SPSO decision report

Case: **201910632, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C was referred urgently to the gynaecology department (medicine of the female genital tract and its disorders). During the vetting procedure the board requested the referral be downgraded to routine and the GP complied with this request. Following a consultation with the first consultant, C was scheduled for an operation. During the pre-operation examination by the second consultant, a cervical tumour was found and the operation cancelled. When informed of this, C made a verbal complaint about their treatment since being referred.

Biopsy results confirmed the tumour as malignant. C lost faith in the clinicians involved and requested a second opinion. A consultant oncologist (cancer specialist) met with C to discuss this and took steps to arrange a second opinion. C also took steps to obtain the second opinion using personal contacts. The second opinions provided concurred with that of the board. C complained to the board in writing regarding their experiences. A significant clinical incident (SCI) investigation was undertaken and following this, the board responded to C's complaints. C was dissatisfied with the board's responses and brought their complaint to this office.

We took independent advice from a consultant gynaecological oncologist. The SCI investigation had found that the board failed to give advice, contrary to relevant guidance, to C's GP regarding the referral submitted as urgent. We upheld C's complaint about this and accepted advice received that the board's revised guidance had addressed the identified failings. However, the board had not apologised to C for these.

The board concluded the time taken between C's referral by their GP and a correct diagnosis being reached was unreasonable and also accepted the time taken to respond to C's complaint was unreasonable. We upheld C's complaints about these and found that the board had not reasonably apologised to C for the delay in diagnosis.

We found that C's verbal complaint had not resulted in reasonable action being taken as there was no evidence of any consideration regarding the complaint until C made a written complaint over two months later.

We accepted the advice we received that the board provided reasonable care and treatment to C following their diagnosis and that there were no concerns about how the SCI investigation had been carried out in relation to the board's policy. We did not uphold these complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified. The apology should make clear mention of each of the failings identified as well as include a clear stated apology for the delay in C's diagnosis. 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 take all reasonably practicable steps in the present circumstances to ensure that they comply with the Treatment Time Guarantee.

In relation to complaints handling, we recommended:

- The second consultant should take action to ensure that all complaints are appropriately recognised, acknowledged and actioned, including verbal 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.