SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201507440, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Outcome: upheld, recommendations

Summary

Mrs C complained about a delay in receiving surgery. She said that she had waited longer than the 12-week treatment time guarantee (TTG) to be given a surgery date, and that this affected her quality of life as she could not work and had distressing ongoing symptoms. Mrs C also raised concerns about the board's handling of her complaint.

During the investigation of Mrs C's complaint, she was given a surgery date with the surgery taking place about 18 weeks after she agreed to the treatment. The board said the time-frame was due to the complexity of the surgery which meant that two different specialists had to be involved.

The board also said that Mrs C requested a named consultant, which Mrs C disputed. When we asked for evidence, the board acknowledged that this was incorrect and explained that staff had misunderstood the process and created a letter stating that Mrs C wished to have a named consultant, instead of the letter explaining that the TTG would not be met.

After taking independent medical advice, we upheld Mrs C's complaint about the delay. Although there was evidence that individual clinicians were aware of delays with this kind of surgery and were taking appropriate action, we were critical that the board did not deliver the TTG in Mrs C's case. We were also critical that the board did not contact Mrs C to explain the delay due to the administrative error. During our investigation we also found that a referral for further investigations had been missed due to the wrong name being given on the letter. Although the medical adviser said it was reasonable in this case for the surgery to go ahead despite these investigations not being done, we were critical that the referral was missed.

We were also critical of the board's handling of Mrs C's complaint as it appeared that the initial complaint, which was made by her mother, was missed by complaints handling staff which lead to a delay in it being investigated. However, instead of acknowledging this error, the board incorrectly said the delay was due to waiting for Mrs C to consent to the complaint.

Recommendations

We recommended that the board:

- feed back the findings of this report on the misdirected referral to the medical staff involved;
- review the arrangements for referrals of this kind to reduce the risk of referrals being misdirected in future;
- demonstrate to this office that a long-term solution has now been put in place to progress waiting lists for this kind of surgery;
- apologise to Mrs C for the failings identified; and
- discuss the findings of this report with relevant complaints handling staff for reflection and learning.