Scottish Parliament Region: Central Scotland

Case 200501792: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Policy; Administration; Waiting Times; Breaches of Confidentiality

Overview

The complainant (Mr C) raised concerns about the handling of his medical treatment by Hairmyers Hospital (the Hospital), the length of the waiting times the treatment involved and the inclusion of parliamentary complaint correspondence within his medical file.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) before and after Mr C saw a Consultant at the Hospital, the waiting times he had been subjected to were unreasonable (*not upheld*);

(b) Mr C felt that he had not experienced continuity of treatment and his individual personal circumstances were not taken into account (*not upheld*); and

(c) Mr C's confidential information was mis-used and that this may have influenced the attitude of those involved with his subsequent care (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 5 October 2005, the Ombudsman received a complaint from Mr C concerning the handling of his medical treatment by Hairmyers Hospital (the Hospital), specifically about the waiting times this involved. Mr C also complained that details about his complaint to politicians concerning the Hospital's waiting times, was inappropriately included in his medical file, by practitioners at the Hospital. Mr C felt (and continues to feel) deserted by the care system and by the waiting times connected to the clinical investigations of the General Surgical, Orthopaedic and Neurosurgical Teams.

2. The complaints from Mr C which I have investigated are that:

(a) before and after Mr C saw a Consultant at the Hospital, the waiting times he had been subjected to were unreasonable;

(b) Mr C felt that he did not experience continuity of treatment and his individual personal circumstances were not taken into account; and

(c) Mr C's confidential information was mis-used and that this may have influenced the attitude of those involved with his subsequent care.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C and Lanarkshire NHS Board (the Board) and Parliamentary correspondence. I have had sight of the Board's complaint file and Mr C's medical records and reviewed relevant national policy documents (the Policy). The investigation was aided by one of the Ombudsman's clinical advisers (the Adviser) who provided a detailed Report on the complaint. The Adviser reviewed all relevant documentation and medical records.

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

(a) Before and after Mr C saw a Consultant at the Hospital, the waiting times he had been subjected to were unreasonable

5. Following an initial referral to the Hospital on 5 August 2003, due to constant pain in his left iliac fosse around the area of his left inguinal ring, Mr C's GP wrote again to the Hospital on 19 August 2003, requesting that Mr C

be considered for a cancellation appointment at short notice. The GP outlined that although he knew that Mr C was on their 'routine' appointment waiting list Mr C now found the pain intractable and wished to be examined 'as soon as possible'.

6. In their letter to Mr C dated 3 September 2003, the Hospital explained that following his GP's request that he be considered for an earlier appointment, the Hospital Consultant Surgeon (Consultant 1) had arranged for Mr C to be seen at another Clinic he ran that had a shorter waiting list. Mr C attended this Clinic on 25 September 2003. After the consultation, Consultant 1 wrote to Mr C's GP on 30 September 2003, advising that he had referred Mr C to the Hospital day surgery unit on Tuesday 29 September 2003, for a flexible sigmoidoscopy and routine blood tests. If the results were negative, Consultant 1 would arrange a CT scan of the area. Between this period and 1 March 2004, Consultant 1 had arranged for a colonoscopy, a CT scan of the abdomen, a lumbar spine MRI and a bone scan - the bone scan was carried out at the Glasgow Royal Infirmary in January 2004. On completion of these clinical procedures, as no abnormality was revealed that could be responsible for Mr C's intractable pain, Consultant 1 in his letter dated 1 March 2004, referred Mr C to a Consultant Orthopaedic Surgeon (Consultant 2), for a second opinion.

7. Although Mr C was categorised as a 'soon' referral to Orthopaedics, the associated waiting time for Orthopaedic appointments at that time, was five months. Mr C was advised by the Board, during telephone discussions on 25 March and 5 April 2004 that there was potential he may be seen earlier.

8. Consultant 2, by letter dated 22 April 2004, requested that a Consultant Neurosurgeon (Consultant 3) at the Southern General Hospital see Mr C. The Southern General Hospital is part of what was NHS Greater Glasgow and Consultant 3 is based there. He said that Mr C had some lateral disc prolapses at L4/5 and L5/S1 on his MRI Scan. Consultant 2 stated that Mr C's complaint about chronic discomfort in the left groin and hip 'are not classically those I would expect from lateral disc prolapses at L4/5 and L5/S1 on the left side'.

9. Within her letter to Mr C's GP dated 10 May 2004, Consultant 3 reached a clinical decision based on the MRI scan that Mr C would not require neurosurgical intervention. Mr C was dissatisfied with this and thereafter, Consultant 3 agreed to meet with Mr C and an appointment was made for him to attend her neurosurgical clinic on 14 December 2004. After reviewing Mr C,

Consultant 3 arranged a scan of Mr C's thoracic spine and as the scan was normal Mr C was discharged from Consultant 3's care.

10. As part of my investigations, I asked the Adviser for his assessment of this aspect of the complaint. I also asked the Adviser to comment on the continuity of care offered to Mr C as he felt he had joined one long waiting list after another as if he was a different patient.

11. The Adviser stated that in his opinion Mr C received an acceptable level of care from Consultant staff. From Mr C's initial GP referral up to the Consultant Surgeon's appointment review on 25 September 2003, 'this length of wait (seven weeks) is reasonable and well within contemporaneous NHS waiting time limits'. The Adviser also stated that 'in the context of arranging and performing a Colonoscopy, CT Scan and MRI Scan before obtaining further advice, this time interval is reasonable in my opinion'. The Adviser also felt it was appropriate that Consultant 1 sought Orthopaedic advice from Consultant 2.

12. The Adviser considered that the referral by Consultant 2 to Consultant 3 on 22 April 2004 and Consultant 3's subsequent case review of clinical findings, (as outlined in her letter to Mr C's GP of 10 May 2004), was 'a reasonable conclusion to reach'. Within this letter, Consultant 3 stated that it was not necessary to personally review Mr C, as from the MRI Scan she felt 'that there was little on the MRI Scan which could be responsible for his (Mr C's) symptoms and that neurosurgical intervention was unlikely to help Mr C'.

13. According to the Adviser, Consultant 3's personal consultation with Mr C on 14 December 2004 - a waiting time of eight months - 'was reasonable given that the surgeon had originally reviewed the MRI on receipt of the referral....the scan showed no indication for neurosurgical intervention and it was not appropriate to assign Mr C any priority to be seen at the clinic'.

14. The Adviser concluded that 'the general and neurosurgical consultants appropriately investigated and excluded any significant pathology in a timely manner. There is no evidence that I can find that there were any shortfalls in the standard of care, waiting times in the context of the NHS, or of continuity of care'.

(a) Conclusion

15. Mr C's felt that he joined one long waiting list after another as if he was a different patient each time. However, given the evidence outlined above and having reviewed all the relevant documentation, medical records and the Policy, I am satisfied that the waiting times Mr C experienced during the course of his medical reviews and treatment by Consultants was reasonable. I, therefore, do not uphold this complaint.

(a) Recommendation

16. The Ombudsman has no recommendations to make.

(b) Mr C felt that he had not experienced continuity of treatment and his individual personal circumstances were not taken into account

17. Mr C stated in his letter to the Ombudsman dated 17 November 2005 that from July 2003, due to the extreme pain he was suffering, 'carrying on with everyday life and work became more than a little of a challenge'. Mr C had also expressed similar views in his complaint correspondence to the Board, to his MSP and within a letter to the Health Minister, dated 18 August 2003.

18. As I have said above the Adviser concluded that he could find no evidence, within Mr C's clinical records that there were any shortfalls in the continuity of care or treatment Mr C received.

(b) Conclusion

19. Linking this complaint to part (a), where the core of the complaint is about waiting times, there is no evidence to support Mr C's view that he did not receive continuity of treatment. There is also no evidence that I have seen, to support Mr C's view that his life and work circumstances were ignored by the medical professionals who he came into contact with. Therefore, I do not uphold this complaint.

(b) Recommendation

20. The Ombudsman has no recommendations to make.

(c) Mr C's confidential information was miss-used and that this may have influenced the attitude of those involved with his subsequent care

21. Mr C attended Consultant 1's clinic on 25 September 2003 and saw a copy of the complaint letter he had written to the Health Minister dated 18 August 2003, filed within his medical file. Mr C believes that the Consultant

had been offended that he had written to politicians. He complained about this at a meeting with the Associate General Manager of the Hospital on 17 May 2004.

22. On 25 May 2004 the Board accepted that correspondence regarding Mr C's complaint was filed within his case records and the file forwarded to both Consultant 2 and Consultant 3. In a further letter to Mr C also dated 25 May 2004, the Board stated that it was not normal practice to hold information about a complaint within a medical record file. They apologised to Mr C for this event and outlined the action they would take, including an investigation by the Associate Medical Director to 'ensure that a similar situation does not arise again'. Nevertheless, they did not feel that Mr C was treated unfairly.

23. The Associate Medical Director confirmed in his letter of 7 July 2004 to the General Manager that it was not appropriate to file Mr C's letter of complaint and his letter to the Health Minister, within Mr C's case record. Furthermore, it was not appropriate to make reference to a patient's complaints in clinical letters. The Associate Medical Director concluded by outlining the correct procedure to be followed when a complaint is received regarding a patient who is being referred.

24. The Adviser endorsed this view and said that Consultant 1 was wrong to include the paragraph about Mr C's complaint, in his letter of referral to Consultant 2. 'It does not contain any relevant clinical material and may well have prejudiced other clinician's management of Mr C. In particular it may have expedited Mr C's clinical appointments to the detriment of other patients already on relevant waiting lists who had not complained but who had an equivalent or greater clinical priority. I can find no evidence that this actually occurred however'.

(c) Conclusion

25. It is clear that correspondence relating to Mr C's complaint should not have been included in the Hospital case file, thereafter circulated for other Consultants to see. When the Board became aware of this issue, they immediately accepted this was wrong, took steps to avoid recurrence of such an event and apologised to Mr C. This happened before the complaint was brought to the Ombudsman. I commend the Board for their swift actions in addressing this failure.

26. There is no evidence that those involved in the subsequent care or treatment of Mr C, showed an unprofessional attitude towards him. There is also no evidence as to whether the complaint's correspondence had a positive or negative influence on anyone involved in his care.

27. Because there is no evidence that the Board's mistake had an adverse effect on the care and treatment of Mr C, and because the Board gave an appropriate remedy before the Ombudsman was involved, I do not uphold the complaint.

(c) Recommendation

28. The Ombudsman has no recommendations to make.

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Hospital	Hairmyres Hospital
The Board	Lanarkshire NHS Board
The Adviser	Ombudsman Clinical Adviser
The Policy	A guide on managing waiting times
Consultant 1	Consultant Surgeon at Hairmyres Hospital
Consultant 2	Orthopaedic Surgeon at Hairmyres Hospital
Consultant 3	Neurosurgeon at Southern General Hospital, Glasgow

Annex 2

Glossary of terms

left iliac fosse around the area of his left inguinal ring	Intractable loin pain

Annex 3

List of legislation and policies considered

Managing Waiting Times – A Good Practice Guide