SPSO decision report

Case: **202009234, Fife NHS Board**
Sector: Health
Subject: Appointments / Admissions (delay / cancellation / waiting lists)
Decision: some upheld, recommendations

Summary

C complained to the board on behalf of their partner (A) about the length of time taken to arrange a lumbar puncture test (LP, a procedure used to collect a sample of fluid from the spine) following assessment by a neurologist (specialist of the nerves and the nervous system). C had regularly contacted the board requesting an update on C's appointment and eventually decided to complain when they were told to ask A's GP to re-refer them. On complaining, A received their LP appointment. The board advised that the delays had been caused by the Covid-19 pandemic and that A had now been appointed to see a neurology consultant.

We found that the board had separate processes in place for arranging LPs depending on whether a patient was seen by a locum consultant or a member of the board's own staff. As A was seen by a locum consultant, they were required to be added to an anaesthetist's (administer of drugs) list which ran every three-four months. Had they been seen by the board's own staff, they would have arranged the LP test directly without the need to refer them to a separate list. In A's case, the original anaesthetist's list that they were appointed to was cancelled, as was the second due to the onset of the pandemic, which meant that A was required to wait 10 months for this test. We upheld this complaint.

C also complained that the board failed to provide pain relief to A while waiting for the LP test. While we considered C's expectations to be reasonable in respect of the results of the LP test confirming A's diagnosis and informing decisions about future care and treatment, including management of their pain, we considered that this aspect of their care to remain the responsibility of A's GP at this time. As such, we did not uphold this part of C's complaint.

Finally, we found that the board's complaint handling was unreasonable, particularly in relation to the failure to act on the lack of equivalence in service provision despite this problem being known following the board's own investigation of C's complaint. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to arrange the LP test reasonably and for failing to reasonably respond to their complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The board should implement a sustainable model for listing the patients of locum doctors to ensure that they timeously receive LP tests. This should include a contingency plan to prevent long delays for patients when lists are cancelled.

In relation to complaints handling, we recommended:

- The board’s complaint handling monitoring and governance system should ensure that complaints are appropriately investigated and that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement. All staff dealing with complaints should be familiar with the Model Complaints Handling Procedure, understanding the importance of communication and the need to demonstrate thorough investigation and action taken on the points raised.

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.