SPSO decision report

Case: **201704119, Fife NHS Board**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A) by the urology service (the service which deals with the male and female urinary-tract system and the male reproductive organs) at Victoria Hospital. Mr A had a diagnosis of metastatic prostate cancer (prostate cancer that had spread to his bones) and had been reviewed roughly every three months by prostate cancer nurse specialists. Mr A received hormone therapy injections and his PSA (prostate specific antigen - a protein produced by normal cells in the prostate and also by prostate cancer cells) levels were measured to monitor his disease.

Over two years following his diagnosis, Mr A experienced back pain and he had a number of consultations with his GP. After Mr A's condition did not improve, the GP made a referral to the urology service to request urgent investigation. The urology service received the referral one day later and then made a referral to the radiology department to request a scan. A week passed following the initial GP referral, and by this time Mr A was struggling to move. Mr A was then admitted to hospital and a scan was performed. This indicated that he had a spinal fracture and cord compression from metastatic cancer. As a result of his condition, Mr A became paralysed below the waist.

Mrs C complained that the urology service did not carry out scans following Mr A's diagnosis, even though it was known that the cancer had already spread to his bones. We took independent advice from a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) and a consultant oncologist (a doctor who specialises in cancer). We found that it was reasonable for the board to monitor Mr A's prostate cancer using PSA testing and not with routine scans. We did not uphold this complaint. However, we noted that the board had failed to respond to this part of Mrs C's complaint and had not handled a request for a meeting about this appropriately.

Mrs C also complained that there was an unreasonable delay in arranging a scan when Mr A's condition began to deteriorate. The board acknowledged that there were issues with how the urology service made the referral for a scan and also how it was handled by the radiology department. The board provided us with details of a process improvement that aimed to help avoid delays in future. However, we found that the referral from the urology service was made using the incorrect pathway. We concluded that the Malignant Spinal Cord Compression Pathway should have been used, which would have resulted in a scan within 24 hours of the referral. We concluded that if this had happened, Mr A would have had an improved chance of receiving treatment to maintain mobility. We informed the board of this finding and asked them to consider what action would effectively reduce the chance of the issue reoccurring. We upheld this complaint and made a recommendation. We also asked for evidence of the actions the board had already said they were taking or planned to take.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the delay in arranging a scan when Mr A's condition deteriorated; not fully

responding to all the points Mrs C raised in her complaint; and not responding to Mrs C's request for a meeting appropriately.The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.