr A to Board 2 for surgery, but the lack of documentary evidence means that we cannot be clear what happened in this regard.

82. I have considered and accept all the advice I received in respect of this part of Mrs C’s complaint. Given the failings above, I consider that Board 1 unreasonably failed to provide Mr A with treatment for his DAVF and I uphold this complaint.

(b) Decision

83. In her complaint to my office, Ms C said that, having advised Mr A that Hospital 2 was willing to provide treatment for his condition, Board 1 then failed to make arrangements for this within a reasonable time.

84. Adviser 3 said that Board 1 did not make sufficient arrangements for Mr A to receive treatment in a reasonable time and a lack of communication and coordination were underlying contributory factors for this unnecessary delay. Adviser 3 indicated that, from October 2016 to April 2017, Board 1 failed to follow their own Policy and Scottish Government Guidance when dealing with Mr A’s referral to Hospital 2. They said that there was a lack of clear documentation or audit trail of the whole decision making process and the communication with the parties involved.

85. It would appear that Board 1 may have made contact with Board 2 in August 2016 with a view to seeking treatment for Mr A, however, there is no documentary evidence of this or confirmation that Board 2 would not accept Mr A's case. Adviser 2 has indicated that the delay in arranging treatment for Mr A was harmful to Mr A's health.

86. I accept the advice in relation to this part of Ms C's complaint, which I uphold.

(c) From August 2015 to April 2017, Board 1 unreasonably failed to communicate with Mr A about treatment for his condition

87. Ms C said Board 1 failed to keep Mr A updated on his proposed treatment and that Mr A and his family had to contact Board 1 repeatedly to find out what was happening. Ms C said Board 1 also failed to respond to Mr A's email of 19 October 2016 detailing his concerns about Board 1's response to his complaint.

Board 1's response to my office

88. In their responses to my office, Board 1 said they tried to communicate regularly with Mr A and his family on his behalf about his treatment wherever possible. They said their complaint response to Mr A's MSP was already in draft when Mr A's email of 19 October 2016 was received, so a single response was intended to address both communications. They said there was discussion with Ms C on 28 October 2016 and she appeared satisfied with the information she was given about Mr A's proposed treatment plan. [On commenting on a draft of this report, Ms C disputed this statement and said she was not satisfied at that time.] Board 1 said there were also a number verbal and email communications with Ms C in an attempt to address the concerns raised.

89. Board 1 said that, after Mr A was referred to Hospital 2, Consultant 1 received a letter from Consultant 3 (on 28 February 2017), which provided an update on treatment options for Mr A, following a review of his scans and discussion at Hospital 2's MDT meeting. Board 1 said Consultant 3 outlined two options for further treatment for Mr A, but advised that the team and Mr A supported option one. They said Consultant 1 replied to this letter on 6 March 2017 confirming

> 'After your expert consideration and further investigation of this fistula, I would support your further treatment endeavours at [Hospital 2]'

90. When my office explained that the letter to Mr A's MSP was undated and was accompanied by an email dated 9 November 2016 indicating that the letter was a draft response only, Board 1 said there did not appear to be any correspondence which suggested there was a direct response to Mr A's email of 19 October 2016 and said they could find no formal record that the letter to Mr A's MSP was sent. They said there was a record that evidence was gathered and a draft letter produced and sent to service colleagues for approval, but no confirmation that this was approved, signed and sent. Board 1 apologised for this and said their records should clearly have shown if a letter had been sent. They said they would use this as a learning opportunity to try and avoid a recurrence of a similar incident.

Medical advice

Adviser 2

91. When asked if, in their experience, Board 1 took reasonable steps from August 2015 to April 2017 to keep Mr A updated on his proposed treatment for his condition, Adviser 2 said the whole process of initial diagnosis, treatment planning, multiple case cancellations, decision to refer to an English centre, delays in agreeing funding and the subsequent difficulties in treatment of Mr A's DAVF at the referral centre was very time consuming. These delays were never desirable and had a detrimental effect on Mr A and his family.

92. Adviser 2 said there was a clear breakdown in communication between Mr A, the clinical team and the managerial team and clear communication pathways should be developed and reasonable response times should be agreed to prevent similar events in the future.

93. Adviser 2 said they were not aware of any specific time targets or limitations in complex cases of this nature, and suggested seeking advice from an adviser with specialist knowledge in this area. We, therefore, obtained advice from Adviser 3.

Adviser 3

94. Adviser 3 said there was no documentation and audit trail that would be expected in cases where NHS Scotland residents were referred for treatment in NHS England. They said it was not the responsibility of the patient or carers to coordinate care. Adviser 3 said there was no evidence that Board 1 took reasonable steps to keep Mr A updated on his referral to/treatment at Hospital 2.

(c) Decision

95. Ms C complained that Board 1 failed to keep Mr A updated on his proposed treatment and that Mr A and his family had to contact Board 1 repeatedly to find out what was happening. Ms C said Board 1 also failed to respond to Mr A's email of 19 October 2016 detailing his concerns about Board 1's response to his complaint.

96. Adviser 2 and Adviser 3 were both critical of Board 1's communication with Mr A in their advice. Adviser 3 said that there was no evidence that Board 1 took reasonable steps to keep Mr A updated on his referral to/treatment at Hospital 2. The evidence suggests that Board 1 did not provide Mr A with a response to his email of 19 October 2016, either directly or via his MSP. I accept this advice

97. I am critical of Board 1 for their poor communication and I uphold Ms C's complaint.

98. 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.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Board 1 to do for Ms C and Mr A:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b) and (c)	Board 1 failed to: 1. provide Mr A with appropriate treatment for his dural arteriovenous fistula; 2. make arrangements for Mr A to receive treatment for his condition at Hospital 2 within in a reasonable time; and 3. communicate with Mr A about treatment for his condition	Apologise to Mr A and his family for the failings identified in Mr A's care and treatment and the communication with him about this. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the record of apology By: 21 September 2018

We are asking Board 1 to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Mr A's angiogram in December 2015 was incomplete, the image quality was poor and the technical report for the imaging was inadequate to inform MDT discussion and treatment planning. Consultant 2 did not have a clear treatment plan for Mr A and it took eight months before Board 1 decided what Mr A's treatment would be and advised him of this. There was a lack of documentation of the MDT process and a poor standard of outpatient clinic discussions between Consultant 2 and Mr A, including discussion of risks of the embolisation procedure	Angiogram images should be complete and the image quality of a reasonable standard. The technical report for the imaging should be adequate to inform MDT discussion and treatment planning. Consultants should ensure patients have a clear treatment plan, setting out the treatment required. Patients should be made aware of the plan within a reasonable time. MDT process documentation and outpatient clinic discussions, including between a consultant and a patient, should be of a standard that provides a reasonable record of the discussion. Clinic discussions should include discussion of risks of procedures	Evidence that this case has been used as a learning tool for radiology and interventional neuroradiology staff. This should demonstrate how, in a supportive way, the Board has learned to ensure that angiograms and technical reports are completed appropriately; that staff understand the risks involved in having to repeat angiograms; and that the MDT process documentation and outpatient clinic discussions should be of a reasonable standard By: 22 November 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	It was unreasonable of the Board to cancel and reschedule Mr A's surgery repeatedly	Patients should receive appropriate treatment in a reasonable time from the appropriate organisation, in line with adequate contingency arrangements	Evidence that this case has been used in a supportive way as a learning tool for interventional neuroradiology staff, to ensure that in future patients receive treatment in a reasonable time, in line with adequate contingency arrangements By: 22 November 2018
(b)	Board 1 did not make sufficient arrangements for Mr A to receive cross border treatment in a reasonable time. Board 1 failed to follow their own Policy and Scottish Government Guidance when dealing with Mr A's referral to Hospital 2 There was a lack of clear documentation or audit trail of the decision making process and the communication with the parties involved, including a lack of documentary evidence of Board 1's contact with Board 2 on Mr A's case.	Board 1 should follow their own Policy and Scottish Government Guidance when making or considering cross border referrals. Treatment should be arranged within a reasonable time. Decisions should be clearly documented and communicated promptly to all parties involved	Evidence that all Board staff involved in cross border referrals are aware of Board 1's Policy and Scottish Government Guidance and the need for clear documentation and communication of the decision making process By: 22 November 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(c)	Board 1 failed to take reasonable steps to keep Mr A updated on his referral to/treatment at Hospital 2	Patients should be kept updated on their referrals to/treatment at other boards	Evidence that this matter has been discussed with the staff involved in a supportive way that encourages learning By: 22 November 2018
(c)	Board 1 failed to provide Mr A with a response to his email of 19 October 2016, either directly or via his MSP	Staff should respond to patients' complaints in a reasonable time	Evidence that this matter has been discussed with the staff involved in a supportive way that encourages learning By: 22 November 2018

Feedback

Response to SPSO investigation

Broad 1 failed to respond to my office's enquiries by the deadlines set and failed to provide full and complete responses, which delayed our investigation of Ms C's complaint.

Terms used in the report — Annex 1

Adviser 1	a consultant neurosurgeon
Adviser 2	A consultant interventional neuroradiologist
Adviser 3	a consultant in public health medicine
angiogram	a type of x-ray used to check blood vessels
AVM	arteriovenous malformation in the brain. Where a tangle of blood vessels in the brain or on its surface bypasses normal brain tissue and directly diverts blood from the arteries to the veins
Board 1	Greater Glasgow and Clyde NHS Board
Board 1's policy	Board 1's Exceptional Treatment Requests Policy - December 2011
Board 2	another NHS Scotland board
Consultant 1	a consultant neurosurgeon
Consultant 2	a consultant interventional neuroradiologist at Hospital 1
Consultant 3	a consultant neuroradiologist

DAVF	dural arteriovenous fistula. Where there are rare, abnormal connections between arteries and veins in a protective membrane on the outer layer of the brain and spine, called the dura. Symptoms can include an unusual ringing or humming in the ears, particularly when the DAVF is near the ear, and some patients can hear a pulsating noise caused by blood flow through the fistula.
embolisation	a procedure to block abnormal blood vessels
endovascular treatment	procedures to treat problem blood vessels
Hospital 1	Queen Elizabeth University Hospital
Hospital 2	a hospital in England
MDT	Multi-disciplinary team
Mr A	Ms C’s nephew
Ms C	the complainant
NSD	National Services Division
The Scottish Government Guidance	The Scottish Government CEL 06 (2013) ‘Establishing the Responsible Commissioner: Guidance and Directions for Health Board’, March 2013

List of legislation and policies considered **Annex 2**

The Scottish Government CEL 06 (2013) ‘Establishing the Responsible Commissioner: Guidance and Directions for Health Board’, March 2013

Board 1’s Exceptional Treatment Requests Policy - December 2011