SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201601493, A Medical Practice in the Forth Valley NHS Board area
Sector: Health
Subject: GP & GP Practices / Clinical treatment / Diagnosis

Summary
Mrs C complained that the practice failed to take appropriate action when her late father (Mr A) presented to them reporting symptoms of back pain. Mr A was 81 years old at the time and Mrs C considered that the GPs failed to recognise potential underlying symptoms and arrange appropriate investigations. Mr C was initially given pain medication and told to return if his symptoms did not improve. When his symptoms had not improved by the following month, a referral was made to urology for further investigation. Shortly after this, Mrs C removed Mr A from the practice and took him to live with her. He was subsequently diagnosed with terminal cancer.

We took independent GP advice, which noted that the GP elected to refer Mr A to urology due to his history of raised prostate-specific antigen (PSA). This is a protein produced by cells of the prostate gland, levels of which can indicate prostate cancer or other problems with the prostate. Mr A had been diagnosed two years previously with benign prostatic hyperplasia (BPH) - an enlarged prostate gland - and he was prescribed medication for this. Mr A's PSA had last been checked around this time and we were advised that this should have been followed up by the practice with an urgent urology referral, rectal examination, and repeat blood tests.

The next clinical prompt for checking Mr A's PSA was when he presented with back pain but this was not done. We were advised that new onset back pain in a man of Mr A's age should have been a red flag sign and should have prompted further investigations and/or specialist referral. The practice acknowledged that further investigations should have been carried out, including a check of Mr A's PSA. We were also advised that Mr A's PSA should have been re-checked at the time of referring him to urology and, again, the practice acknowledged that this should have happened. It was also noted that the referral was sent on a routine basis, when we were advised it should have been given an urgent priority.

We found nothing to link the identified failings to Mr A's death. His death certificate recorded gastric cancer and no prostate cancer diagnosis was evident. However, we were advised that the actions taken by the GPs were unreasonable irrespective of the cause of death. We found it particularly concerning that their knowledge of Mr A's history of raised PSA, and lack of follow-up in this regard, did not appear to have prompted a higher degree of suspicion when he presented with new onset back pain. In the circumstances, we upheld the complaint. While we were satisfied that the practice had ultimately demonstrated adequate reflection, we considered that there were earlier opportunities for them to have recognised the noted failings. In particular, they carried out a significant event analysis which did not identify any shortcomings in the care provided.

Redress and Recommendations

The Ombudsman recommends that the practice:	*Completion date*
(i) apologise to Mrs C for the failings this investigation has identified; and	18 August 2017
(ii) ensure that the Practice team involved in carrying out significant event analyses have familiarised themselves with the relevant NHS Education for Scotland guidance and report back to the Ombudsman when this has been done.	18 August 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify

individuals, so in the report the complainant is referred to as Mrs C and the aggrieved as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to my office about the care and treatment provided to her late father Mr A by his medical practice in the Forth Valley NHS Board area (the Practice). Mr A, who was 81 years old, reported symptoms of back pain to the Practice, which Mrs C did not consider were appropriately investigated. In particular, she raised concerns that the GPs failed to recognise potential underlying symptoms and arrange an appropriate referral. Mrs C later took Mr A directly to hospital for tests, which diagnosed terminal cancer. The complaint from Mrs C I have investigated is that the GPs at the Practice failed to provide Mr A with appropriate treatment for his reported symptoms (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer reviewed the documentation provided by both Mrs C and the Practice. They also obtained independent clinical advice from two GPs (Adviser 1 and Adviser 2). Consideration was given to the outcomes Mrs C indicated she was seeking from her complaint, namely that she wanted to receive an apology from the Practice for any identified failings and wished for procedures to be amended to avoid a similar future occurrence.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Practice were given an opportunity to comment on a draft of this report. The Practice subsequently provided further evidence, some of which was previously available, and I am critical that this was not shared with me earlier.

Background

4. Mr A presented to the Practice reporting that he had been suffering from lower back pain for several weeks. He was seen by one of the GPs (Doctor 1) who prescribed a topical pain-relieving gel and regular paracetamol, with advice to return in four to six weeks if things were not improving, or earlier if his pain got worse.

5. Mr A returned to the Practice less than two weeks later, reporting that his back pain was worse and was affecting his sleep. He said that paracetamol was having no effect, and the pain was radiating into his left thigh. He was seen on this occasion by another GP (Doctor 2), who prescribed co-codamol, along with a laxative due to co-codamol's constipating effect.

6. Doctor 1 then called Mr A later that week to enquire if there was any improvement. Mr A reported that the co-codamol was helping to control his pain and Doctor 1 advised him to reduce it and to also cut back on the laxatives.

7. Mr A presented to the Practice again a week later and was seen by a different GP (Doctor 3), who made a routine referral to a urologist. A referral was also made to physiotherapy for Mr A's back pain and he was prescribed further pain medication (codeine phosphate).

8. The following week, Mr A had a telephone consultation with a trainee doctor at the Practice (Doctor 4) and his pain medication was discussed. He was then reviewed by Doctor 4 a week later when he reported chest pain, which Doctor 4 thought may have been related to Mr A's history of chronic obstructive pulmonary disease (COPD) and he was encouraged to increase his inhalers. This was the last time Mr A was seen by the Practice as he subsequently moved away to live with Mrs C.

9. Three weeks after Mr A's consultation with Doctor 4, Mrs C took him to see an osteopath, who advised that Mr A be taken to hospital urgently for tests and scans. Upon doing so, the results revealed that Mr A had cancer which had metastasised (spread). Sadly, he passed away around three months later.

Complaint: The GPs at the Practice failed to provide Mr A with appropriate treatment for his reported symptoms

Mrs C's complaint to the Practice

10. Mrs C stated in her complaint that, when Mr A first presented to the Practice with his back pain, Doctor 1 did not seem to appreciate the pain and discomfort he was experiencing. She noted that Mr A returned to the Practice several times with the same complaint but was refused referral to a specialist on the basis that this was deemed unnecessary. She said at no time was it felt that there may have been an underlying cause for Mr A's pain which might have merited further investigation.

11. Mrs C noted that she was compelled to intervene and Mr A requested that Doctor 3 call her during their consultation. Mrs C said she raised the question with Doctor 3 of a specialist referral, possibly to a neurologist and at the very least a scan. She noted that Doctor 3 suggested that a urology referral might be more appropriate. Mrs C said she asked for this referral to be made without further delay but she noted that it was not sent as an urgent referral despite

Mr A's obvious pain and general decline. Mrs C noted that she also asked Doctor 3 why physiotherapy had not been considered and said it was agreed that this would also be arranged.

12. Mrs C advised that, as Mr A later started struggling to cope on his own, she arranged for him to come and stay with her. She said she later spoke to Doctor 1 about a test that the hospital had indicated should have been carried out by the Practice, which she suspected was a PSA (prostate-specific antigen) test. She said Doctor 1 did not seem to have any awareness of this.

13. Mrs C confirmed that she then took Mr A to an Accident & Emergency department for tests, based on the concerns of the osteopath they had consulted with. She noted that the results of the tests came as a shock and Mr A died 12 weeks later. Mrs C said she was extremely concerned and very angry that the Practice did not at any point consider that Mr A may have had a serious illness that would have benefited from further investigation, when it was clear he was in persistent and excruciating pain.

14. Mrs C considered that Mr A's life may have been extended had he not been denied a referral that could have detected the underlying cause and resulted in him receiving appropriate treatment. She expressed surprise that a non-medically qualified practitioner (the osteopath) was able to immediately assess that there may have been an underlying problem and direct them to hospital. Mrs C considered that this raised concerns about the knowledge and diagnostic skills of those involved in Mr A's care.

The Practice's response to Mrs C

15. The Practice said that, whilst Mr A was seen on several occasions for his lower back pain, there were no areas highlighted which would have led them to believe there was a significant problem. They further stated that the standard guidelines for lower back pain had been followed, and that Mr A's pain was gradually managed by increasing pain relief medication, along with laxatives to prevent constipation. They noted that Mr A subsequently informed Doctor 1 that his symptoms had more or less resolved with co-codamol, and it was planned to reduce this pain medication due to its constipating effect.

16. The Practice noted that Mr A was referred to a urologist following his consultation with Doctor 3, as he was found to have a rising PSA level. They noted that he was also referred for physiotherapy at that time as the next step in

managing his back pain. They observed that it was a period of four weeks from Mr A's initial presentation to his last consultation.

17. The Practice said that staff knew Mr A well and that, in particular, he had a good relationship with the practice nurse. However, they said that despite Mr A having seen the practice nurse regularly for blood tests, they did not raise any concerns about him having any worsening symptoms. The Practice said that this was a very unfortunate case and that they were sorry they had been unable to diagnose Mr A's condition earlier, but that there was nothing in the short time they assessed him that would have led them to consider a more significant diagnosis.

18. The Practice noted that Mr A was seen regularly throughout the time period described but there was no indication of more severe illness which would have pointed them in the direction of an urgent referral. They said Mr A's treatment was escalated in accordance with his presentation of symptoms and they considered this appropriate within the timescale that they saw him.

Mrs C's complaint to the SPSO

19. Mrs C complained to my office that the Practice incorrectly diagnosed the cause of Mr A's back pain and provided him with inappropriate treatment, ignoring important signs and symptoms as his condition deteriorated. She said that the Practice repeatedly refused to make appropriate referrals to specialists for further investigations, and unreasonably delayed in arranging physiotherapy for Mr A.

20. Mrs C said the reasons given by the Practice for not referring Mr A were that back pain is very common in the elderly; he was not losing weight; he did not present with any red flag symptoms; and as he had at one stage informed Doctor 1 that his pain was a bit better. However, Mrs C noted that Mr A had returned to the Practice the following week (after indicating to Doctor 1 that his pain was a bit better) with still worsening symptoms. She said that this was when a referral was made.

21. Mrs C noted that the referral was made reluctantly by Doctor 3, upon her insistence, and that it was felt a urology referral was more appropriate than neurology. She noted that this referral did not appear to have been actioned until almost three weeks after the consultation with Doctor 3, and was only made as a routine referral, meaning Mr A had to wait for a further six weeks.

Mrs C complained that there was no attempt to properly investigate the cause of Mr A's pain.

The SPSO's enquiries

22. In writing to my office, the Practice noted that Mr A presented initially with lower lumbar back pain and was treated and referred for this within 22 days. They did not consider that there were any obvious red flag symptoms when he initially presented to Doctor 1. They noted that his pain was radiating into his left thigh when he subsequently saw Doctor 2 but that it was not affecting either his bladder or bowels, and it was considered consistent with musculoskeletal or disc type pain.

23. The Practice noted that Mr A's consultation with Doctor 3 the following week lasted for 36 minutes and resulted in a routine urology referral. They said Doctor 3 felt the referral priority was appropriate and reflected Mr A's wishes. In addition, they noted that the physiotherapy referral made by Doctor 3 was in line with the NHS Forth Valley policy for back pain referral, explaining that this referral was prioritised as Mr A's symptoms were felt to be musculoskeletal in nature. They advised that there is no back pain specialist in Forth Valley so the policy is to refer to physiotherapy in the first instance. They noted that this referral pathway was explained to Mrs C on the telephone.

24. The Practice considered that Mr A's symptoms of lower back pain seemed adequately treated at the point he was reviewed by Doctor 4, noting that he awaited appointments for physiotherapy and urology. They said they were not aware at that time that Mr A had cancelled his physiotherapy appointment, scheduled for two days prior to his consultation with Doctor 4. They noted that Mr A then left the Practice and his notes were recalled three weeks later. The Practice said they felt they provided the correct care and treatment from Mr A's initial presentation with back pain until he was last seen 35 days later.

25. It was noted by the Practice that Mr A had been seen on seven separate occasions by the practice nurse in the first half of that calendar year, including a full chronic disease review 12 weeks prior to his initial presentation with back pain. They also noted that he had six face-to-face GP consultations and seven telephone consultations over this same time period, with a further eight calls made by the Practice team regarding his blood test results and warfarin dosage.

26. The Practice said an x-ray referral would not have been considered routine management without a trial of adequate analgesia (pain relief) and review if this failed to manage Mr A's symptoms. They noted that they have good access for follow-up of patients, both routine and emergency, and they said this treatment would be consistent with the management carried out in other practices locally. They advised that, at the time of Mr A's presentation, Forth Valley NHS Board had a policy in place that lumbar x-rays were not routinely accessible to GPs. They said that, even if the GPs at the Practice had felt that an x-ray might have been useful, this was only available on consultant request and referral to secondary care.

27. The Practice maintained that, during what was a very short period of time from first presentation, they followed the correct treatment and referral pathway for back pain given the history and presentation. They noted that they have an easy access system offering their patients a variety of appointments, including urgent on the day slots and routine appointments within two working days. They observed that Mr A was always accommodated without delay for any appointment request.

28. The Practice concluded that Mr A was appropriately managed with his presentation of lower back symptoms, noting that he also presented with prostatic symptoms, chest pain symptoms and COPD symptoms which were being investigated. They reiterated that referrals to urology, physiotherapy and for COPD review were made but Mr A chose to delay the initial appointment. They considered it unfortunate that they were unable to follow up the new symptoms of chest pain or the referrals that had been made, due to Mr A moving away and transferring to another practice. In commenting on a draft of this report, the Practice emphasised that it was not new prostatic symptoms that Mr A presented with.

29. The Practice informed my office that they have undertaken a review of the management of Mr A, and events surrounding Mrs C's complaint. They said they identified the following learning points:

- encouraging patients to see the same doctor for the duration of a new problem to allow improved continuity of care;
- creating more time for patients with language difficulties and the use of speech aids to enable improved communication; and
- review and consolidation of pathways, access to diagnostic tools and referral for patients with back pain in the older age group.

In commenting on a draft of this report, the Practice noted that in addition to the steps outlined above, they conducted a significant event analysis (SEA) following Mrs C's initial complaint. This had not previously been shared with me. When subsequently sharing a copy of this, the Practice also shared evidence of their further reflection on Mr A's care, including a review of the SEA (which they carried out following receipt of the draft report) and a certificate of recent attendance at a back pain management course.

Medical advice

30. Adviser 1 reviewed Mr A's records and observed his background of a raised PSA and prostatic symptoms. They noted that the raised PSA test was recorded two years previously and advised that, in line with the Scottish Referral Guidelines for Suspected Cancer, in relation to prostatic symptoms, a referral should have been sent to a urologist at that time for further investigation. The guidelines at that time indicated that a PSA above 5.3 nanograms per millilitre (ng/ml) was abnormal for a man of Mr A's age. They also noted that early prostate tumours, which are potentially curable, have a PSA of less than 10 ng/ml. Mr A's was 8.4ng/ml, thus Adviser 1 said an urgent referral was supported.

31. Adviser 1 noted that the Practice failed to refer Mr A at that time and also failed to follow-up on this abnormal result by re-checking his blood test. Adviser 1 also noted that there was no evidence that a rectal examination was carried out when Mr A returned the following week, despite Doctor 1 having recorded that this was the plan when they saw him four weeks earlier. They said that Mr A should have had a rectal examination performed to assess his prostate for enlargement or suspicious signs.

32. In commenting on a draft of this report, the Practice expressed concern that they had not previously been invited to comment on this earlier period of care. They noted that Mr A's PSA had actually fallen to 8.4 after treatment, having been 12.7 six months earlier. They also noted that two years before this it had risen to 6 and Mr A had refused treatment at that time, following a rectal examination which suggested benign prostatic hyperplasia (BPH – an enlarged prostate gland). They said follow-up review was recommended if Mr A's symptoms deteriorated. They advised that, although it remained outwith the normal range at 8.4, it was agreed they would monitor Mr A and refer him if there was no continuing improvement. They noted that Mr A did not return for

review but continued his treatment, and that no further complaints of his symptoms were recorded. They said it was clearly recorded that Mr A had been diagnosed with BPH and fully understood the diagnosis, and that he was taking treatment for this condition in the form of tamsulosin hydrochloride.

33. The Practice's review of their SEA acknowledged that they did not pick up on Mr A's failure to return for review of his PSA (further to it having fallen to 8.4), despite him having other regular blood tests for his other chronic diseases. They noted that they had no register for BPH patients or regular planned recall in place and they planned to introduce a BPH register and recall system. They provided evidence that this had since been implemented.

34. Adviser 1 confirmed that the reason for them having referred to this earlier period of care was due to the Practice themselves having specifically mentioned the raised PSA of 8.4 when they referred Mr A to urology following his presentation with back pain. Adviser 1 confirmed that their review of this case did not include consideration of Mr A's earlier PSA results or the actions taken by the Practice in this regard. Adviser 2 was, therefore, asked to review the records and provide comment from the start of Mr A's prostate issues.

35. Adviser 2 noted that when Mr A's PSA was first found to have risen to 6, he had presented with symptoms suggestive of simple age related enlargement of his prostate. They noted that a thorough assessment was carried out, including a digital rectal examination, and a benign (not cancerous) feeling prostate was noted. Although just outside the normal reference range for a man of Mr A's age, Adviser 2 considered that this would be acceptable in the context of a prostate examination that supported BPH only. They noted that options were discussed with Mr A at that point and he did not want any treatment. Adviser 2 was not critical of the actions taken at this time, and their only suggestion was that the Practice may have arranged a follow-up PSA test in six months rather than relying on symptoms alone to trigger a review.

36. Adviser 2 noted that there was no further review of Mr A's prostate or PSA until two years later. Mr A saw the practice nurse for his six monthly blood pressure review and, as he mentioned his ongoing urinary symptoms, a PSA test was added to the other blood tests being taken that day. This PSA came back at 12.7. Adviser 2 said there was no recognition of this raised result in the notes, or action to be taken, until Mr A returned to see Doctor 1 the following month, with ongoing symptoms of BPH. Doctor 1 started Mr A on tamsulosin

hydrochloride medication, which Adviser 2 considered was a reasonable thing to do. However, it was noted that Doctor 1 elected to wait for three months prior to re-testing Mr A's PSA. Adviser 2 explained that tamsulosin hydrochloride acts to relax the blood vessels and smooth muscle in the prostate but has no impact on the PSA. They said they were, therefore, unclear as to Doctor 1's clinical reasoning for not examining Mr A's prostate at that time (two years since he had last been examined) and why they waited three months to have the PSA repeated.

37. While Doctor 1 had noted that the PSA was raised, Adviser 2 noted that it had in fact doubled since the last review. While Adviser 2 said this increase could be attributed to BPH, they observed that Mr A was symptomatic and the PSA level was now more than double the upper level of the reference range for his age. Adviser 2, therefore, considered that most reasonable GPs would have examined Mr A's prostate at this appointment and arranged an urgent urology referral to look at the possibility of him having developed prostate cancer. They said this would have been in keeping with the advice available to the Practice at the time from the Scottish Referral Guidelines for Suspected Cancer.

38. Adviser 2 noted that, as Mr A's PSA had dropped to 8.4 when Doctor 1 next reviewed it, they planned to make a urology referral only if it was raised when repeated in six months' time. However, as Mr A did not return for review six months later, Adviser 2 confirmed that the next clinical prompt to look at this was two years later when Mr A presented to Doctor 1 with low back pain.

39. Adviser 1 reviewed the management of Mr A's back pain and noted that he was 81 years old at the time of his initial presentation. They advised that, in line with the Scottish guideline on 'Low Back Pain With or Without Sciatica: Referral and Management Pathways', presentation aged over 55 with first time onset of back pain is a red flag sign, necessitating further investigations and/or referral. They noted that the Practice failed to recognise this red flag symptom. They also noted that the Practice failed to re-check the PSA test when they referred Mr A to urology. Adviser 1 said that, despite knowledge of the previous raised PSA result and its lack of follow up, the Practice failed to arrange an urgent referral at this stage, instead sending the referral as routine. In commenting on the draft report, the Practice accepted that it would have been normal practice to check the PSA prior to making the urology referral.

40. Adviser 1 concluded that the care provided to Mr A, both in relation to the management of his back pain and the management of his abnormal prostate hormone, fell below a reasonable standard. They explained that the reason for linking the two events is that prostatic cancer is known to commonly spread to the bones and can present as back pain. They considered that the evidence suggested a lack of knowledge of commonly used national guidelines that they would expect a reasonable GP to be aware of, relating to the management of both acute back pain presenting in an elderly patient and also the management of a raised PSA arising in an elderly patient.

41. Adviser 1 did not initially consider that the Practice had demonstrated sufficient reflection and learning from this case to address the identified failures and ensure the sequence of events could not recur. However, in responding to this report in draft, the Practice provided further evidence of reflection on their part, including the SEA and a later review of the SEA. Adviser 1 noted that the initial SEA did not appear to recognise any failures to follow guidelines, however, they noted that the review of the SEA (carried out following receipt of the draft report) acknowledged a failure to check bloods, including PSA. They also noted that additional training on acute back pain had been undertaken and a prostatic hormone register had been set up. Adviser 1, therefore, considered that sufficient reflection had been demonstrated.

42. Adviser 2 similarly noted that the SEA was flawed in that it did not recognise the main areas of concern. They also noted that the subsequent SEA review did recognise the failing of not investigating the back pain by arranging blood tests, but observed that this was not followed up with recommendations. In addition, Adviser 2 noted that the author's assessment of the facts did not appear to correlate with the contemporaneous notes, and that the review failed to focus on the key issue of a lack of a sufficiently high index of suspicion and flawed interpretation of guidance around red flags. They, therefore, considered that the review was incomplete and learning was minimised. However, like Adviser 1, they were encouraged to note the attendance at a back pain course, noting that this recognised the need to update the knowledge base around this issue. Overall, Adviser 2 was also reassured that the Practice had reflected on their actions and recognised that things should have been done differently. They noted, however, that the Practice may benefit from reviewing NHS Education for Scotland's guidance on conducting SEAs.

Decision

43. The basis I make my decisions on is 'reasonableness'. I look at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

44. The advice I have received is that on presenting with lower back pain, given that this was a new onset at the age of 81 and had already been present for a few weeks, the Practice should have recognised this as a red flag sign and arranged urgent further investigations and/or onward referral to a specialist, in line with the relevant national guidelines. Adviser 1 was clear that the failure to do this represented an unreasonable standard of care. The Practice have acknowledged that further investigations should have been carried out, including a PSA check.

45. The Practice were aware that Mr A's PSA was previously raised and had not been followed up. Both advisers were critical that Mr A's raised PSA level two years earlier was not appropriately followed up at the time with an urgent urology referral, rectal examination, or repeat blood tests. In addition, the urology referral eventually made subsequent to Mr A's presentation with back pain was sent as routine, when I am advised that this should have been an urgent referral. The Practice have recognised the failure to follow-up and re-check Mr A's PSA and have introduced a BPH register and recall system to ensure that the onus is not on patients to re-attend for review. They have also acknowledged that the PSA should have been re-checked when the urology referral was eventually made.

46. In commenting on a draft of this report, the Practice have expressed concern that it gives the reader the impression that Mr A died as a result of prostate cancer. They noted that the death certificate recorded metastatic gastric cancer. I should emphasise that I saw no evidence to demonstrate that Mr A had metastatic prostate cancer and I found nothing to link the identified failings to his death. My investigation focussed, without the benefit of hindsight, on the reasonableness of the doctors' actions when Mr A presented to them, referencing these actions against national guidelines. The medical advice I have received is that the actions taken were unreasonable irrespective of the cause of death. Of particular concern is that the Practice's knowledge of Mr A's history of raised PSA, and lack of follow-up in this regard, does not appear to have prompted a higher degree of suspicion when Mr A presented with new

onset back pain that had persisted for several weeks. In the circumstances, I uphold this complaint.

47. While I am reassured that the Practice have now adequately reflected on the identified failings, I am critical that the SEA did not pick these up initially. I am also critical that the SEA was not shared with me earlier. Further, when the SEA was subsequently reviewed and failings acknowledged, this was not accompanied by recommendations for improvement. I, therefore, have the following recommendations to make.

Recommendations

48. I recommend that the Practice:	*Completion date*
(i) apologise to Mrs C for the failings this investigation has identified; and	18 August 2017
(ii) ensure that the Practice team involved in carrying out significant event analyses have familiarised themselves with the relevant NHS Education for Scotland guidance and report back to the Ombudsman when this has been done.	18 August 2017

49. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Practice are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved
the Practice	a medical practice in the Forth Valley NHS Board area
Adviser 1	a GP adviser to the Ombudsman
Adviser 2	a GP adviser to the Ombudsman
Doctor 1	a GP partner at the Practice
Doctor 2	a GP partner at the Practice
Doctor 3	a locum GP at the Practice
PSA	prostate-specific antigen
Doctor 4	a trainee GP at the Practice
COPD	chronic obstructive pulmonary disease
SEA	significant event analysis
ng/ml	nanograms per millilitre
BPH	benign prostatic hyperplasia

Annex 2

Glossary of terms

chronic obstructive pulmonary disease (COPD)	a condition that inflames the lungs and restricts airflow
prostate-specific antigen (PSA)	a protein produced by cells of the prostate gland, levels of which can indicate prostate cancer or other problems with the prostate
benign prostatic hyperplasia (BPH)	an enlarged prostate gland
prostatic	relating to the prostate gland
tamsulosin hydrochloride	a medication used to treat the symtoms of BPH

Annex 3

List of legislation and policies considered

Low Back Pain With or Without Sciatica Referral and Management Pathway, Scottish Government Task and Finish Group 2011

Scottish Referral Guidelines for Suspected Cancer, Scottish Government Health Department, February 2007 (as amended)

Significant Event Analysis Guidance for Primary Care Teams, NHS Education for Scotland 2011