Scottish Parliament Region: Highlands and Islands

Case 200600461: Highland NHS Board

Summary of Investigation

Category

Health: Hospital Out-Patient appointment waiting times and complaint handling

Overview

The complainant, Ms C, raised a number of concerns about the delay in obtaining an appointment at Neurosurgery Out-Patient Services at the Southern General Hospital (Hospital 1). This was arranged by Highland NHS Board (the Board) as part of Ms C's ongoing treatment for back pain.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Orthopaedic Consultant Service contracted from NHS Greater Glasgow and Clyde failed to refer Ms C to the Neurosurgeon within Hospital 1 in September 2005 (*upheld*); and

(b) the complaint response from the Board did not address the complaint that was raised (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review the current pilot in progress and let her know the outcome;

(ii) consider introducing a system to ensure that a referral has been received by the receiving clinic;

(iii) provide a local contact for a patient to be able to enquire about their referral;

(iv) apologise to Ms C for the additional wait experienced as a result of the delay in treatment;

(v) ensure they have a mechanism in place to follow up on any outstanding issues when an offer of a meeting, as part of local resolution in line with the NHS complaints procedure, has been made and declined;

(vi) ensure, where appropriate, that they consider if there are any problems which may be faced by a complainant offered a meeting to discuss a complaint and the venue for the meeting is not local to the complainant; and

(vii) apologise to Ms C for not providing a further response to her complaint.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Ms C made a complaint to Highland NHS Board (the Board) on 5 May 2006 about the delay in arranging an appointment for her to be seen by a Neurosurgeon at the Southern General Hospital (Hospital 1), within NHS Greater Glasgow and Clyde. Ms C had been seen in Lorne and Islands District General Hospital (Hospital 2) in September 2005 and was told this referral would be made. Ms C considered that her wait from September 2005 for an appointment to be seen at Hospital 1 was too long. She had not received any communication about her referral and a consultant at Hospital 2 suggested she might follow this up herself. When she made enquiries to Hospital 1 on 13 April 2006, she was advised that a referral had not been received. She was unhappy with this and complained to the Board, who responded to her on 5 June 2006. Ms C was unhappy with the outcome of her complaint and her further attempts to reach a resolution to her complaint. She brought her complaint to the Scottish Public Services Ombudsman on 19 June 2006.

2. The complaints which I have investigated are that:

(a) the Orthopaedic Consultant Service contracted from NHS Greater Glasgow and Clyde failed to refer Ms C to the Neurosurgeon within Hospital 1 in September 2005; and

(b) the complaint response from the Board did not address the complaint that was raised.

Investigation

3. As part of the investigation into this complaint I have read through the detailed information provided by Ms C and I have seen the medical records and the complaint correspondence from the Board. Additionally, I asked for further information from the Board and clarified a number of points with Ms C. I also obtained advice from a health adviser to the Ombudsman (the Adviser).

4. 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 the Board were given an opportunity to comment on a draft of this report. The abbreviations used in this report have been explained in Annex 1.

(a) The Orthopaedic Consultant Service contracted from NHS Greater Glasgow and Clyde failed to refer Ms C to the Neurosurgeon within Hospital 1 in September 2005

5. Ms C saw her GP with symptoms of worsening back pain and he referred her to the Orthopaedic Clinic at Hospital 2 on 14 April 2005. She attended an Orthopaedic Clinic appointment on 9 August 2005 and saw an Orthopaedic Surgeon (Consultant 1). As part of the investigations of her back pain she was seen again at the Orthopaedic Clinic on 27 September 2005, when Consultant 1 confirmed he would refer her to Hospital 1. There was also a referral letter dated 27 September 2005 from Consultant 1 to Hospital 1 on the hospital medical records and a copy of a letter to Ms C's GP dated 27 September 2005 on Ms C's hospital medical record confirming the arrangement for the referral to the Consultant in Neurosurgery in Hospital 1 and to the Consultant Anaesthetist (Consultant 2) in Hospital 2.

6. The Adviser reviewed Ms C's hospital medical records. He indicated he would have expected to see these letters in the medical record and they should act as evidence of the referral but the progress of the referral was not recorded at that point.

7. When Ms C contacted Hospital 1 on 13 April 2006 (see paragraph 1), she was told the referral had not been received. Further contact by Ms C with Hospital 2 resulted in the referral being sent again on 18 April 2006, by facsimile. The Board confirmed, in a letter dated 3 September 2007, that it was common practice for patients to follow up their appointment when referrals have been made to find out when their appointment was scheduled. This particular referral was made to a Consultant Neurosurgeon within NHS Greater Glasgow and Clyde. In a letter dated 13 June 2006 to Ms C from NHS Greater Glasgow and Clyde, she was advised that the referral had been vetted as routine priority and an earlier appointment would only be considered if she had a higher priority. As a result Ms C was placed on the waiting list to be seen as a routine referral at the Neurosurgery Clinic in Hospital 1 from the date of 18 April 2006. However, I have been advised by the Board that Ms C's appointment was brought forward as the clinic had a cancellation.

8. When responding to Ms C's complaint, the Board advised that the referral letter for Ms C had been prepared at the time Ms C was seen at the clinic and a copy of the letter was filed in the records. I was advised by the Board that, at the time, the procedure was that the consultant dictated the letter at the clinic,

which was then typed and forwarded to the receiving hospital. At the time, there was no protocol in place to confirm receipt of referrals sent from the Board. Nor was there a process in place to confirm proof of posting. The Board have confirmed that they have introduced a pilot where referrals to other hospitals are recorded by a medical secretary. I understand this is being conducted in a specific area within the Board.

(a) Conclusion

9. As part of my investigation I have established that, while there is a record of the referral letter having been prepared, there is no record of it having been sent and there was no method of recording or tracking the progress of a referral made from Hospital 2 (see paragraphs 5 and 9). There should be a robust system to follow up and support a patient subject to a referral on for assessment, opinion or treatment elsewhere. The Board should ensure that the matter of follow-up and tracking a referral is carried out within the Board. I do not consider it is appropriate to expect a patient to follow up referrals (see paragraphs 6 and 10) as the patient has no influence to affect change when there is a problem arising as a result of a failed referral. In this regard, I uphold this aspect of the complaint.

10. While I commend the Board for introducing the pilot referred to at paragraph 9, there is no system in place to check to ensure a referral has been received. The Ombudsman, therefore, has the following recommendations to make.

(a) Recommendations

11. The Ombudsman recommends that the Board:

(i) review the current pilot in progress and let her know the outcome;

(ii) consider introducing a system to ensure that a referral has been received by the receiving clinic;

(iii) provide a local contact for a patient to be able to enquire about their referral; and

(iv) apologise to Ms C for the additional wait experienced as a result of the delay in treatment.

(b) The complaint response from the Board did not address the complaint that was raised

12. As part of my investigation I have seen the complaint correspondence between the Board and Ms C. The Board advised that Ms C was offered the

opportunity to meet and discuss her concerns with the Medical Director as part of local resolution to her complaint but, due to annual leave and diary constraints, the earliest date available to the Medical Director was unacceptable to Ms C.

13. The complaint to the Board on 5 May 2006 included Ms C's concern about the delay in a referral to Hospital 1 and a complaint that there is no record of the referral having been sent (see paragraphs 8 and 9). Ms C received a response to her complaint dated 5 June 2006. In that letter the Board confirmed that a referral was sent to Hospital 1 on 27 September 2005. Additionally, the response indicated that a further copy of the referral was faxed to Hospital 1 on 18 April 2006 and an enquiry had been made to Consultant 1 (the referring consultant) to see if any other clinical information should be included in the repeat referral (see paragraph 8). Following that letter of 5 June 2006, the Board made no further written response to Ms C about her complaint after she declined an invitation to meet the Medical Director to discuss her complaint (see paragraph 12).

14. The Board did not provide a further written response to the complainant, which might have incorporated the points that had been intended for the face-to-face meeting. In this way, the Board would have been able to demonstrate their attempts to resolve Ms C's complaint as far as they could.

15. The Board have explained that they telephoned Ms C on or around the 21 June 2006. They have provided a retrospective file note of the telephone call that was made. During the telephone call, they recall a discussion confirming they were considering procedures for recording referrals made. They also recall that Ms C declined the offer to meet the Medical Director especially given the distances involved. The date which had been offered was suitable to the Medical Director but not to Ms C.

16. Ms C has let me know that she recalled having a conversation about the meeting but did not recall indicating that the meeting was not needed. She claimed that the meeting was going to be in Inverness and she was not offered assistance in getting to the appointment or with the cost overnight accommodation which would have been required. Additionally, no offer was made to hold the meeting more locally in Oban. Whilst two key aspects of the complaint were addressed, in the Board's response of 5 June 2006 the raised

expectation of a meeting was not met and the Board did not enquire if all matters of concern for Ms C had been resolved.

(b) Conclusion

17. Whilst a response was made, when further opportunities to discuss Ms C's complaint through a meeting was offered but did not come to fruition, the Board did not enquire if all matters of concern had been resolved for Ms C. While the letter of 5 June 2006 addressed two aspects of the complaint, I consider that, in the circumstances, further contact should have been made by the Board in an effort to further address Ms C's complaint. This was also a missed opportunity for the Board to try to resolve Ms C's outstanding concerns. In this respect, therefore, I have partially upheld this aspect of the complaint.

(b) Recommendations

18. The Ombudsman recommends that the Board:

(i) ensure they have a mechanism in place to follow up on any outstanding issues when an offer of a meeting, as part of local resolution in line with the NHS complaints procedure, has been made and declined;

(ii) ensure, where appropriate, that they consider if there are any problems that may be faced by a complainant offered a meeting to discuss a complaint and the venue for the meeting is not local to the complainant; and

(iii) apologise to Ms C for not providing a further response to her complaint.

19. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	Highland NHS Board
Hospital 1	Southern General Hospital
Hospital 2	Lorne and Islands District General Hospital
The Adviser	A medical adviser to the Ombudsman
Consultant 1	Orthopaedic Surgeon
Consultant 2	Consultant Anaesthetist