SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Glasgow

Case ref: 201605095, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C complained about the care and treatment provided to his late wife (Mrs A). Mrs A was diagnosed with bladder cancer in April 2015 and Mr C complained that both before and after the diagnosis there were delays in providing necessary appointments. Mr C also complained that there were unreasonable delays in the treatment of Mrs A's cancer after she had cardiac surgery, and that there were failings in communication between specialists treating her.

We took advice from a consultant urologist. With regards to delays in appointments, we found that there was an unreasonable delay between the results of a biopsy being taken and a subsequent resection. We also found that there was an unreasonable delay from the time of diagnosis to the time that Mrs A discussed definitive management with a surgeon. We considered these delays to be unreasonable. We upheld this aspect of Mr C's complaint.

We also found that there was a delay in Mrs A being provided with treatment for her bladder cancer. We identified a failure of the urology service to act upon a letter which stated that Mrs A would be suitable to go ahead with treatment for her bladder cancer in a months' time. We further found that the possibility of Mrs A's condition deteriorating, and her treatment options, were not fully discussed with her, and that there was a delay in Mrs A being offered palliative radiotherapy. We determined that there were multiple failings in communication between specialists treating Mrs A regarding her condition and treatment.

Mr C also complained about the board's handling of his complaint, specifically that they did not address all of the issues which he had raised. We considered that the board had failed to address some important questions Mr C had asked, and therefore we upheld this aspect of Mr C's complaint.

Redress and Recommendations
The Ombudsman's recommendations are set out below:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and deadline
(a), (b) and (c)	• There were unreasonable delays in Mrs A being provided with the relevant appointments following her diagnosis of bladder cancer; • There were unreasonable delays in the treatment of Mrs A's cancer; • There were unreasonable failings in communication between the specialists treating Mrs A regarding her condition and treatment; and • The Board's handling of Mr C's complaint was unreasonable	Provide a written apology to Mr C for the failings identified	Copy of apology letter which meets with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance By: 27 September 2017

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There was a delay between the results of the biopsy being reported on 10 February 2015 and Mrs A having a resection on 22 April 2015	In similar cases patients should receive treatment within 31 days from decision to treat to first treatment, as per the Scottish Government targets	Documentary evidence of a review of urology treatment waiting times for patients with cancer and the steps being taken to better meet National guidelines By: 22 November 2017
(a)	There was a period of approximately two and a half months from the time Mrs A was diagnosed with muscle invasive bladder cancer to the time she saw a surgeon to discuss definitive management	In similar cases, timescales between histology reporting and out-patient appointments in the urology service should be shorter	Documentary evidence of a review of the timescales between histology reporting and out-patient appointments in the urology service and details of steps being taken to shorten timescales By: 22 November 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	The urology service failed to act on the letter of 3 November 2015 stating that Mrs A could go ahead with surgery for her bladder cancer in a month's time	Letters between services should be shared at the appropriate time and acted upon where necessary	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 25 October 2017
(b)	Mrs A was not offered palliative radiotherapy at an earlier point	Palliative radiotherapy should be considered and offered as early as possible to reduce patients' pain	Documentary evidence of the learning from this case and any subsequent changes to procedures, instructions and training provided to clinical staff By: 25 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	When Mrs A suffered the MI, her options should have been discussed more thoroughly with her and the possibility of disease progression whilst she was undergoing cardiac surgery and recovery should have been made clear	The Board should demonstrate that staff are aware of the need to ensure patients are made fully aware of the possibility of disease progression if treatment for other health issues is required; and of their options for treatment	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 25 October 2017
(c)	There were failings in communication between the oncology and urology teams with regard to Mrs A's condition and treatment	The Board should demonstrate that they have reflected and learned from this case to ensure that there is better communication and coordination between teams, including discussion at multi-disciplinary team meetings as appropriate, so that patients receive good and timely care	Documentary evidence that the relevant board staff have considered Ms A's case and how to ensure better communication and coordination of care between departments and hospitals. This could include evidence such as a minute of a staff meeting; an action plan, instructions to staff and/or a revised protocol By: 25 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(d)	The Board failed to address all of the issues that Mr C raised in his original complaint	The Board should ensure that complaint responses correctly identify and respond to all issues raised by complainants	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 27 September 2017

Evidence of action already taken

Greater Glasgow and Clyde NHS Board - Acute Services Division told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(b)	There were unreasonable delays in the treatment of Mrs A's cancer	Reviewed the pathway available to bladder cancer patients to improve the services available and the coordination of care	Copy of the bladder cancer pathway, highlighted to show the changes and/or additions By: 27 September 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 Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to the Ombudsman about the care and treatment provided to his late wife (Mrs A) by Greater Glasgow and Clyde NHS Board (the Board). The complaints from Mr C I have investigated are that:

(a) the Board unreasonably delayed in providing Mrs A with the relevant appointments following her diagnosis of bladder cancer (*upheld);*

(b) there were unreasonable delays in the treatment of Mrs A's cancer (*upheld*);

(c) there were unreasonable failings in communication between the specialists treating Mrs A regarding her condition and treatment (*upheld*); and

(d) the Board's handling of the complaint was unreasonable (*upheld*).

Investigation

2. My complaints reviewer considered all of the information provided by Mr C and the Board and sought independent clinical advice from a consultant urological surgeon (the Adviser). In this case, I have decided to issue a public report on Mr C's complaint because of the significant failings identified.

3. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, although I have not included every detail of the information considered, my complaints reviewer and I have reviewed all of the information provided during the course of the investigation. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

4. Following a GP referral, Mrs A underwent a flexible cystoscopy (a procedure used to examine the inside of the bladder) and biopsy (sampling of cells) on 5 February 2015. As a result of this, Mrs A was diagnosed with bladder cancer on 24 February 2015. She was listed for a resection (a procedure used to cut away a tumour for testing) which was carried out on 22 April 2015, after it had been rescheduled several times. Following these procedures, Mrs A was diagnosed with muscle invasive bladder cancer.

5. A scan of Mrs A's chest, abdomen and pelvis was carried out on 3 June 2015 and a multi-disciplinary team (MDT) meeting discussed her case on 11 June 2015. Mrs A had further out-patient reviews with urology and oncology on 11 and 18 June 2015. Mrs A decided that her preferred treatment

would be radical cystectomy (removal of the bladder and nearby lymph nodes). It was decided that the surgery would be arranged for mid-August 2015.

6. On 7 July 2015, Mrs A suffered a myocardial infarction (MI) (a heart attack). She had an appointment with a consultant urologist on 15 July 2015 and it was determined that the MI meant that the timing of any possible intervention for Mrs A's bladder cancer required to change.

7. Mrs A was then referred to another health Board for cardiac treatment. It was decided that she would have a coronary artery bypass graft (CABG), a procedure which diverts blood around narrowed or clogged parts of the arteries to improve blood flow and oxygen to the heart. The surgery was undertaken on 16 September 2015.

8. After undergoing the CABG, Mrs A was again referred by her GP on 30 October 2015 to the urology department at the Board, as she had been suffering from recurrent infections and haematuria (blood in the urine). The referral did not mention Mrs A's existing diagnosis of bladder cancer. Mrs A had an ultrasound carried out, the results of which were sent to her GP on 17 December 2015.

9. Mrs A had an out-patient cardiac review at the other Board on 3 November 2015 and, on the same day, a letter was sent to her GP and the urology service stating that she should be able to have surgery for her bladder cancer in around a month's time.

10. On 8 January 2016, Mr C's sister rang the Board's urology service on Mrs A's behalf, as she had not been seen by a urologist since before her cardiac surgery. As a result of this, Mrs A was given an appointment with a urology consultant on 14 January 2016. The consultant was concerned that the cancer may have progressed and requested a scan.

11. A scan was carried out on 5 February 2016 (almost a year since bladder cancer was diagnosed) and showed that the cancer had spread to Mrs A's lungs. An oncology MDT meeting discussed her case on 11 February 2016 and it was determined that she could not undergo a radical cystectomy anymore but that she should have radiotherapy and be referred to palliative care. Radiotherapy was arranged on 18 February 2016, and Mrs A was referred to

palliative care on 24 February 2016 by her GP. Very sadly, Mrs A passed away on 31 May 2016.

(a) The Board unreasonably delayed in providing Mrs A with the relevant appointments following her diagnosis of bladder cancer

Concerns raised by Mr C

12. Mr C explained that after Mrs A was diagnosed with bladder cancer on 24 February 2015, she was keen to move on to the resection of the tumour and further treatment. However, Mr C said that pre-assessment clinics were booked and cancelled by the Board without notice, and that this period of confusion and delay lasted for two months before Mrs A was given treatment on 22 April 2015. Mr C said there were further delays between appointments after this.

The Board's response

13. In response to Mr C's complaint, the Board explained that the reason for the rescheduling of Mrs A's appointments once she was diagnosed with bladder cancer was because the pre-operative assessment has to be carried out 14 days or fewer before any surgery taking place. They said that as Mrs A's pre-operative assessment had initially been booked before the surgery was booked, it later had to be rescheduled. The Board apologised for the confusion and inconvenience caused by the rescheduling of appointments.

14. In response to SPSO enquiries, the Board said that Mrs A was seen appropriately following diagnosis up until the point that she suffered an MI.

Medical advice

24 February to 22 April 2015

15. I first asked the Adviser whether they considered the Board's explanation for the delays in providing Mrs A with urology appointments after her diagnosis of bladder cancer on 24 February 2015 to be reasonable.

16. The Adviser noted that, following referral by Mrs A's GP, she had attended urology for a cystoscopy and biopsy in early February 2015 which had confirmed cancer. The results were conveyed to Mrs A at an out-patient appointment on 24 February 2015. The Adviser said that Mrs A was then listed for cystoscopy, biopsy and resection under general anaesthesia, but that this did not take place until 22 April 2015 which the Adviser said is a longer time scale than the 31 day target from decision to treat to first treatment as advised

by the Scottish Government. The resection was reported on 27 April and this confirmed that Mrs A had muscle invasive bladder cancer.

17. Although the Adviser had identified a delay, they did not think that the delay led to any worsening of Mrs A's condition. This was because she was still suitable for curative treatment at this point.

27 April to 15 July

18. I went on to ask the Adviser whether they considered there to have been any unreasonable delays in Mrs A receiving urology appointments, from the finding that she was suffering from muscle invasive bladder cancer on 27 April 2015 to her appointment on 15 July 2015 (when a definitive management plan was agreed). The Adviser said that the time between the finding of muscle invasive bladder cancer and the appointment to discuss cystectomy was long and that the delay was unreasonable.

19. The Adviser said that Mrs A underwent bladder resection on 22 April 2015 and this was reported on 27 April 2015, but that she was not seen in the clinic until 28 May 2015. The Adviser said that an urgent staging scan was then arranged and Mrs A was referred to an oncologist to discuss neo-adjuvant chemotherapy (administration of chemotherapy before the main treatment). The Adviser said that Mrs A was seen in the oncology clinic on 11 June 2015 and deemed unsuitable for neo-adjuvant chemotherapy and that radiotherapy was also discussed at this consultation.

20. The Adviser explained that Mrs A then returned to the urology clinic to discuss radical cystectomy on 18 June 2015 and, after deciding to proceed with surgery, was subsequently seen with regard to this on 15 July 2015 (when definitive management was agreed). The Adviser also said that there was, therefore, a period of approximately two and a half months from the time Mrs A was diagnosed with muscle invasive bladder cancer to the time she saw a surgeon to discuss definitive management.

21. The Adviser considered the process followed was reasonable with regard to the discussions about neo-adjuvant chemotherapy, radiotherapy, and surgery, but the cumulative delays of these appointments to be unreasonable given the high grade, high risk muscle invasive bladder cancer diagnosed. The Adviser noted, however, that, despite these delays, Mrs A was still suitable for curative treatment when her definitive management plan was agreed.

(a) Decision

22. The advice I have received is that, after Mrs A was diagnosed with bladder cancer, there was unreasonable delay before the resection of her bladder was carried out on 22 April 2015 and unreasonable delay before a definitive management plan was agreed on 15 July 2015. I accept this advice.

23. I note and accept the Adviser's comments that although the process followed with regard to discussions with different specialisms about various treatment options was reasonable, the timescales of these appointments resulted in unreasonable cumulative delays. I also note that the Adviser did not think that these delays had an effect on Mrs A's eventual outcome, as throughout this period there was no evidence to suggest that Mrs A would not be able to undergo curative treatment. However, I recognise that this was an extremely distressing time for Mr C and Mrs A and that the delays would have added to this distress.

24. Given the above, I uphold this complaint. My recommendations for action by the Board can be found at the end of this report.

(b) There were unreasonable delays in the treatment of Mrs A's cancer

Concerns raised by Mr C

25. Mr C said that when Mrs A had an MI on 7 July 2015, she was then told that the treatment for her heart condition would take priority over any cancer treatment. Mr C said that after she underwent CABG surgery on 16 September 2015, she asked at her cardiac out-patient appointment whether the urology team at the Board were aware that she had undergone the surgery. He said she was told that they had been informed. However, Mr C explained that Mrs A did not hear from urology or oncology during this period, until his sister rang the urology department in January 2016.

26. Mr C said that after this Mrs A was quickly given an appointment but that she was then told that she could no longer have a radical cystectomy and that she would be given palliative treatment only. Mr C said that Mrs A suffered extreme pain for some time and that, when she was eventually given palliative radiotherapy, she was told that she could have received it a lot earlier.

The Board's response

27. In response to Mr C's complaint, the Board explained that it was initially suggested to Mrs A that her planned bladder surgery could be undertaken four to six weeks after cardiac surgery. The Board said that this had been noted in the surgeon's out-patient letter on 13 August 2015. The urology service was unaware that the surgery had been completed, as Mrs A's discharge letter after the CABG was carried out in September 2015 was not copied to it. The Board said that as a result of Mr C's complaint this had been followed up with the other Board and they could confirm that for all future patients who are required to continue cancer treatment, the responsible consultant for the patient and the oncology team will now be copied into the discharge letter. The Board provided evidence of this.

28. They also said that senior medical management were reviewing the pathway available to bladder cancer patients, to improve the services available and the coordination of care.

29. The Board said that a further letter was sent from cardiology to Mrs A's GP and the urology service, which explained that Mrs A remained on medication called Ticagrelor (used to prevent blood clots). The Board said that this would have been unsafe for her to stop and, therefore, Mrs A was unable to undergo further surgery. The Board apologised for the additional distress caused by this.

30. The Board also explained that, in October 2015, Mrs A was referred to the urology service by her GP with concerns regarding haematuria, recurrent infection and possible narrowing of her urethra, which resulted in an ultrasound being arranged. The Board said that the results of the ultrasound were reported to Mrs A's GP, who wrote to the urology department to highlight the results of the scan. This communication was not then viewed by the urologist until January 2016, which was when Mr C's sister contacted the service and an appointment was confirmed.

31. In response to SPSO enquiries, the Board added that the service had employed a Bladder Cancer Nurse Specialist to improve the pathway for patients who have bladder cancer.

Medical advice

Decision to delay surgery for bladder cancer

32. I first asked the Adviser whether they considered it reasonable that, after Mrs A suffered an MI on 7 July 2015, the urology service said that it would not be possible to give her surgery for bladder cancer until she had cardiac treatment.

33. The Adviser said that given the risk of a further cardiac event, especially within six months of an MI, the urology service's view was reasonable. The Adviser explained that, from the evidence available, the rate for a second MI would be 33 percent if bladder surgery was performed within a month of the initial MI, but would drop steadily to six percent if bladder surgery was postponed for three or more months.

Urology follow-up

34. I then asked the Adviser whether they considered urology to have taken reasonable action on the basis of Mrs A's GP referral of 30 October 2015.

35. The Adviser explained that the GP referral letter contained no information with regard to Mrs A's history of bladder cancer and, therefore, the referral would have been triaged as routine and resulted in an out-patient appointment. The Adviser said that this was reasonable.

36. I asked the Adviser whether it was reasonable that no action was taken by urology as a result of the clinic letter from Mrs A's cardiac surgery review, dated 3 November 2015.

37. The Adviser explained that Mrs A had been seen by a cardiac surgeon for follow-up on 3 November 2015 and the clinic letter was copied to a consultant urologist and a consultant cardiologist. The Adviser noted that the clinic letter stated that Mrs A was 'keen to get on and have her bladder problem sorted' and that 'this can go ahead pretty well in a month's time if required.' The Adviser said that it was unreasonable that no action was taken by urology as a result of the letter, especially since Mrs A had not had any definitive treatment for her bladder cancer since diagnosis.

38. The Adviser went on to say that they would have expected the urology team to have acted upon the clinic letter and arranged to review Mrs A in clinic

urgently with regard to the ongoing management of her bladder cancer, especially given the time elapsed since the bladder cancer diagnosis.

39. In addition, the Adviser considered that there was an unreasonable delay between the cardiac surgery in September 2015 and Mrs A being seen by urology in January 2016. The Adviser noted that the cardiac surgeon stated that Mrs A could proceed with bladder surgery in a month from 3 November 2015 and, therefore, the earliest Mrs A could have undergone surgery would have been 3 December 2015.

40. The Adviser said that Mrs A was not reviewed in the clinic until 14 January 2016. When she was seen it was felt that her disease had progressed and a scan was requested. The Adviser said that, given the extent of the disease progression shown on the scan, even if Mrs A had been seen earlier by urology following her cardiac surgery, it is likely that the outcome would have been unchanged as the disease progression was likely to have already occurred by 3 December 2015 (the earliest surgery could have been carried out). The Adviser did say, however, that if Mrs A had been seen sooner she could have been offered palliative radiotherapy earlier, which would have helped with symptom control and pain management.

Oncology follow-up

41. In the Adviser's opinion, Mrs A should have been offered radiotherapy again after she suffered the MI in July 2015. Mrs A had initially decided against having radical radiotherapy to treat her bladder cancer, instead opting for radical surgery. The Adviser said that Mrs A was seen by urology on 15 July 2015, one week after she suffered the MI. At this point the urologist had indicated that the MI would change the timing of any possible surgical intervention. The urologist had suggested that Mrs A should consider alternative treatment options such as radiotherapy and the Adviser said that the clinic letter stating this was copied to oncology. Following this, there was no documentation to suggest that a further detailed discussion was held with Mrs A to discuss the implications of her recent MI and the potential risks of deferring treatment to allow recovery from the MI.

42. The Adviser said that it would have been good practice to re-discuss Mrs A's case at an MDT meeting, given the recent MI. It would also have been good practice to clearly explain and document the risk of progression of Mrs A's bladder cancer by not having immediate treatment. The Adviser said that Mrs A

should also have been referred back to oncology to re-discuss the option of radiotherapy.

Overall comments

43. Overall, the Adviser said that there had been a number of failings in this case which had led to Mrs A's bladder cancer ultimately progressing without treatment. The Adviser said that Mrs A subsequently underwent palliative radiotherapy once curative surgery was no longer possible. However, she should have been warned regarding the likelihood of the cancer progressing while she underwent cardiac surgery and rehabilitation. The Adviser said that she should have been offered radiotherapy again after she suffered an MI, although she may still have ultimately passed away from the cancer.

(b) Decision

44. I accept the advice that, when Mrs A suffered an MI, it was reasonable for the urology service to postpone surgery for her bladder cancer. I also accept the advice that when Mrs A's GP referred her to the urology service in October 2015, the referral was dealt with appropriately, given that it had not mentioned Mrs A's diagnosis of bladder cancer.

45. However, the Adviser said that, clearly, once the urology service had received the letter of 3 November 2015 stating that Mrs A could go ahead with surgery for her bladder cancer in a month's time, the urology service should have urgently arranged to review her. I accept that it was unreasonable for the urology service to have not acted on this letter.

46. The Adviser said that the earliest Mrs A could have had surgery for her bladder cancer was 3 December 2015 and that she was not seen until 14 January 2016. However, the Adviser said that the disease progression shown on the scan taken in January suggests that Mrs A would not have been able to undergo the surgery for bladder cancer even if she had been seen sooner after her cardiac surgery. I accept this advice but also note that the Adviser said that, had Mrs A been seen earlier, she could have been offered palliative radiotherapy at an earlier point.

47. Given the amount of pain Mr C has described Mrs A as having been in, and the distress this evidently caused both of them, I consider this point to be extremely important. The Adviser said that earlier palliative radiotherapy would have helped to reduce Mrs A's pain and, therefore, I consider the fact that this

was not offered to Mrs A at an earlier point to be a significant failing on the part of the Board.

48. I further note the Adviser's comments that when Mrs A suffered the MI, her options should have been discussed more thoroughly with her. The possibility of disease progression whilst she was undergoing cardiac surgery and recovery should also have been made clear. I recognise that finding out after the cardiac surgery had been undertaken that Mrs A was no longer suitable for radical cystectomy must have been extremely upsetting for her and for Mr C. The Adviser also said that it would have been good practice for Mrs A's case to be discussed at an MDT meeting once she had suffered the MI and for her to be referred back to oncology to discuss her options. I accept this advice.

49. The complaint I have investigated is that there were unreasonable delays in the treatment of Mrs A's cancer. My investigation has identified that there was a failure by the urology department to act on the letter from cardiac surgery, which stated that Mrs A could go ahead with treatment in a month from 3 November 2015. I have also identified that Mrs A's treatment options were not properly discussed with her after she suffered an MI and that there was a delay in her being given palliative treatment. Given this, I uphold this complaint. My recommendations for action by the Board are set out at the end of this report.

(c) There were unreasonable failings in communication between the specialists treating Mrs A regarding her condition and treatment

Mr C's concerns

50. Mr C said that:

- there seemed to have been a lack of communication between the urology team at the Board and the cardiology and cardiac surgery teams under the other Board;
- Mrs A had been told that the urology service were aware that she had undergone cardiac surgery but that she still did not hear anything from urology; and
- there was a lack of communication from the oncology team.

51. As the cardiology and cardiac surgery teams are part of the other Board, I will not be addressing their actions in this report but note that the communication issues referenced in paragraph 27 have since been addressed.

My investigation has instead focused on the communication of specialists under the Board.

The Board's response

52. In response to Mr C's complaint, the Board acknowledged that he felt there had been a breakdown in communication and said that they were sorry to read this. They said that the urology service had not been copied into the discharge letter from the cardiac team and, therefore, were not notified that Mrs A had undergone cardiac surgery (as noted at paragraph 27, the Board confirmed that this had been followed up with the other Board). The Board apologised for the distress and concern these matters caused Mr C and his family.

Medical advice

53. I asked the Adviser if they considered it reasonable that urology took no action to determine whether Mrs A's cardiac surgery was undertaken. The Adviser said that it was reasonable as urology would not be expected to chase this up.

54. The Adviser commented more generally on the communication between specialists involved in Mrs A's care and treatment. The Adviser said that given the likely delay that would ensue whilst awaiting cardiac surgery, there should have been better communication between urology and oncology following Mrs A's MI in order to re-discuss treatment options for the cancer. The Adviser also said that there should have been better communication between the urology team and the oncology team to discuss the option of proceeding with radical radiotherapy before any cardiac surgery.

55. The Adviser referenced National Institute of Health and Care Excellence (NICE) guidance, which comments that MDTs can bring benefits to patient care when communication is timely and relevant but that problems can arise when communication is poor or responsibilities are unclear. The Adviser noted that there were delays in Mrs A receiving appointments and treatment (discussed above) and said that this may have been due to poor communication between teams.

(c) Decision

56. The advice I have received is that there were failings in communication between the oncology and urology teams after Mrs A had an MI. The Adviser

said this meant that treatment options were not properly discussed with Mrs A. I accept this advice. This was a distressing and difficult time for Mrs A and Mr C, so it was vitally important that they received full and open discussions on treatment and prognosis. I am very concerned that this did not happen. Whilst urology and oncology working well together will bring benefits to patient care, in this case poor communication between specialisms may have had an adverse effect on patient care. I uphold this complaint and my recommendations for action by the Board are set out at the end of this report.

(d) The Board's handling of the complaint was unreasonable

Mr C's concerns

57. Mr C said that the Board's response to his complaint had not explained why Mrs A was not offered palliative radiotherapy earlier on and, therefore, he did not feel that the response addressed all of the issues which he had raised.

58. In his original complaint to the Board, Mr C stated that Mrs A had seen an oncologist in January 2016 who suggested that she have a CT scan followed by palliative radiotherapy. This was after she had been told that she could no longer have a radical cystectomy. Mr C said that the scan was booked for 5 February 2016 and then rescheduled for 18 February 2016. Mr C went on to say that when Mrs A received palliative radiotherapy, she was told that she could have had it a lot sooner than she received it. When making his complaint to the Board, Mr C said that he felt that had Mrs A had radiotherapy earlier, she may have had longer with her family.

The Board's response

59. In their response to Mr C's complaint, the Board explained that there had been a period of leave which meant that Mrs A could not have a scan earlier than 18 February 2016. They also said that they realised how difficult it must have been to hear that Mrs A could have had palliative radiotherapy sooner than she had received it and apologised that this comment had compounded Mr C's doubts regarding Mrs A's care.

(d) Decision

60. I can understand how being told that Mrs A could have received palliative radiotherapy earlier than she did would be deeply upsetting to Mr C. (I have addressed the failure of the Board to offer radiotherapy earlier in my decisions above.)

61. It was important that the Board provided a full and open explanation for the delay when responding to the complaint. I acknowledge some feedback and explanation was given, but I consider that the Board failed to address the matters of radiotherapy reasonably. Mr C wished for an explanation of the reasons why Mrs A was not offered palliative radiotherapy earlier and I consider that the Board should have recognised this. I note that they addressed the delay in the scan that Mr C mentioned and that they apologised that the comment made by a member of medical staff, that Mrs A could have had radiotherapy earlier, distressed Mr C. However, there was no explanation why Mrs A did not receive radiotherapy earlier. I consider that a full and open explanation regarding the timing of radiotherapy should have been given and I am critical that this did not happen. I uphold this complaint. Again, my recommendations for action by the Board are set out below.

62. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board 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.

Recommendations

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and deadline
(a), (b) and (c)	• There were unreasonable delays in Mrs A being provided with the relevant appointments following her diagnosis of bladder cancer; • There were unreasonable delays in the treatment of Mrs A's cancer; • There were unreasonable failings in communication between the specialists treating Mrs A regarding her condition and treatment; and • The Board's handling of Mr C's complaint was unreasonable	Provide a written apology to Mr C for the failings identified	Copy of apology letter which meets with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance By: 27 September 2017

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There was a delay between the results of the biopsy being reported on 10 February 2015 and Mrs A having a resection on 22 April 2015	In similar cases patients should receive treatment within 31 days from decision to treat to first treatment, as per the Scottish Government targets	Documentary evidence of a review of urology treatment waiting times for patients with cancer and the steps being taken to better meet National guidelines By: 22 November 2017
(a)	There was a period of approximately two and a half months from the time Mrs A was diagnosed with muscle invasive bladder cancer to the time she saw a surgeon to discuss definitive management	In similar cases, timescales between histology reporting and out-patient appointments in the urology service should be shorter	Documentary evidence of a review of the timescales between histology reporting and out-patient appointments in the urology service and details of steps being taken to shorten timescales By: 22 November 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	The urology service failed to act on the letter of 3 November 2015 stating that Mrs A could go ahead with surgery for her bladder cancer in a month's time	Letters between services should be shared at the appropriate time and acted upon where necessary	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 25 October 2017
(b)	Mrs A was not offered palliative radiotherapy at an earlier point	Palliative radiotherapy should be considered and offered as early as possible to reduce patients' pain	Documentary evidence of the learning from this case and any subsequent changes to procedures, instructions and training provided to clinical staff By: 25 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	When Mrs A suffered the MI, her options should have been discussed more thoroughly with her and the possibility of disease progression whilst she was undergoing cardiac surgery and recovery should have been made clear	The Board should demonstrate that staff are aware of the need to ensure patients are made fully aware of the possibility of disease progression if treatment for other health issues is required; and of their options for treatment	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 25 October 2017
(c)	There were failings in communication between the oncology and urology teams with regard to Mrs A's condition and treatment	The Board should demonstrate that they have reflected and learned from this case to ensure that there is better communication and coordination between teams, including discussion at multi-disciplinary meetings as appropriate, so that patients receive good and timely care	Documentary evidence that the relevant board staff have considered Ms A's case and how to ensure better communication and coordination of care between departments and hospitals. This could include evidence such as a minute of a staff meeting; an action plan, instructions to staff and/or a revised protocol By: 25 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(d)	The Board failed to address all of the issues that Mr C raised in his original complaint	The Board should ensure that complaint responses correctly identify and respond to all issues raised by complainants	Documentary evidence that this finding has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 27 September 2017

Evidence of action already taken

Greater Glasgow and Clyde NHS Board - Acute Services Division told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(b)	There were unreasonable delays in the treatment of Mrs A's cancer	Reviewed the pathway available to bladder cancer patients to improve the services available and the coordination of care	Copy of the bladder cancer pathway, highlighted to show the changes and/or additions By: 27 September 2017

Terms used in the report **Annex 1**

biopsy	sampling of cells
coronary artery bypass graft (CABG)	a procedure which diverts blood around narrowed or clogged of the arteries to improve blood flow and oxygen to the heart
flexible cystoscopy	a procedure used to examine the inside of the bladder
haematuria	blood in the urine
MDT	multi-disciplinary team
Mr C	the complainant
Mrs A	the aggrieved, Mr C's late wife
myocardial infarction (MI)	a heart attack
neo-adjuvant chemotherapy	administration of chemotherapy before the main treatment
NICE	National Institute for Health and Care Excellence
radical cystectomy	removal of the bladder and nearby lymph nodes
resection	a procedure used to cut away a tumour for testing
the Adviser	a consultant urological surgeon
the Board	Greater Glasgow and Clyde NHS Board