SPSO decision report

Case: **201700690, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her by Southern General Hospital and Victoria Infirmary in relation to a diagnosis of follicular lymphoma (a type of blood cancer). Ms C had two appointments with extended scope physiotherapy practitioners (ESPs) within the orthopaedics department regarding pain in her shoulder which later developed a lump. She complained that the ESPs did not carry out reasonable assessments which resulted in a delay in her being diagnosed with lymphoma. Ms C also complained that after her diagnosis of lymphoma, there was a failure on the part of the haematologists (doctors who specialise in medicine of the blood) to investigate her reports of back pain appropriately, and that this turned out to be due to another lymphoma mass pressing on her spine. Finally, Ms C complained that the board failed to communicate reasonably with her regarding her condition.

We took independent advice from an ESP and from a consultant haematologist. We found that the ESPs failed to take a full history and assess for 'red flag' symptoms (symptoms which may be indicative of a serious illness such as cancer) when seeing Ms C. We also found that when Ms C was unable to tolerate a scan which had been arranged, no further attempts were made by the ESP to investigate the lump on Ms C's shoulder. We found that this resulted in a delay of around four months in Ms C being diagnosed with follicular lymphoma and we upheld this aspect of Ms C's complaint.

We found that the assessments and examinations by haematologists when Ms C was reporting back pain after her diagnosis of lymphoma were reasonable. However, there was a failure to make suitable arrangements to enable her to undergo a scan and this resulted in a delay in identifying the lymphoma masses pressing on Ms C's spine. Therefore, we considered that the care and treatment Ms C received following her diagnosis of lymphoma was unreasonable. We upheld this aspect of Ms C's complaint.

In relation to the boards communication with Ms C, we found that the clinic letters regarding her treatment were only sent to her GP. We considered that it would have been beneficial for these letters to be sent to Ms C as well in order for her to have a better understanding of her care and treatment. We also noted that it would have been beneficial for Ms C to have an identifiable key worker who could act as her first point of contact. Therefore, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for unreasonably delaying in diagnosing her with follicular lymphoma; failing to provide her with reasonable care and treatment after she was diagnosed with lymphoma; and failing to communicate reasonably with her regarding her condition. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- A full history, including assessment of red flag symptoms, should be taken by ESPs; and painful lumps or swellings should be scanned.
- When a patient is unable to, or finds it difficult to tolerate scanning, discussion should take place between departments and with the patient in order to make suitable arrangements for them to undergo necessary scanning.
- Haematology patients should be copied into clinic letters to their GPs.
- Haematology patients should have an identifiable key worker (either a named consultant or clinical nurse specialist) who serves as their first point of contact.

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.