SPSO decision report

Case: **202405058, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their sibling (A) about the cancer care and treatment that A received and the handling of C's subsequent complaint about this.

We took independent advice from a consultant urological surgeon (specialist in the male and female urinary tract, and the male reproductive organs) and a consultant oncologist (specialist in cancer).

We found that there was a delay in arranging an MRI scan and a ureteroscopy (a procedure that uses a thin telescope with a camera on the end to look inside the ureters and kidneys) for A. We also found that it was unreasonable that A had to involve their GP to prompt urology treatment and that there was no evidence that A's scan results were revealed or discussed with them.

We found that the board's investigation of the failings were inadequate. The board should have carried out a local significant adverse event review and there appeared to have been no process changes to prevent similar failings in future. The board also failed to keep C updated on the reason for the delay in issuing their complaint response. We upheld C's complaints. However, we considered that it is unlikely that earlier treatment would have changed A's prognosis.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to advise C that a named member of staff was available to clarify any aspect of the complaint response. 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:

- Staff should discuss scan results with patients and record this in the patient's records.
- The board should ensure that where events meet the definition of a Category 1 adverse event (events that may have contributed to or resulted in permanent harm), as set out by Healthcare Improvement Scotland, they carry out a local SAER.
- The board should have systems in place which adhere to the Royal College of Radiologists recommendations on cancer imaging alerts and a robust system for booking procedures in theatre that does not rely on email.

In relation to complaints handling, we recommended:

- The board should keep complainants updated on the reason for any delay in issuing their complaint response and when the response is issued, advise complainants that a named member of staff is

available to clarify any aspect of the complaint response. [In response to a draft copy of this decision notice that was issued to both parties, the board indicated that since this complaint, they had implemented a new complaint system that provided a facility to monitor when holding letters were due.]

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.