SPSO decision report

Case: **201900435, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) by the board in relation to the diagnosis, treatment, and management of A's cancer, especially regarding a delay in A receiving a Positron Emission Tomography scan (PET, a scan that produces detailed 3D images of the inside of the body). We took independent advice from a consultant gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the stomach and intestines). We found that A's cancer pathway took 17 months, which was significantly longer than it should have taken. We found that the most significant issue for the delay in the process was the error which resulted in the PET scan not being booked, as requested by the multi-disciplinary team (MDT). Additionally, the PET scan should have been requested on a suspected cancer pathway and we were critical that this was not the case.

We found that the delay in A's diagnosis was unreasonable and on balance, due to the increase in size of A's tumour during the delay, it is likely this negatively impacted on their outcome. We considered that the care and treatment A received from the board was unreasonable and upheld this aspect of C's complaint.

C also complained about the out-of-hours service (OOHS). A developed a postoperative wound infection, and was admitted to hospital. C complained that the OOHS, who saw A prior to admission, requested a non-life-threatening response from the Scottish Ambulance Service (SAS), rather than a life-threatening ambulance. We took independent advice from a GP. We found that the OOHS GP requested the ambulance in line with the SAS guidance, and any delays in the ambulance attending were outwith the GP's control. Therefore, we did not uphold this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with reasonable care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- MDT requests for investigations, booking of investigations, results being shared, and follow-up MDT discussions should be actioned as soon as possible in cancer pathways.
- Patients and their family should be appropriately involved in discussions regarding their condition and management and these discussions should be recorded in the patient's notes.
- Requests from MDTs should be emailed directly to the clinicians to be actioned, rather than being sent to the gastrointestinal secretaries to be passed to the consultants.
- Where cancer is being considered as a strong possibility within the differential diagnosis, a PET scan should be requested on a suspected cancer pathway.

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.