SPSO decision report

Case: **202200504, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their infant (A). C's concerns related to A's urinary function. C had concerns about the monitoring they had received whilst pregnant with A, the care provided to them and A immediately post- birth as well as during A's early years. C raised issues about the assessment of A's bladder function, A's renal health and the pain and discomfort A was suffering. C also felt that the family had not been listened to and their concerns dismissed or minimised. C had sought a second opinion at a hospital in England and believed board medical staff criticised the family for taking this step. They also said that the board failed to liaise with the hospital in England, resulting in A not receiving treatment or care for an extended period.

The board had accepted that communication with the family could have been better but considered the standard of care and treatment provided to A was reasonable.

We took independent advice from a consultant paediatrician. We found that A's symptoms were reasonably investigated initially and that they were referred to urology timeously. We also found no clear evidence that A's bladder had been damaged by failings on the part of the board. Therefore, we did not uphold these parts of C's complaint.

We found that the impact on A and their family of their condition was not adequately acknowledged and that the board had failed to communicate appropriately with C and their family. We also found that the board did not act when it became apparent that A was no longer being cared for by a hospital in England, resulting in avoidable delays in their care. Finally, we considered that the board failed to handle C's complaint reasonably. We upheld these parts of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's parents for the failures identified in this report. 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 share this decision with the staff involved in A's care with a view to identifying any aspects of the care and treatment that could have been improved. This should include consideration of whether there are any immediate actions which need to be taken to address A's ongoing issues.
- Patients' families should receive clear explanations and be provided with appropriate information which addresses their concerns.
- The board should reflect on the experience of A's family with a view to identifying any ways that communication and care planning for A could have been better managed.

In relation to complaints handling, we recommended:

- The board's complaint monitoring should ensure that failings, as well as good practice are identified and that learning and information gathered from complaints is used to drive service improvement.

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.