SPSO decision report

Case: **202311619, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Appointments / Admissions (delay / cancellation / waiting lists)
Decision: upheld, recommendations

Summary

C complained about the lack of care and treatment that the board provided in relation to not being recalled for a colonoscopy. C had undergone regular colonoscopies to monitor disease progression. C was not recalled when the next colonoscopy was due. The COVID-19 pandemic led to suspension of services with a long backlog of patients. When C did subsequently undergo a colonoscopy, this led to a diagnosis of cancer.

We took independent advice from a consultant gastroenterologist and hepatologist. We found that the board failed to identify C as someone at significant increased risk that needed the procedure to be re-booked as a priority. We found that it was unreasonable that C's colonoscopy was an overdue procedure that was not clinically reviewed. Therefore, we upheld this complaint. We also found that it was unreasonable that the board had not carried out a significant adverse event review into the matter.

C also complained that the board failed to provide a reasonable response to their complaint. We found that the board's complaint handling of C's complaint was unreasonable, as the failure to clinically review C's overdue procedure and failure to identify C as someone at significant increased risk, were inadequately investigated as part of the complaints process. In light of that specific failing, we also upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- The board should have a robust clinical prioritisation process for rescheduling endoscopy procedures that may have been delayed for whatever reason
- When a relevant adverse event occurs, the board should promptly carry out an SAER to investigate the cause and identify any potential learning.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the board's complaint handling procedure and the NHS Model Complaints Handling Procedure. Complaints investigators should fully investigate and address the key issues raised, identify and action appropriate learning and apologise where issues have been identified. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.