SPSO decision report

Case: **202108769, A Medical Practice in the Lanarkshire NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) by the practice. A was provisionally diagnosed with torticollis (where the head becomes persistently turned to one side associated with painful muscle spasms) by the practice. Six months later A was admitted to hospital and diagnosed with transitional cell carcinoma (a type of bladder cancer) and a secondary tumour was growing on the spine. A died a few month's later. C complained that the practice failed to provide a reasonable standard of care and treatment in the months before A's diagnosis and once A was discharged from hospital.

We took independent advice from a GP. We found that the practice unreasonably failed to arrange face-to-face appointments, or carry out more detailed clinical examinations, history taking and assessment of red flag symptoms. There was a lack of continuity in the care A experienced and it was unreasonable that there was a delay in actioning a referral upgrade to urgent. While we accepted that there was a poor prognosis, earlier intervention might have improved the management of A's pain. Therefore, we upheld this part of C's complaint.

In relation to A's care after their hospital admission, we found that it was unreasonable that A was not reviewed by a GP until seven days after discharge and not directly examined by a clinician when they reported a new symptom. We also noted that no detailed assessment was carried out of A's analgesic (painkiller) requirements. We found that the practice did not provide reasonable care in accordance with the relevant standards on discharge. Therefore, we upheld this part of C's complaint.

We also found that while the practice completed a Significant Event Analysis, this learning could have been carried out in a more timely way. We noted that the practice's own complaint investigation did not identify the full extent of the failings in this case. While areas for learning and improvement have been recognised and acknowledged by the practice, these were only identified in response to our enquiries.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the principles/standards set out in SPSO's guidance on apology available at www.spso.org.uk/meaningful-apologies.

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

- Wherever possible and where it is clinically appropriate, patients should receive face-to-face appointments, where a detailed clinical examination can be carried out, a detailed history taken and assessment of any red flag symptoms, and receive continuity of care.
- Patients with new diagnoses of cancer should receive prompt review by a GP, including appropriate Anticipatory Care Planning, completion of an eKIS summary and be added to a Palliative Care disease register to facilitate multi-disciplinary care planning.

- When a relevant adverse event occurs, the practice should promptly carry out an appropriate adverse event review to investigate the cause and identify any potential learning in line with the National Framework for Scotland (www.healthcareimprovementscotland.scot/).

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the Model Complaints Handling Procedures. They should ensure that failings, as well as good practice are identified and that learning and information gathered from complaints is used to drive service improvement.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.