SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: South of Scotland

Case ref: 201701715, Dumfries and Galloway NHS Board
Sector: Health
Subject: Hospitals / Appointments / Admissions (delay / cancellation / waiting lists)

Summary
Mr C complained about the care and treatment provided to him by the board after he was diagnosed with prostate cancer. His prostate cancer was considered low risk and the plan was for active surveillance, which involves having a PSA test (prostate specific antigen: a marker in blood tests which can indicate prostate problems) three to four times a year, and an MRI scan six months after diagnosis. However, Mr C complained that he was not given a PSA test until nearly a year after his diagnosis, and the MRI scan was not organised in a timely manner.

We took independent, professional advice from a urologist. We found that the board failed to:

- arrange follow-up appointments;
- arrange PSA tests that required to be undertaken;
- check that PSA tests were undertaken as intended;
- make adequate and timely arrangements for an MRI scan which took Mr C's special needs into account; and
- provide Mr C with information that might have enabled him to make alternative arrangements to get the necessary tests done.

Given these failings, we upheld this aspect of Mr C's complaint.

Mr C also complained that the board failed to communicate appropriately with him regarding the monitoring of his prostate cancer. We found that when Mr C was diagnosed the need for regular PSA testing and the MRI scan were not communicated to him or his GP appropriately. We also found that when Mr C was contacted regarding the MRI scan, the information he was given did not answer all of his questions, nor was he fully informed of his options. We upheld this aspect of Mr C's complaint.

Finally, Mr C complained about the board's handling of his complaint. We found that Mr C's complaint to the board had been incorrectly logged as a concern rather than a complaint. We also found that communication with Mr C throughout and after the complaints process had been poor. We upheld this aspect of Mr C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C:

Complaint number	**What we found**	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
(a), (b), & (c)	The Board failed to provide appropriate monitoring following a diagnosis of prostate cancer; failed to communicate appropriately; and handled Mr C's complaint unreasonably	Apologise to Mr C for failing to provide appropriate monitoring following a diagnosis of prostate cancer; failing to communicate appropriately; and handling his complaint unreasonably The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	Copy or record of apology By: 20 June 2018

We are asking The Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Board failed to provide appropriate monitoring following a diagnosis of prostate cancer	Prostate cancer patients on active surveillance should be properly and appropriately monitored	Evidence of a review of current systems to monitor prostate cancer patients on active surveillance, which includes an assessment of the reliability and effectiveness of these systems and any improvements to be made as a result of the review Evidence that there has been a review of all prostate cancer patients on active surveillance to ensure they are being actively followed up By: 15 August 2018
(a)	There was a failure to make adequate and timely arrangements for a scan which took Mr C's needs into account	There should be a system in place to accommodate patients with special needs such as claustrophobia who are required to undergo scanning	Evidence that a system has been put in place to make arrangements for patients with special needs such as claustrophobia to undergo scanning and that this system has been communicated to all the relevant staff By: 15 August 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	When Mr C was diagnosed with prostate cancer it was not communicated to him that he would need three monthly testing and scanning after six months	Patients on active surveillance for prostate cancer should have the follow-up requirements clearly explained to them	Evidence that this has been considered and a system is in place to ensure that patients on active surveillance for prostate cancer have the follow-up requirements clearly explained to them By: 15 August 2018
(b)	When Mr C was contacted regarding scanning, the information he was given did not answer his questions, nor was he fully informed of his options	Clear information should be given regarding options for scanning, and staff should make efforts to ensure they are answering all of a patient's questions	Evidence that this has been fed back to the relevant staff in a supportive way that encourages learning By: 4 July 2018
(c)	Mr C's complaint was handled unreasonably	Complaints should be accurately logged and responded to in line with the complaints handling process	Evidence that this has been fed back to the relevant staff in a supportive way that encourages learning By: 4 July 2018

(c)	Communication with Mr C during and after the complaint process was poor	Communication with complainants should be pro-active, and complainants' requests for contact should be returned	Evidence of a review of the communication during and after the complaints process in this case, including an assessment of why staff failed to return Mr C's requests for contact and what action will be taken to avoid this recurring in the future By: 15 August 2018

Feedback

Points to note

The Board could consider raising awareness of their clinical staff about the current options of Healthcare in Europe for patients.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to me about the care and treatment provided to him by Dumfries and Galloway NHS Board (the Board), and the communication from them regarding the same. The complaints from Mr C I have investigated are that the board:

(a) failed to provide appropriate monitoring following a diagnosis of prostate cancer (*upheld*);
(b) failed to communicate appropriately (*upheld*); and
(c) handled Mr C's complaint unreasonably (*upheld*).

Investigation

2. I and my complaints reviewer considered all of the information provided by Mr C and the Board, including relevant medical records and the complaints file. We also obtained independent advice from a consultant urologist (the Adviser).

3. I have decided to issue a public report on Mr C's complaint due to the significant failures identified and because I consider it is in the wider public interest.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but I can confirm that all of the information provided during the course of the investigation has been reviewed. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mr C was diagnosed with prostate cancer in March 2016. The cancer was considered low risk and the plan was for active surveillance.

6. In January 2017 the Board wrote to Mr C's GP requesting that he have his Prostrate Specific Antigent (PSA: a marker in blood tests which can indicate prostate problems) levels checked and regarding a magnetic resonance imaging scan (MRI scan - a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body). Throughout February and March 2017 Mr C was in communication with the Board's urology cancer nurse specialist about trying to arrange an MRI scan. This was complicated by the fact he was travelling between the UK and France, and because he required sedation or open MRI scanning due to claustrophobia.

7. Mr C was concerned that there had been a delay in calling him for PSA testing following his diagnosis in March 2016 and he complained to the Board on 22 March 2017. The Board responded on 24 April 2017. Mr C was dissatisfied with this response and further emailed the Board on 3 May 2017. Before they responded, he brought his complaint to this office.

(a) The Board failed to provide appropriate monitoring following a diagnosis of prostate cancer

Concerns raised by Mr C

8. Mr C told us that following diagnosis he had learned he should have had PSA tests three to four times a year, and that an MRI scan should have been considered for the autumn of 2016. Mr C explained that he was not called for a PSA test until nearly a year after his diagnosis.

The Board's response

9. In response to our enquiries, the Board said they were sorry Mr C felt that there was a failure to provide appropriate monitoring following his diagnosis of prostate cancer. They explained that follow-up would normally be three monthly PSA tests which are completed by the patient's GP and six monthly examinations at the Board's clinic. However, they said that with Mr C living overseas this was challenging.

10. The Board also said that Mr C was due to have an MRI scan, however, due to Mr C living overseas and his desire to have this procedure in either an open scanner or with sedation, this was also challenging. They said that numerous attempts were made to accommodate this.

Medical advice

11. The Adviser first explained that the Board are part of the South East Scotland Cancer Network (SCAN), which has up-to-date, quality controlled documentation on procedures, protocols and charts. The Adviser explained that SCAN has an agreed comprehensive protocol for prostate cancer management, which includes a management plan for active monitoring.

PSA Monitoring

12. The Adviser considered the level of PSA monitoring Mr C was given was unreasonable, noting that he had no follow-up or PSA tests between March 2016 and January 2017. They explained that active monitoring, also called active surveillance, aims to achieve correct timing for curative treatment of

clinically localised prostate cancer with the aim to minimise treatment-related toxicity without compromising survival. The Adviser said that SCAN guidance for active surveillance recommends three-monthly PSA tests, six-monthly examinations and a repeat biopsy within twelve months. They said that none of these recommendations were achieved in Mr C's case. The Adviser commented that regular PSA testing is a key recommendation and is essential in order to detect disease progression if it occurs.

13. The Adviser noted that the time of Mr C's clinic visit in March 2016 he was seen by a locum middle grade urologist who stated in the clinic letter 'we would plan to see him three or four times a year for PSA monitoring' and 'we will see him back in the summer with another PSA'. The Adviser said that it was the Board's responsibility to ensure adequate follow-up: this can involve shared care protocols with GPs or virtual follow-up clinics arranged by the Board, with reminders to GPs and patients regarding PSA tests being due.

14. However, the Adviser said that no such arrangements appear to have been made. The Adviser noted that, according to the clinic letter from 10 March 2016, follow-up arrangements were to be made solely by out-patient clinic attendance and there were no instructions to the GP as regards the exact follow-up schedule for the GP to do blood tests. Therefore, the Adviser considered the follow-up monitoring to be entirely the Board's duty and that there was no evidence to suggest that any attempts were made to arrange prostate cancer follow-up for Mr C prior to him being contacted in January 2017.

15. The Adviser said that the Board should have a reliable system in place which guarantees adequate cancer follow-up and PSA monitoring for all patients. They went on to comment that, if part or all of this follow-up is delegated to primary care, the Board should have steps in place to ensure that instructions for the delegated follow-up have been received and understood.

MRI Scanning

16. The Adviser went on to consider whether Mr C should have been provided with an MRI six months after his diagnosis. They explained that for the low risk prostate cancer group (the group Mr C was in) on active surveillance, SCAN guidance recommends consideration of assessment with an MRI scan at four to six months after the prostate biopsy. The Adviser said that whilst this recommendation is just to consider an MRI scan, it was noted in Mr C's clinic

letters of March 2016 that he would have an MRI scan in the autumn, and therefore the Board should have organised this.

17. Mr C had some concerns about the handling of arrangements for the MRI scan when it was arranged in 2017; in particular that it did not seem to be taken into account that he would need either an open scanner or sedation due to his claustrophobia. I asked the Adviser to consider whether the Board should have provided further assistance regarding arranging a scan.

18. The Adviser noted that when the MRI referral form was completed by the clinical nurse specialist on 8 February 2017, it was noted on the safety checklist that Mr C had claustrophobia, but no further comment on this was made in the open text. The Adviser further noted that in email communication between Mr C and the clinical nurse specialist he requested information on the possibility of sedation or an open MRI. He repeated this request in further correspondence, but there was no response to his questions about this matter until the Board's complaints response (I consider this in more detail under complaint (b)).

19. An MRI scan was arranged by the Board in a hospital outwith the Board area (the Hospital) to be carried out on 4 April 2017. However, this was subsequently cancelled as it was not arranged in accordance with Mr C's needs.

20. The Adviser said that if the Board offers their prostate cancer patients active surveillance then it has an obligation to arrange any recommended imaging. They said that at the point of the MRI which had been organised by the Board to be carried out on 4 April 2017 being cancelled, the Board should have taken steps to proactively inform Mr C about his options and to arrange an open MRI. I understand that Mr C subsequently arranged to have an MRI scan in France.

21. Overall, the Adviser considered the monitoring provided for Mr C's prostate cancer by the Board was not of a reasonable standard, due to a failure to:

- arrange follow-up appointments;
- arrange PSA tests that required to be undertaken;
- check that PSA tests were undertaken as intended;

- make adequate and timely arrangements for an MRI scan which took Mr C's needs into account; and
- provide Mr C with information that might have enabled him to make alternative arrangements to get the necessary tests done.

22. The Adviser also said it would be advisable for the Board to check there are no other prostate cancer patients on active surveillance who have been lost to follow-up.

(a) Decision

23. The basis on which I reach decisions is 'reasonableness'. My investigations consider whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time. I have carefully considered all the information supplied by Mr C and the Board, and the independent advice (as outlined above) received on Mr C's complaints.

24. The advice I received is that the monitoring provided to Mr C for his prostate cancer was not reasonable. I accept this advice. I note the multiple failings identified by the Adviser; in particular: that there is no evidence of any PSA monitoring being carried out for the period March 2016 to January 2017 despite this being the Board's responsibility; and a failure to organise an MRI scan at the appropriate time. When an MRI scan was organised, the Board then failed to address Mr C's needs in this regard which led to it being cancelled.

25. The Board should have a reliable system in place to monitor prostate cancer patients on active surveillance to ensure essential testing such as PSA levels are carried out. I am concerned that this did not happen in Mr C's case and that ultimately Mr C had to arrange MRI scanning himself in France.

26. Given the above, I uphold this complaint. In addition to addressing the individual failings my investigation has identified, I consider the Board also needs to ensure they have reliable monitoring systems and processes in place for patients in a similar situation to Mr C and that patients on active surveillance are receiving the appropriate monitoring. I have therefore made a number of recommendations for action by the Board at the end of this report.

(b) The Board failed to communicate appropriately

Concerns raised by Mr C

27. Mr C complained that the Board's communication regarding the monitoring of his prostate cancer was not sufficient. Mr C said that despite numerous requests for clarification on various matters the responses he received were not timely or accurate, and they did not sufficiently answer his questions.

The Board's response

28. In response to Mr C's complaint, the Board explained that, with regards to his communication with the clinical nurse specialist, they do not usually use email as a way of communication at all, and that an exception was made in Mr C's case. They said that Mr Cs emails were responded to in a timely and accurate manner. They acknowledged that written email communication can be difficult and said that after reviewing the case they felt that all communication would need to be verbal in order to ensure understanding and prevent any further confusion.

Advice obtained

29. I asked the Adviser to consider this matter. The Adviser first noted that Mr C said that he was not informed of the need for three monthly PSA tests. The Adviser considered it likely that the communication regarding this was deficient, given that the relevant out-patient clinic letter of 10 March 2016 did not give any precise instructions to Mr C's GP, and that Mr C did not appear to have been given any written information about the follow-up or a copy of the GP letter. The Adviser also commented that it appears Mr C was not informed about the need for an MRI scan at the appointment of 10 March 2016, otherwise the difficulties around organising this could have been addressed earlier.

30. With regards to the email communication Mr C had with the clinical nurse specialist, the Adviser was of the opinion that the responses to Mr C's emails did not include answers to some of his questions, most importantly the main questions of options regarding sedation or an open MRI.

31. The Adviser noted that Mr C was informed in a timely manner about the booked MRI at the Hospital, and said that it was clear that the nurse specialist was doing all they could to accommodate his requests around timing, and making a special effort to communicate by email. However, the Adviser said that several questions remained unanswered.

32. The Adviser observed that the information Mr C had received about fasting was unclear in that the nurse specialist failed to acknowledge that Mr C had received advice to be fasting for the MRI scan from the hospital, and in their email response stated 'fasting is not normally required'.

33. The Adviser said that if the instructions from the hospital about fasting for an MRI were not clear, the nurse specialist should have contacted the Hospital to clarify them and then confirmed them to Mr C. The Adviser noted that some generic patient information about MRI scans was offered, and said that whilst this was not incorrect it was unhelpful as it was only sent to Mr C after the MRI at the Hospital had been cancelled.

34. The Adviser further noted that Mr C was not informed about the option or offered an open MRI scan until the Board's final complaint response, despite awareness of his claustrophobia at the time of the initial recommendation for MRI scan in February 2017.

(b) Decision

35. Having reviewed the evidence provided to me by both Mr C and the Board, and the advice I have received and that I accept, I consider the Board to have failed to communicate appropriately with Mr C.

36. I note the Adviser's comments that when Mr C was diagnosed it appears that the need for three monthly PSA testing and an MRI scan after six months was not communicated to him or his GP appropriately. Additionally, when Mr C was contacted regarding the MRI, I accept the advice that the information Mr C was given did not answer all of his questions, nor was he fully informed of his options. I consider this was unreasonable, and I uphold this complaint. My recommendations for action by the Board are at the end of this report.

(c) The Board handled Mr C's complaint unreasonably

Concerns raised by Mr C

37. Mr C telephoned Patient Services on 22 March 2017 and explained his concerns. Mr C had a number of questions to which he was seeking answers.

38. Mr C telephoned again on 3 and 10 April 2017 seeking an update regarding progress and so that he could make arrangements to come back to the UK for the MRI scan.

39. The Board responded to Mr C's complaint on 24 April 2017. On 3 May 2017 Mr C called the Board to explain that he was not happy with the response. Mr C followed up this telephone call with an email. Throughout May 2017 Mr C telephoned and emailed on a number of occasions and the Board said that a response was being prepared.

40. Having had no response by 15 June 2017, Mr C contacted my office. A member of my advice team contacted the Board asking if a further response was going to be provided. The Board said that the response they had given was their final say on the matter and that the complaint was ready for our office.

The Board's response to SPSO enquiries

41. In response to our enquiries on complaints handling, the Board acknowledged that their handling of Mr C's complaint and communication with him regarding his complaint could have been better. They apologised that Mr C's points of concern were responded to four working days over the 20 working day timescale, and that their handling of his complaint was below the standard they strive to achieve. They commented that a number of improvement actions have been taken since to improve complaints handling.

42. The Board told us that when Mr C first contacted Patient Services on 22 March 2017 the purpose of his telephone call was to seek answers to specific questions he felt had not been answered by corresponding directly with the clinical nurse specialist. The Board said that the concerns were passed to Acute Services who have a responsibility for the service in question. The Board said that this was logged on their system as a concern rather than a complaint, which is why a formal acknowledgement was not sent to Mr C at the time.

43. The Board went on to explain that when Mr C made contact with Patient Services on two further occasions to tell them he had not had any further contact regarding his concerns, Patient Services sent requests to the Acute Services team to contact him directly. I have not been provided with evidence that confirms that the Acute Services team did, in fact, contact Mr C.

44. The Board noted that a response was sent to Mr C on 24 April 2017, and that he contacted the Acute Services team directly on 3 May 2017 by email to advise that there were still questions he felt had not been answered. The Board said that the Acute Services team attempted to look into Mr C's further enquiries but that there was a delay in getting back to him. They said that when my office

contacted them to ask whether they considered the matter closed, they advised that as Mr C had progressed the complaint to SPSO they halted their investigation into his concerns.

45. The Board explained that at the time Mr C raised his concerns, the feedback coordinator post within Acute Services was vacant. Whilst every effort was made at the time to ensure continuity of the complaints and feedback process, this was challenging. The Board said that the vacant post was filled by the end of April 2017 and Patient Services had, and continue to, work closely with Acute Services to ensure understanding of the NHS complaints handling process and compliance with the complaints handling procedure (CHP) timescales.

46. The Board further said that Patient Services are working closely with teams across the Board to monitor and review internal processes to ensure the CHP is streamlined and user friendly both for staff and for those making complaints. They also said that they have an ongoing action plan in place to address any issues identified.

47. Finally, the Board said that they have trained over 100 staff on the new CHP and investigation skills, and that they are continually reviewing and implementing internal reporting on the key performance indicators which they hoped would ensure compliance with the CHP timeframes.

Relevant legislation and guidance

48. The Patient Rights (Scotland) Act 2011 and associated Regulations and Directions came into effect in 2012. The 2011 Act introduced the NHS Can I Help You? (CIHY) guidance. The aim of this was to assist NHS bodies and their health service providers in handling and learning from feedback, comments, concerns or complaints about health care services. This was statutory guidance with which NHS service providers were required to comply.

49. Section 2.2 of CIHY guidance notes that feedback, comments and concerns are not complaints. It is therefore necessary for staff to be able to distinguish between issues that are feedback, and those which constitute a complaint. To do this they must use their judgement and discretion and make the person aware of the options and the distinct process for dealing with complaints.

50. Section 2.6.2.1 states that best practice in responding to complaints and concerns would be to provide a response within seven working days or within a timescale agreed with the patient. The response should include an explanation, an apology where appropriate and indicate any improvement that has been identified at this early stage.

51. CIHY guidance defines a complaint as 'an expression of dissatisfaction about an action or lack of action or standard of care provided'. It also notes that complaints must be acknowledged within three working days and investigated within 20 working days or as soon as reasonably practicable, with any delay over the 20 working days being discussed with the complainant.

52. When considering how the Board handled Mr C's complaint, I have examined both the clinical aspects of the issues he raised and the process by which he received responses.

Advice obtained

53. The Adviser commented on the clinical aspects of the Board's complaint response dated 24 April 2017.

54. They noted that the response did not mention the specification 'multiparametric' MRI, which was the required procedure, nor did it answer Mr C's question as to whether this could be carried out in France.

55. The Adviser went on to note that an explanation was given as to why the MRI scan (which was later cancelled) had been arranged to be carried out outwith the Board's boundaries, but no acknowledgement or apology was given for the arranged MRI scan being unsuitable despite the knowledge of Mr C's claustrophobia.

56. The Adviser further noted that the Board's response did not:

- provide any information as to the urgency of the scan;
- acknowledge or apologise for the fact that the scan was at this point in time eight months overdue; or
- provide reassurance that the scan was non-urgent at this time.

57. The Adviser also noted the response did not appear to be based on a consultant's advice.

58. The Adviser said that the Board's response failed to acknowledge that Mr C had received differing advice about fasting and the possibility of sedation from the nurse specialist and to give an explanation for this. The Adviser also said that the Board failed to acknowledge that some essential patient queries were not answered.

59. Overall, the Adviser said that the Board's response failed to see the greater picture of a cancer patient who had not been appropriately managed so far, address Mr C's concerns and offer an early resolution, noting the lack of an apology for the Board's deficiencies in arranging follow-up appointment and PSA tests.

60. Finally, the Adviser commented that under the European Union Cross-Border Healthcare Legislative there is currently a possibility for Scottish citizens to have their treatment carried out elsewhere within the European Union and apply for the costs to be re-funded to them, provided they would have been entitled to the same treatment on the NHS in the UK. The Adviser said that they would expect Mr C to be eligible for this and said it might have been helpful to point this option out to him.

(c) Decision

61. The Board stated that when Mr C first contacted Patient Services this was logged as a concern, not a complaint, and this is why he was not sent a complaint acknowledgement letter as specified in the CIHY guidance. However, if this was regarded as a concern, according to best practice they should have responded in seven working days, which they did not do. Whilst I accept that best practice is not the same as a required timescale, I would have expected there to be some form of update or communication with Mr C to keep him informed if the timescale was to be exceeded.

62. In any case, given the issues raised, I consider that this should have been treated as a complaint and handled in line with complaints handling procedures from the beginning. Indeed, I have noted that when responding to Mr C, the Board referred to his communication as a complaint and referred him on to this office. They also referred to the 20 day timescale in communication with us, suggesting that they considered Mr C's concerns to constitute a complaint.

63. I am also critical that when Mr C contacted Patient Services seeking an update he was not given one. Whilst the Board have stated that Patient

Services asked Acute Services to update Mr C directly, I consider that it would have been preferable for them to either give Mr C a direct contact number for the team handling his complaint or to actively seek an update for him themselves.

64. The Board's response to Mr C's contact was slightly beyond (by four working days) the 20 working day timescale given in the CIHY guidance. While I recognise that sometimes it will not be possible to respond within the 20 day timescale, I consider Mr C should have been informed, and should have received a response that addressed his concerns properly. It is clear to me from the advice I received that the substance of the complaint response was not of a reasonable standard.

65. Finally, when Mr C contacted the Board on 3 May 2017 to explain his dissatisfaction with their complaint response, the Board should have re-opened the complaint, made Mr C aware of such, and taken action to respond within a further 20 working days. Whilst the Board have stated that they attempted to look into Mr C's further enquiries, this was not supported by evidence.

66. It is clear that due a lack of communication and inaccurate and incomplete responses, Mr C experienced a poor complaints journey and that this has added to his frustration and upset.

67. Given the above, I uphold this complaint. My recommendations for action by the Board are at the end of this report.

68. On 1 April 2017 the CIHY guidance was superseded by the NHS Scotland Model Complaints Handling Procedure (CHP). The CHP was implemented by the NHS across Scotland. It requires NHS organisations to follow a two-stage procedure with specific timescales for responding: stage one within five working days and stage two within 20 working days. Generally meetings should be held and investigation carried out within these timescales. The CHP recognises that some complaints can be complex so allows for the timescales to be extended in certain circumstances. Where this applies the health board must keep the complainant updated. The SPSO has been and continues to work closely with the Scottish Government to monitor compliance with the CHP.

69. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are

asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b), and (c)	The Board failed to provide appropriate monitoring following a diagnosis of prostate cancer; failed to communicate appropriately; and handled Mr C's complaint unreasonably	Apologise to Mr C for failing to provide appropriate monitoring following a diagnosis of prostate cancer; failing to communicate appropriately; and handling his complaint unreasonably The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	Copy or record of apology By: 20 June 2018

We are asking The Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Board failed to provide appropriate monitoring following a diagnosis of prostate cancer	Prostate cancer patients on active surveillance should be properly and appropriately monitored	Evidence of a review of current systems to monitor prostate cancer patients on active surveillance, which includes an assessment of the reliability and effectiveness of these systems and any improvements to be made as a result of the review Evidence that there has been a review of all prostate cancer patients on active surveillance to ensure they are being actively followed up By: 15 August 2018
(a)	There was a failure to make adequate and timely arrangements for a scan which took Mr C's needs into account	There should be a system in place to accommodate patients with special needs such as claustrophobia who are required to undergo scanning	Evidence that a system has been put in place to make arrangements for patients with special needs such as claustrophobia to undergo scanning and that this system has been communicated to all the relevant staff By: 15 August 2018
(b)	When Mr C was diagnosed with prostate cancer it was not communicated to him that he would need three	Patients on active surveillance for prostate cancer should have the	Evidence that this has been considered and a system is in place to ensure that patients on

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
	monthly testing and scanning after six months	follow-up requirements clearly explained to them	active surveillance for prostate cancer have the follow-up requirements clearly explained to them By: 15 August 2018
(b)	When Mr C was contacted regarding scanning, the information he was given did not answer his questions, nor was he fully informed of his options	Clear information should be given regarding options for scanning, and staff should make efforts to ensure they are answering all of a patient's questions	Evidence that this has been fed back to the relevant staff in a supportive way that encourages learning By: 4 July 2018
(c)	Mr C's complaint was handled unreasonably	Complaints should be accurately logged and responded to in line with the complaints handling process	Evidence that this has been fed back to the relevant staff in a supportive way that encourages learning By: 4 July 2018
(c)	Communication with Mr C during and after the complaint process was poor	Communication with complainants should be pro-active, and complainants' requests for contact should be returned	Evidence of a review of the communication during and after the complaints process in this case, including an assessment of why staff failed to return Mr C's requests for contact and what action will be taken to avoid this recurring in the future By: 15 August 2018

Feedback

Points to note

The Board could consider raising awareness of their clinical staff about the current options of Healthcare in Europe for patients.

Terms used in the report **Annex 1**

the Adviser	a consultant urologist who provided medical advice on the treatment provided to Mr C
the Board	Dumfries and Galloway NHS Board
CHP	NHS model complaints handling procedure
CIHY guidance	Can I help you? guidance
the Hospital	a hospital in a different board area
Mr C	the complainant
MRI	a scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body
PSA	Prostate Specific Antigen - a marker in blood tests which can indicate prostate problems
SCAN	South East Scotland Cancer Network

List of legislation and policies considered — Annex 2

The Patient Rights (Scotland) Act 2011