SPSO decision report

Case: **202505720, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment
Decision: upheld, recommendations

Summary

C complained about care and treatment provided to their parent (A). Following symptoms of abdominal pain and weight loss, A was referred to colorectal and upper gastrointestinal (GI) specialists and was subsequently diagnosed with hepatocellular carcinoma (a type of liver cancer). C raised concerns about a number of aspects of A's nursing and medical care during admissions following the diagnosis, as well as the diagnostic journey leading up to that point.

We took advice from a consultant gastroenterologist in relation to the medical aspects of C's complaint. We found that following referrals for investigation of suspicion of cancer, appointments were not scheduled within the national standards time of 14 days. Though the board acknowledged this when highlighted by our investigation, they had not identified the failing in their own complaint investigation.

We determined that while earlier appointments and diagnosis may not have changed A's outcome, they could have resulted in better certainty and understanding for A's family, and potential improved symptom control and quality of life.

There were also a number of times when A attended hospital and there were issues with waiting times in the emergency department, care having to be carried out in corridors due to a lack of beds, and delays in medical reviews. The board had acknowledged and apologised for these failings in their complaint response to C.

Finally, we found that there appeared to have been a lack of specialist care pathways and input from the relevant specialisms in this case. We upheld the complaint about the medical care and treatment provided to A.

We also took advice from a nursing adviser. It was clear from the board's own investigation that there were failings in the nursing care provided to A. We assessed whether the board had taken reasonable learning and improvement action after identifying these failings. While some action had been taken, overall we did not consider the board had reasonably identified and addressed the failings in nursing care, which included documentation, blood sugar monitoring, lack of nutritional planning, and lack of medication management. The board also failed to create an action plan following their complaint investigation and learning points were only followed up after we became involved in the case. We upheld the complaint about nursing care and treatment provided to A.

The board said they have since strengthened processes by reinforcing the requirement for action plans, improving oversight at directorate level, providing additional training for managers, and ensuring learning actions are monitored and evidenced before complaint responses are finalised. We asked for evidence of this improvement action.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C that appointments following referrals for investigation of suspicion of cancer were not scheduled within the timescale required by national standards, that there was a lack of specialist care pathway/input from relevant specialisms, that the board failed to take reasonable action to address identified failings in nursing care and treatment and that complaint handling was unreasonable. 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:

- Appropriate specialisms should be available and involved at relevant times.
- When failings are identified in complaint investigations, appropriate action should be taken to address these failings.

In relation to complaints handling, we recommended:

- Where the original agreed date for a complaint response will not be met, the complainant should be updated on the reason for the delay and given a revised timescale for completion. 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.

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.