Scottish Parliament Region: Lothian

Case 200701919: Lothian NHS Board

Summary of Investigation

Category
Health: Complaint Handling

Overview
The complainant (Mrs C) raised a number of concerns about the manner in which Lothian NHS Board (the Board) had responded to complaints raised originally by her mother (Mrs A) and continued by Mrs C after Mrs A's death.

Specific complaint and conclusion
The complaint which has been investigated is that the Board failed to deal with Mrs A and Mrs C's complaints in a timely and appropriate manner (*upheld*).

Redress and recommendation
The Ombudsman recommends that the Board apologise to Mrs C for their failure to deal with the complaints raised by Mrs A or Mrs C in a timely or appropriate manner.

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

Main Investigation Report

Introduction

1. On 14 September 2007 the Ombudsman received a complaint from Mrs C about the inadequate response both she and her late mother (Mrs A) had had from Lothian NHS Board (the Board) in response to complaints Mrs A had initially raised about her former GP (the GP) in June 2005.

2. The complaint from Mrs C which I have investigated is that the Board failed to deal with Mrs A and Mrs C's complaints in a timely and appropriate manner.

3. Mrs C also raised her concerns about the GP with this office but following receipt of advice from a GP adviser to the Ombudsman, I decided that there were no grounds to pursue that matter further and closed that aspect of the complaint.

Investigation

4. Investigation of this complaint involved reviewing all the papers supplied by Mrs C and obtaining further documentation and comment from staff at the Board. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed to deal with Mrs A and Mrs C's complaints in a timely and appropriate manner

5. Mrs A attended her GP practice (the Practice) in July and September 2004 reporting unexplained post-menopausal bleeding. She was referred for further (non-urgent) investigations by the GP following the September 2004 appointment. Mrs A attended the Practice again in late November 2004 reporting further symptoms and was referred for a chest x-ray (reported on 2 December 2004) and was subsequently found to have lung cancer secondary to cancer of the womb. Mrs A was concerned that she should have been referred for more urgent tests following her appointment at the Practice in July and September 2004 which would have allowed the cancer to be detected at an earlier stage and might have allowed her to receive treatment which would have prevented the spread of the cancer.

6. Mrs A raised her concerns at an appointment with her cardiologist (the Consultant) on 10 May 2005. The Consultant wrote to the Medical Director of Primary Care (the Medical Director) on 11 May 2005 asking that he (or the appropriate person) investigate Mrs A's concerns. The Medical Director met with the GP on 27 May 2005 and discussed Mrs A's concerns. The Medical Director wrote to the Consultant in June 2005 and advised him that he had discussed the concerns with the GP and did not feel that any further action was needed. The Consultant wrote to Mrs A on 13 June 2005 about the Medical Director's response and suggested it would be helpful if she were to contact the Medical Director directly as there appeared to be some disagreement between Mrs A's recollection of events and that of the GP record, which the Medical Director might be able to resolve for her. Mrs A duly wrote to the Medical Director on 16 July 2005 seeking a meeting with him to discuss her concerns and noting that her condition was terminal. Mrs A did not receive any response to this letter and the Consultant wrote to the Medical Director again in September 2005 chasing up a response on her behalf. This letter also went unanswered. A subsequent letter from the Consultant sent on 19 June 2006 did prompt a response from the Medical Director to Mrs A on 19 July 2006. In this letter the Medical Director invited Mrs A to meet with him to discuss her ongoing concerns. Although Mrs A received this letter, she died in August 2006 before a meeting could be arranged.

7. Mrs C continued to pursue Mrs A's concerns and contacted the Medical Director. A meeting was arranged for 14 September 2006. At that meeting and in a letter of the same date summarising the meeting, the Medical Director apologised that he had not replied to Mrs A's letter of July 2005 which he had received but had misfiled. The Medical Director noted that it should in fact have been passed on to the relevant complaints officer to deal with but he had failed to do this. At the meeting it was agreed that the Medical Director would arrange for a clinical director (the Clinical Director) from one of the Community Health Partnership's to review Mrs A's GP records and following a later discussion with the Clinical Director, the Medical Director would re-contact Mrs C within three weeks.

8. The Medical Director sent a detailed letter to Mrs C on 13 October 2006 outlining the results of the Clinical Director's review and highlighting issues where Mrs C's concerns about the GP, other hospital/acute clinical actions and the handling of her complaint had resulted in a change in practice or approach. Mrs C was not satisfied with this and a further meeting was arranged for

5 December 2006 but subsequently cancelled at short notice without being rearranged. Mrs C wrote to the Medical Director again on 12 February 2007 noting her dissatisfaction at the late cancellation and seeking further specific documents, a number of which referred to Mrs C's concerns about hospital/acute attendances as well as Mrs A's GP records. The Medical Director replied on 21 February 2007 suggesting dates for a further meeting which was arranged for 30 March 2007.

9. There is no note of the content of this meeting. Mrs C has told me that she had expected a further response from the Medical Director following up on points raised in her correspondence and at the meeting but this did not happen. She contacted the Ombudsman's office for advice and decided to bring her complaint to us. The Medical Director and the complaints officer who were present at the meeting have both told me that they advised Mrs C that she should contact this office if she remained dissatisfied and that other than arranging for her to access Mrs A's medical records there were no other action points.

10. It is of note that the Medical Director's written responses contained a number of date errors about letters and meetings which caused confusion and added to the distress of Mrs C. The letters also referred in error to correspondence with the General Medical Council regarding another complaint which was unrelated to Mrs A's original complaint and this in turn caused further anxieties for Mrs C.

11. The NHS Complaints Process has changed in a number of significant respects since these issues were first raised in 2005. While concerns raised by a consultant about a GP, on behalf of a patient, would still require direct involvement from the patient before it could be regarded as a formal complaint; the process once a complaint is received has now altered. In similar circumstances today the complaint would be passed on to the GP practice concerned to deal with directly as they are the responsible party. If the complainant was not satisfied with the response from the GP practice they would then have the right to complain directly to the Ombudsman's office. The involvement of the Board in this situation is not necessary although the Board can act as 'go-between' at the request of the complainant but will not actively 'investigate' a complaint about a GP. A further change has occurred in recognition of the need for a joined-up approach to complaint handling which would have had an impact on Mrs A's complaints. Historically, the Medical

Director could only deal with issues pertaining to the provision of primary care services in Lothian, passing on any possible concerns about hospital services for the attention of colleagues in the acute division. Now any complaint which involves more than one health care division will be addressed jointly and in this circumstance, the Medical Director (or more correctly the complaints officer) would investigate and provide a direct response to all the issues raised (with the possible exception of the GP issues as mentioned previously).

Conclusion

12. In a number of respects there is no dispute between the parties in this case; the Medical Director failed to address Mrs A's letter of complaint in a timely manner and subsequently acknowledged errors in his responses which had contributed to the anxiety and distress in this case. I acknowledge that Mrs C is still of the view that more prescriptive action should have been taken against the GP by the Board. It is a matter of considerable regret when mismanagement of the complaint process prevents possible resolution of a complaint. In the circumstances of this case, I am satisfied that the errors which occurred were attributable to human error on the part of the Medical Director and that he has apologised personally for these. I am also of the view that the current complaint process would significantly reduce the possibilities of some of these errors occurring again; although care must always be taken to avoid inadvertent factual errors, for example in dates, which can add considerably to the anxiety of an already stressful situation. I uphold this complaint.

Recommendation

13. The Ombudsman recognises that there have been changes both in the local process and the national process for handling of complaints which will assist in preventing the problems which occurred in the handling of Mrs A and Mrs C's complaint and has no specific process recommendation to make. The Ombudsman does recommend that the Board apologise in writing to Mrs C for their failure to ensure that Mrs A and Mrs C's complaints were addressed in a timely and appropriate manner.

14. 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

Mrs C	The complainant who approached our office
Mrs A	The original complainant and the aggrieved (Mrs C's mother)
The Board	Lothian NHS Board
The GP	Mrs A's GP at the time of the events originally complained of
The Practice	Mrs A's GP practice at the time of the events originally complained of
The Consultant	Mrs A's cardiologist who originally raised her concerns with the Medical Director
The Medical Director	The person responsible for responding to Mrs A's original complaint
The Clinical Director	The director of a Lothian Community Health Partnership who reviewed Mrs A's GP records at the request of the Medical Director