

## SPSO decision report

**Case:** 202207277, Lothian NHS Board - Acute Division  
**Sector:** Health  
**Subject:** Clinical treatment / diagnosis  
**Decision:** some upheld, recommendations

### Summary

C complained about the care and treatment that they received in respect of their cancer. C was diagnosed with colorectal cancer which had spread to their liver and required surgery. The surgery was to be performed in two stages. C complained that the second surgery was not performed within a reasonable timescale and about poor pain relief following the second surgery.

The board apologised to C for the poor communication about the arrangements for the second surgery and explained that repeating imaging was required before arranging the surgery and that they did not consider the delay to be significant. The board provided an overview of the pain relief provided and noted that any issues identified were addressed at the time.

We took independent advice from a colorectal and surgical consultant. We found that communication with C about when they could reasonably expect to have their second surgery was poor and there was an unexplained delay in their case being reviewed by the multi-disciplinary team. This resulted in a delay of around one month, however we did not consider this would have caused further spread of C's cancer. We upheld this complaint.

We noted that there were some issues with the equipment used to deliver pain relief post surgery, however these were rectified and appropriate additional pain relief was provided promptly. We found the post surgical care and treatment provided to be reasonable and we did not uphold this complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the issues identified. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets).

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

- That the board review their approach to communication with patients to ensure that cancer patients are proactively kept informed of progress in their treatment plan.
- That the board review their processes for prioritising the review of important cases by the MDT to ensure that such cases are progressed without delay.

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.