SPSO decision report

Case: **201303993, Ayrshire and Arran NHS Board**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Outcome: some upheld, recommendations

Summary

Mr C had suffered prostate problems since his forties and his prostate health was regularly monitored. Until 2011, the tests had shown that although his prostate was enlarged, he was not suffering from cancer. Early in 2011, Mr C's blood test results began to indicate that he might have prostate cancer. Tissue samples were taken but these showed no sign of cancer. Mr C was given an appointment for a review within 12 weeks. However, this was cancelled and Mr C was not seen again until December that year. Following this appointment Mr C was diagnosed with advanced prostate cancer, which was incurable.

Mr C complained that the delay in rescheduling his review appointment was unacceptable. He felt that this happened because staff did not follow departmental procedures properly and because the board failed to appropriately implement a new appointment management system. Mr C said he believed the delay had adversely affected his treatment options and that when he complained the board did not handle his complaint reasonably or appropriately.

We took independent advice from a medical adviser on the clinical aspects of Mr C's case, and upheld most of his complaints. We found that the delay in rescheduling the appointment was unreasonable. The board did not give a reason for the delay and our adviser said that they should have explained why he needed the review appointment. Their failure to do so meant that Mr C did not pursue a rescheduled appointment after the original was cancelled. We did not uphold the complaint that his treatment was adversely affected, however, as our adviser said that it was likely that the cancer had already spread outside the prostate and the delay in rescheduling the appointment did not affect Mr C's prognosis or the available treatment.

We upheld Mr C's other complaints. The board could not show that they had implemented their appointment management system correctly, or that they had identified learning from the failures in Mr C's case. Their handling of his complaint was inadequate and there was no evidence that they had since introduced robust complaints handling procedures to stop these mistakes happening again.

Recommendations

We recommended that the board:

- review the urology department procedures, to ensure that patients are informed of the reason for a follow-up appointment and the timescale for this;
- provide us with evidence that they have identified the causes of the delay in manually transferring appointments during the introduction of the Patient Management System to prevent a reoccurrence, including the checks carried out to ensure that all patients were manually transferred at the time;
- provide evidence that the new Patient Management System will alert medical staff when appointments are cancelled;
- provide evidence of the steps they have taken to improve the accuracy of complaint responses;
- provide evidence that all staff have been reminded of the importance of using appropriate language when

corresponding about patients;

- audit their new complaints process to ensure complaint investigations are conducted with appropriate rigour and that adequate records of the investigation are be maintained; and provide us with a copy of the findings; and
- apologise in writing for the failings our report identified.