SPSO decision report



Case: 201905172, Greater Glasgow and Clyde NHS Board - Acute Services Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Ac

Sector: Health

Subject: Complaints handling

Decision: some upheld, recommendations

Summary

C made a complaint on behalf of their partner (A), who had a cancer diagnosis. C complained that there was a failure to keep A reasonably informed about appointments for treatment. C considered that the board had failed to ensure that they had A's address correctly recorded on the patient database. C also raised concerns about a delay in responding to the complaint, and a failure to provide a consistent explanation about why A was not reasonably informed of appointments for treatment.

We found that the board were able to provide copies of letters with the correct address, and whilst these had not been received by A, it was not possible to say that they had not been sent. In addition, whilst A turned up for an appointment that A did not know had been cancelled, the consultant did see A to carry out a full consultation. We did not uphold this aspect of C's complaint.

We found that the board provided conflicting accounts of what address information was held on the databases for C and for SPSO and whether or not this required to be corrected/had been corrected.

We also found that there was a delay in responding to C's complaint. We noted that the complaints department had moved, but we considered that it was reasonable to expect that the board would have in place a mechanism to forward the mail addressed to the complaints department to the new location within a reasonable period of time. We upheld these aspects of C's complaint.

Recommendations

What we asked the organisation to do in this case:

Apologise to C for (i) a failure to ensure they had correctly recorded on their patient databases A's address
which he had lived at since August 2015, (ii) a failure to provide a response to C's complaint within a
reasonable period of time and (iii) a failure to provide a consistent explanation regarding why there was a
failure to ensure A was reasonably informed of appointments for treatment. The apology should meet
thestandards set out in the SPSO guidelines on apology available atwww.spso.org.uk/information-leaflets.

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

• Ensure patient addresses are accurate on all databases.

In relation to complaints handling, we recommended:

- Ensure complaint correspondence received is directed to the correct department.
- Ensure a thorough investigation is carried out before a stage 2 response is sent to a complainant.

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.