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: North East Scotland

Case ref: 201606803, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Ms C complained about the care she received from Grampian NHS Board (the board). As Ms C was experiencing post-menopausal bleeding, her GP urgently referred her to the gynaecology service of Aberdeen Royal Infirmary.

Ms C's referral was downgraded from urgent to routine by the gynaecology service. She was offered an appointment six weeks after her GP referral. Her GP contacted the gynaecology service on two occasions to request an earlier appointment but was told it was unnecessary for Ms C to be seen any sooner. When Ms C contacted the gynaecology service, they agreed to bring her appointment forward by a week. Given her concerns, Ms C was told that a consultant gynaecologist would look at her ultrasound scan report. Ms C received a phone call from a non-clinical staff member reassuring her that she did not need an urgent appointment.

When Ms C attended her appointment at the gynaecology service, an endometrial biopsy was carried out. When the results were issued, Ms C was diagnosed with endometrial cancer.

During our investigation, we took independent advice from a consultant gynaecologist and from a consultant obstetrician and gynaecologist. We found that Ms C's referral should not have been downgraded to routine and she should have been seen by the gynaecology service within two weeks of her GP referral. We found that the target for the treatment of Ms C's cancer was missed by 19 days. We found that Ms C should not have been given reassurance about the findings of her ultrasound scan report as they could have indicated cancer. We also found that this reassurance should not have been given to Ms C by a non-clinical staff member. We upheld Ms C's complaint.

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

What we are asking The Board, to do for Ms C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) and (b)	There was an unreasonable delay in giving Ms C a gynaecology appointment and a delay in treatment after her diagnosis. Ms C was given inappropriate advice about her ultrasound scan results by a non-clinical member of staff	Provide a written apology which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter. By: 2 October 2017

We are asking The Board 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 an unreasonable delay in the gynaecology service offering Ms C an appointment	Patients with postmenopausal bleeding should be offered a gynaecology appointment in line with the NICE guidelines [NG 12]	Documentary evidence of the steps to being taken to prevent similar failings in future cases, such as an action plan, instructions to staff, revised guidance By: 30 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There was an unreasonable delay in treating Ms C's cancer	In similar cases, patients should receive treatment within 62 days of referral as per the Scottish Government targets	Documentary evidence of the steps being taken to reduce waiting times for treatment By: 30 October 2017
(a)	The Board's vetting guidance on endometrial cancer is incorrect	The guidance should be updated urgently taking into account NICE guidance	New or updated guidance, highlighted to show the changes and/ or additions By: 2 October 2017
(b)	Ms C was given inappropriate advice about the ultrasound scan results	Staff should reflect and learn from the adviser's comments in relation to the ultrasound scan results	Documentary evidence that this decision has been shared and discussed with staff. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails, or notes of feedback given about this complaint By: 30 October 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	Ms C was given clinical advice by a non-clinical member of staff	The Board (including staff) should reflect and learn from the adviser's comments about the inappropriateness of non-clinical staff giving clinical information to patients	Documentary evidence that this decision has been shared and discussed with staff. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails, or notes of feedback given about this complaint. By: 30 October 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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to my office about the care she received from Grampian NHS Board (the Board). The complaints from Ms C I have investigated are that:

(a) there was an unreasonable delay in Ms C being seen at the gynaecology out-patient clinic (*upheld*); and

(b) in a telephone conversation on 13 June 2016, Ms C was wrongly told she had fibroids (*upheld*).

Investigation

2. My complaints reviewer considered carefully all the information provided by Ms C and the Board and sought independent medical advice on the care and treatment Ms C received from a consultant gynaecologist (Adviser 1). Independent medical advice on the Board's vetting guidance was also obtained from a consultant obstetrician and gynaecologist (Adviser 2). In this case, I have decided to issue a public report on Ms C's complaint because of the significant failures identified by my investigation and the Board's failure to identify any failings in this case when they investigated Ms C's complaint.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Background

4. Ms C attended her GP as she was experiencing postmenopausal bleeding. On 26 May 2016, her GP urgently referred her to the gynaecology service of Aberdeen Royal Infirmary (the Hospital). Ms C was also referred for an abdominal ultrasound scan, which was carried out on 31 May 2016. On 1 June 2016, her GP forwarded her ultrasound scan results to the gynaecology service and asked the Hospital for a fast track appointment. Ms C was offered an appointment at the Hospital for 8 July 2016 (six weeks after her GP referral). Her GP contacted the gynaecology service on two occasions to request an earlier appointment and was told it was unnecessary for Ms C to be seen any sooner.

5. On 13 June 2016, Ms C contacted the unit manager who agreed to bring her appointment forward by over a week. As Ms C was concerned, the unit manager asked a consultant gynaecologist to look at Ms C's ultrasound scan report in the meantime. Later that day, Ms C received a telephone call reassuring her that she did not need a fast track appointment.

6. On 28 June 2016, Ms C attended her appointment at the gynaecology service and an endometrial biopsy was carried out. When the results were issued, Ms C was diagnosed with endometrial cancer (grade 3 stage 1A).

7. Ms C was referred for a magnetic resonance imaging (MRI) scan to decide on appropriate treatment. The results of the MRI were discussed in the multi-disciplinary team meeting. It was decided that a total hysterectomy and removal of her ovaries, fallopian tubes and several lymph nodes was the appropriate treatment. Ms C's surgery took place on 15 August 2016.

(a) There was an unreasonable delay in Ms C being seen at the gynaecology out-patient clinic

Concerns raised by Ms C

8. Ms C complained to the Board on 3 October 2016. Ms C said she should have been seen by the gynaecology service within two weeks of her referral, as it was suspected she had cancer. Ms C said it appeared that her ultrasound scan results had been ignored by the gynaecology service. Ms C wondered if she could have had a lesser grade of cancer, had she received an earlier appointment.

The Board's response to Ms C and to this office

9. The Board said Ms C was urgently referred to the gynaecology service by her GP. The referral did not meet the urgent criteria so the vetting consultant gynaecologist downgraded it to a routine referral. The Board said that after Ms C telephoned the Hospital, her GP's referral and the ultrasound scan results were reviewed by a second consultant gynaecologist who supported the decision to downgrade her referral to routine.

Medical advice

Relevant guidance

10. The National Institute of Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) issue clinical guidelines designed to improve the quality of care for patients.

11. Adviser 1 explained that there is a NICE clinical guideline [NG12] that relates to the referral of patients suspected to have cancer. In relation to Ms C, Adviser 1 specifically referred to the following excerpt from that guideline:

'1.5.10 Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) for endometrial cancer if they are aged 55 and over with postmenopausal bleeding.'

12. Adviser 2 explained that there was a SIGN guideline about the investigation of postmenopausal bleeding (SIGN guideline no. 61). However, it was withdrawn in February 2015. Adviser 2 said that NG12 was a new NICE recommendation for 2015, to reflect the withdrawal of the SIGN guideline. Adviser 2 said that NG12 is the current standard for good clinical practice as patients with postmenopausal bleeding have a 10 percent to 15 percent risk of endometrial cancer.

13. Adviser 1 said that with reference to the NICE guideline above, there was an unreasonable delay in the gynaecology service offering Ms C an appointment. At the time of her GP referral on 26 May 2016, Ms C was aged over 55 with postmenopausal bleeding. They said that Ms C was correctly referred for a two week cancer pathway appointment by her GP. This meant that she should have been offered an appointment by the gynaecology service by 9 June 2016. Adviser 1 said the Hospital offered Ms C an appointment six weeks after her GP referral, having downgraded the urgency of the referral to routine. Adviser 1 considered it was inappropriate that Ms C's referral was downgraded prior to her being seen and investigated.

14. Adviser 1 said that Ms C's GP contacted the Hospital to request an earlier appointment for her. Adviser 1 said that presumably, her GP was trying to correct what they assumed to be an error on the Hospital's behalf. The Hospital declined the request, saying the referral did not include 'alarm symptoms'. Adviser 1 commented that the NICE guidelines do not subdivide postmenopausal bleeding into categories which are more or less suggestive of cancer. They said that postmenopausal bleeding in someone aged over 55 is all that is required to trigger an appointment within two weeks.

Board vetting guidance

15. Adviser 2 said that the Board's vetting guidance for GPs sets out the Board's 'alarm symptoms' for patients suspected to have cancer. Adviser 2 said that the alarm symptom listed for endometrial cancer is 'persistent intermenstrual bleeding especially with other risk factors despite a normal pelvic examination'. Adviser 2 said the Board's vetting guidance needs to be urgently amended to also include postmenopausal bleeding as a symptom of

endometrial cancer, in line with the NICE guidelines. Adviser 2 went on to comment that although the Board's vetting guidance on endometrial cancer is incorrect, their vetting guidance does list postmenopausal bleeding as an 'alarm symptom' for cervical cancer. Therefore, Adviser 2 said Ms C should still have been seen by the gynaecology service as an urgent referral, despite the error in the Board's vetting guidance relating to endometrial cancer.

16. Regardless of the 'alarm symptoms' listed by the Board for GP referrals, Adviser 1 considered that as Ms C was aged 66, with prolonged bleeding and fluid (presumably blood) evident in her endometrial cavity (see paragraph 28), her symptoms were very suggestive of endometrial cancer. Adviser 1 said that her background was an additional consideration. They said the notes from her earlier gynaecologist assessments recorded she had an increased risk of endometrial cancer given her family history. In her GP's referral letter to the gynaecological service, Ms C's family history of gynaecological cancer was mentioned.

Target timescales

17. Adviser 1 went on to say that there is a standard in Scotland that patients urgently referred with a suspicion of cancer will begin treatment within 62 days of referral. Specifically, Adviser 1 said the Scottish Government's target for the treatment of cancer is for:

> '95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.'

18. Ms C was urgently referred to the gynaecology service by her GP on 26 May 2016 and underwent surgery on 15 August 2016. The target for the treatment of her cancer was missed by 19 days. Adviser 1 considered this was mainly due to the delay in Ms C being offered a gynaecology appointment. However, Adviser 1 also considered it was due to the length of time Ms C had to wait for surgery, after her biopsy results confirmed her diagnosis of cancer. Adviser 1 said Ms C's biopsy was carried out on 28 June 2016 and although it was not entirely clear when her biopsy results arrived, it took about a week. This meant that Ms C's surgery took place around five weeks after her biopsy results. Adviser 1 said the Board could have still met the 62 day referral to treatment target, if Ms C had undergone surgery sooner. Therefore, Adviser 1 considered there was an undue delay in the Board undertaking definitive treatment for Ms C's cancer after her diagnosis.

19. Adviser 1 said it was not possible to say what effect the delay in treatment had on the progress of the tumour or on Ms C's prognosis. They advised that initially Ms C was seen 17 days after she should have been (if she had received an appointment within two weeks in line with NICE guidance). Taking into account the 62 day referral to treatment target, Adviser 1 considered that the overall delay in treatment was 19 days. Given this, they considered the effect was likely to have been minimal. However, Adviser 1 said the standard of 62 days is in place as it is considered to be a reasonable timescale to give someone treatment for cancer. Adviser 1 said that any delay outwith that timescale is clearly not ideal.

(a) Decision

20. The advice I have been given is that Ms C should have been seen by the gynaecology service within two weeks of her urgent GP referral, given her age and symptoms. I have been advised that Ms C's ultrasound scan results and history were very suggestive of Ms C having endometrial cancer. Ms C would have had to wait six weeks for an appointment, if she had not contacted the Hospital to express her concerns and asked to be seen earlier. Even with Ms C's appointment having been brought forward, it was still over four weeks from her GP referral until she was seen by the gynaecology service. I have been advised that this was an unreasonable delay. I accept this advice.

21. In addition, it is of concern that Adviser 2 has advised that the Board's vetting guidance is incorrect and should be urgently amended to describe postmenopausal bleeding as an alarm symptom for endometrial cancer, in line with NICE guidelines. I have included a recommendation for urgent action to this effect at the end of this report.

22. Once the biopsy result confirmed Ms C's diagnosis of cancer, there was a delay in treatment. Overall, Ms C should have received treatment within 62 days of her referral and this target was missed by 19 days. This was largely due to the delay in Ms C being seen at the gynaecology clinic but was also due to the time she had to wait to undergo surgery, after her diagnosis.

23. I am critical of these failings. I am particularly concerned that Ms C's GP was told the referral did not include alarm symptoms when, under the Board's vetting guidance, it did. This meant that both Ms C's GP and then Ms C herself had to contact the Hospital to expedite her treatment during what would have

been a very stressful time for Ms C. In addition, I am concerned that Ms C's case was reviewed by two consultants neither of whom recognised that she should have received an urgent two week appointment. Overall, I consider that these were significant failings and that there was an unreasonable delay in Ms C being seen at the gynaecology out-patient clinic. I uphold the complaint.

24. I have made recommendations to address all the failings identified at the end of this report.

(b) In a telephone conversation on 13 June 2016, Ms C was wrongly told she had fibroids

Concerns raised by Ms C

25. Ms C complained that on 13 June 2016, she contacted the unit manager by telephone to ask for an earlier appointment. The unit manager confirmed that she had brought Ms C's appointment forward. Ms C explained the circumstances about why she was requesting an earlier appointment. The unit manager said she would speak to a doctor and telephone Ms C back. When she later telephoned Ms C, the unit manager told her not to worry as a doctor had looked at her ultrasound scan and said she had fibroids. Ms C complained that when she attended her gynaecology appointment on 28 June 2016, the consultant gynaecologist told her it was not fibroids and they would need to arrange a biopsy to check for cancerous cells.

The Board's response to this office

26. The Board said the unit manager did not tell Ms C that she had fibroids. They said Ms C was told that a second consultant gynaecologist had reviewed her GP referral and ultrasound scan results. Ms C was told that as they were indicative of fibroids, her referral would continue to be treated as routine. The Board also said they had not had sight of the actual pictures from her ultrasound scan and that this advice was based on the ultrasound scan report.

Medical advice

27. My complaints reviewer noted there was a difference between Ms C's understanding of what the unit manager had said and the response from the Board. According to Ms C, she was told she had fibroids whereas the Board said Ms C was told her results were indicative of fibroids.

28. My complaints reviewer asked Adviser 1 if it was inaccurate to tell Ms C she had fibroids or that her results were indicative of fibroids. Adviser 1 said the

ultrasound scan report was described in the consultant gynaecologist's clinic letter of 28 June 2016. They said there was a small fibroid present. However, there was also a much more concerning finding of increased endometrial thickness and the presence of fluid in Ms C's endometrial cavity. They considered that given Ms C's symptom of postmenopausal bleeding, this could indicate cancer.

29. My complaints reviewer asked Adviser 1 to comment on the unit manager telling Ms C she had fibroids or that the results were indicative of fibroids. Adviser 1 said that in general, it is not appropriate for a patient to be given clinical information by a non-clinical staff member. They also said Ms C should have been seen at the clinic within two weeks of referral. There should have been no need to give her any telephone reassurance about her ultrasound scan results. In any case, Adviser 1 said that for the reasons outlined above, it was not appropriate or indeed possible to give Ms C any reassurance from the ultrasound scan result alone as it may have indicated she had cancer.

(b) Decision

30. The advice I have received and accept from Adviser 1 is that Ms C should have received an appointment within two weeks of her GP referral so it should not have been necessary for the unit manager to try to reassure her about her condition. It was inappropriate for Ms C to be given advice about her ultrasound scan results by the unit manager, as she was a non-clinical member of staff. I have also been advised that it was inappropriate to give Ms C any reassurance about her condition on the basis of the ultrasound scan results, as they showed findings of increased endometrial thickness and the presence of fluid which could represent cancer.

31. Taking account of the Board's position and in view of the advice I have received, I consider it was unreasonable that Ms C was either told she had fibroids or that her ultrasound scan results were indicative of fibroids. I am particularly concerned that this information was provided, given the findings of the ultrasound scan report and the fact that it had been reviewed by a doctor. I also consider it was inappropriate that this information was given to Ms C by a non-clinical staff member.

32. Given the above, I uphold this complaint.

33. 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 Ms C:

Complaint Number	**What we found**	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
(a) and (b)	There was an unreasonable delay in giving Ms C a gynaecology appointment and a delay in treatment after her diagnosis. Ms C was given inappropriate advice about her ultrasound scan results by a non-clinical member of staff.	Provide a written apology which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy of the apology letter By: 2 October 2017

We are asking the Board 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 an unreasonable delay in the gynaecology service offering Ms C an appointment.	Patients with postmenopausal bleeding should be offered a gynaecology appointment in line with the NICE guidelines [NG 12].	Documentary evidence of the steps to being taken to prevent similar failings in future cases, such as an action plan, instructions to staff, revised guidance. By: 30 October 2017
(a)	There was an unreasonable delay in treating Ms C's cancer.	In similar cases, patients should receive treatment within 62 days of referral as per the Scottish Government targets	Documentary evidence of the steps being taken to reduce waiting times for treatment By: 30 October 2017
(a)	The Board's vetting guidance on endometrial cancer is incorrect.	The guidance should be updated urgently taking into account NICE guidance.	New or updated guidance, highlighted to show the changes and/ or additions. By: 2 October 2017

Complaint Number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	Ms C was given inappropriate advice about the ultrasound scan results.	Staff should reflect and learn from the adviser's comments in relation to the ultrasound scan results.	Documentary evidence that this decision has been shared and discussed with staff. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails, or notes of feedback given about this complaint. By: 30 October 2017
(b)	Ms C was given clinical advice by a non-clinical member of staff.	The Board (including staff) should reflect and learn from the adviser's comments about the inappropriateness of non-clinical staff giving clinical information to patients.	Documentary evidence that this decision has been shared and discussed with staff. This could, for example, include minutes of discussions at a staff meeting or copies of internal memos/emails, or notes of feedback given about this complaint. By: 30 October 2017

Terms used in the report **Annex 1**

Adviser 1	a consultant gynaecologist who assessed Ms C's care and treatment
Adviser 2	a consultant obstetrician and gynaecologist who assessed the Board's vetting guidance
biopsy	tissue sample
endometrial cancer	cancer in the lining of the womb
endometrial cavity	a layer of mucus membranes that lines the uterus (womb)
fibroids	non-cancerous growths that develop in or around the uterus (womb)
gynaecology	medicine of the female genital tract and its disorders
hysterectomy	surgery to remove the uterus (womb)
MRI	magnetic resonance imaging
Ms C	the complainant
NICE	National Institute of Health and Care Excellence
postmenopausal bleeding	vaginal bleeding occurring twelve months after the menopause
SIGN	Scottish Intercollegiate Guidelines Network
the Board	Grampian NHS Board

the Hospital	Aberdeen Royal Infirmary
ultrasound scan	a scan that uses sound waves to create images of organs and structures inside the body