SPSO decision report

Case: **201700911, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the follow-up care and treament he received at Dumfries and Galloway Royal Infirmary. Mr C underwent surgery for prostate cancer in another NHS board area but follow-up care was to take place within his own area. Mr C complained to the board about the way they handled his follow-up care as there were a number of delays. The board decided to undertake a Significant Adverse Event Review (SAER) as a result. Mr C was provided with a draft copy of the SAER at a meeting, however, the response to his complaint was not supplied until a number of months later with a copy of the finalised SAER report. Mr C complained to us that the board had unreasonably failed to provide him with appropriate follow-up care and treatment. He was also concered that the board had not followed their SAER policy appropriately and that there had been unreasonable failings in the way they handled his complaint.

We took independent advice from a consultant urologist. We found that there was a lack of appropriate follow-up care for Mr C and that poor communication between staff caring for him in different board areas had contributed to the issues with his follow-up. We upheld this aspect of Mr C's complaint but noted that the board had acknowledged and apologised for this failing.

In relation to the SAER, we found that it was reasonable in its findings. However, it took far longer to complete than Mr C had been advised, and we found a lack of evidence that the board had kept him updated on their progress. We upheld this aspect of Mr C's complaint.

In relation to Mr C's complaints handling concerns, we found that there had been significant delays in the investigation process and that the board had acknowledged and apologised for this. We also noted that the SAER was a separate process from the investigation of Mr C's complaints and we considered that it would have been helpful had the board's complaint response more clearly addressed the specific concerns he had raised in his original letter of complaint.

Recommendations

What we asked the organisation to do in this case:

- Review Mr C's follow-up care plan to ensure that he receives the appropriate standard going forward.

What we said should change to put things right in future:

- There should be systems in place to facilitate communication between staff where more than one NHS board is involved in caring for a patient.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.