SPSO decision report

Case: **201304447, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C complained about the care and treatment she received for endometrial cancer (cancer in the lining of the womb) between April 2011 and March 2012 at Raigmore Hospital. Specifically, she was concerned that she was not given enough information about the cancer and her treatment options. She also raised concerns about the treatment she received in 2011 and about delays in surgery going ahead after evidence of cancer was identified in 2012. Mrs C also complained about inaccuracies in the board's response to her complaint.

We found the record-keeping by the staff involved in Mrs C's care and treatment was of an appropriate standard and reflected reasonable attempts to help her understand the diagnosis and treatment plan. We considered that this was done within a reasonable timescale after she presented with abnormal symptoms in 2011. The board also ensured Mrs C had the opportunity to discuss her concerns about her care with relevant specialists.

We took independent advice on her case from one of our medical advisers who found that the treatment given in 2011 was appropriate and in line with national guidance. Our adviser said that there were certain factors that had to be properly considered before decisions could be made regarding Mrs C's care, because of the risk to her life. Whilst we noted a slight delay in a second opinion being sought after it was indicated in 2012 that there was residual evidence of the cancer, this did not impact on Mrs C's outcome as the cancer was in the early stages and had not spread. We also found that it was not clear whether the results of an abnormal scan were highlighted to the gynaecology team through the multi-disciplinary team process. Although the subsequent delay did not have any impact on Mrs C's prognosis, it is important that radiology staff acknowledge that the referring team may not have the experience to interpret any identified abnormalities and action these appropriate. Whilst we made a recommendation to address this, we concluded that there were justified reasons why the management of her care took time to consider and did not uphold the complaint.

We did not identify any significant inaccuracies in the board's written response to the complaint.

Recommendations

We recommended that the board:

- review the current arrangements for multi-disciplinary team meetings to ensure that there are processes in place for abnormal scan or x-ray results to be flagged and actioned as appropriate.