SPSO decision report

Case: **201202677, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, with recommendations

Summary

Mrs C complained about the care and treatment that her father (Mr A) received from the board during the four months it took to provide a definitive diagnosis of pancreatic cancer (cancer of the pancreas - a gland in the digestive system). Mr A had been attending his medical practice, and they referred him to hospital for a range of tests. When the test results indicated the possibility of pancreatic cancer, Mr A was referred on an urgent suspected cancer pathway (a route into further treatments which are not available to GPs directly) for a scan. Following this, his case was discussed at a team meeting, and he was referred on for another specialist scan. The results of this test were reviewed at further team meetings, which identified a need for a specialist form of endoscopy (a medical procedure where a tube-like instrument is put into the body to look inside). Mr A had to wait four weeks for this test, and was given a final diagnosis of pancreatic cancer four months after he first attended his GP. During his hospital visits, he was seen by a clinical nurse specialist three times, but never had a clinic appointment with a consultant.

We obtained independent advice on this complaint from two medical advisers. Their advice indicated that pancreatic cancer is difficult to diagnose, so it took several tests to get a diagnosis. In Mr A's case, there were no significant delays in delivering the tests or results. However, we upheld Mrs C's complaint as our investigation found that the lack of contact with a consultant indicated a lack of good patient care. Mr A's needs and concerns were not kept at the heart of the process, and this made it more difficult for him and his family to accept the apparently slow progress in reaching a diagnosis.

Recommendations

We recommended that the board:

conduct a significant event analysis around the substance of this complaint, particularly in relation to the conduct and role of doctors and specialist nurse practitioner in the delivery of diagnostic service, taking into account our advisers' concerns on this issue;

ensure that the findings of this complaint become a significant part of the relevant consultant's next appraisal; and

issue an apology to Mr A for failing to provide him with appropriate care and attention while he was undergoing diagnostic tests.