SPSO decision report

Case: **202106013, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Appointments / Admissions (delay / cancellation / waiting lists)
Decision: upheld, recommendations

Summary

C complained on behalf of their parent (A) that the board unreasonably failed to proceed with hip replacement surgery within a reasonable timeframe.

C said that A was referred for physiotherapy before being added to the waiting list for surgery. They complained that this was unreasonable as it was known that it would not help given the extent of deterioration in A's hip joint. C also complained that several of A's appointments had been cancelled or postponed, and that the board had failed to act on an urgent referral sent by A's GP. As it was unclear when A would receive their surgery, they opted to have this carried out privately.

In responding to C's complaint, the board confirmed that they must take all reasonably practicable steps to ensure that they comply with treatment time guarantees. This includes considering whether to send patients to another care provider if they cannot provide treatment by the patient's treatment time guarantee. In A's case, the board noted that A had elected to make their own arrangement for private surgery and, therefore, the NHS offer of treatment was no longer relevant to them.

We took independent medical advice from a consultant orthopaedic surgeon (a specialist in the treatment of diseases and injuries of the musculoskeletal system). At the point of referral to orthopaedics, we found that A was reasonably referred for physiotherapy and added to the waiting list as a routine category patient. At the pre-operative assessment clinic, we found that an x-ray was taken but it had not been reported or reviewed. At this point, A should have been re-prioritised to urgent in keeping with the physical changes that they had reported and the radiological deterioration evident on the x-ray. It was unreasonable not to re-prioritise A at this time. In reference to the urgent referral sent by A's GP, A continued to be considered as a routine category patient. However, it was clear A's case had been expedited as they were offered a place on a private sector list for surgery run by the board at the time. The board could not provide evidence to support their decision making. We also found that the board did not meet their legislative requirements when communicating with A about their treatment time guarantee date. On balance, we upheld C's complaint.

During our investigation, we identified issues with the board's handling of the complaint. We made a recommendation to the board to support improvement of their complaint handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for not reasonably communicating with A about the breach of their treatment time guarantee date, for not acting on the changes reported by A at the pre-assessment clinic, for not reviewing or reporting the x-ray, for not appropriately reviewing and reprioritising A following the urgent GP referral, and for not documenting the reason for the decision to add A to the private list for surgery. 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:

- Patients on waiting lists for surgery should be managed in keeping with the relevant policies and guidance, and they should be kept informed about delays particularly when a treatment time guarantee has been breached. The outcome of assessments and test results including x-rays taken at pre-assessment clinics should be timeously reviewed and documented in the medical record. Patients should be appropriately reviewed and reprioritised based on assessment and the clinical evidence available. Decisions made in respect of the patient should be documented by the relevant person in the medical record.

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 The final complaint response should include information about the SPSO, including the timescale for making a complaint, in line with the Model Complaints Handling Procedure.

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.