SPSO decision report

Case: **201600032, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained that she had not received a reasonable standard of care at the Southern General Hospital. She was referred on two occasions with the same spinal symptoms but neither occasion had been treated as an emergency. Ms C said she had to wait an excessive length of time for an out-patient appointment, despite the severe pain she was suffering. Although she had phoned the hospital numerous times about her condition, she did not receive an appointment until she made a complaint. Ms C was offered an appointment a few days after she made this complaint and at the appointment she was told that she would be operated on a few days later. Ms C also complained that the board did not reply adequately to her complaints, and that they failed to communicate effectively with another health board about her condition and treatment.

We took independent advice from a consultant neurosurgeon. We found that it was not unreasonable for Ms C to be treated as an out-patient, given the information available to the board. The advice we received said that there was an unreasonable delay in providing an out-patient appointment for Ms C, which meant the nature of her pain was not considered fully. We therefore upheld the aspect of the complaint regarding Ms C's care and treatment.

We found that the board had expedited Ms C's appointment following her complaint. We considered this to be inappropriate given that Ms C had made contact through the appropriate channels in an effort to explain the pain she was suffering. We found the board had failed to respond adequately to Ms C's complaint and we upheld this aspect of the complaint.

We found that the board did not fully investigate a misunderstanding of communication between themselves and another health board, and so we also upheld this part of the complaint.

The advice we received was that, although the care and treatment Ms C had received had not been of a reasonable standard, there was no evidence that she had been deliberately misled by board staff, or that she had suffered permanent damage as a result of the delays to her treatment. We did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failings identified in our investigation.

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

- Action should be taken to address extended delays in providing out-patient appointments, taking into account the learning from this case.

In relation to complaints handling, we recommended:

- The complaints handling in this case should be reviewed, and the reasons for the delays in providing a response should be identified.
- A reminder should be sent to all complaints handling staff about the need to inform complainants about the reasons for any delays in handling their complaints.

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.