

SPSO decision report



Case: 202408721, A Medical Practice in the Lothian NHS Board area
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the practice did not give sufficient consideration to their symptoms of ovarian cancer, and previous medical history, resulting in missed opportunities to help diagnose the cancer earlier. C also complained that they had not been referred to secondary care in a timely manner and that a CA125 blood test (a diagnostic tool used to help identify ovarian cancer) was not carried out despite presenting with symptoms which met the criteria according to relevant guidelines.

The practice noted that C's symptoms could be attributed to a wide range of possible differential diagnoses at that time and that the investigations they carried out provided a reasonable standard of care.

We took independent advice from a registered GP. We found that it would not be normal practice for a GP practice to refer a patient to secondary care before completing their own diagnostic testing. We also noted that a GP practice would not usually refer a patient to oncology before a diagnosis is made, even if the patient has previously been treated for cancer.

However, we found that the practice failed to recognise that a CA125 blood test should have been considered for C's symptoms in line with the guidance and should have been done in parallel with the pelvic ultrasound scan that was requested. The failure to do so meant that C was incompletely investigated for possible ovarian cancer. Therefore, we upheld C's complaint.

In regards to complaints handling, we found that there was a lack of clear communication around a meeting with C to discuss their dissatisfaction with the care provided. While it was good practice to offer a meeting, the practice should have explained the purpose of the meeting and shared the outcome, as agreed with C. We made a recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C's family for the failings identified in respect of care and treatment and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/meaningful-apologies.

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

- The practice should ensure that patients are appropriately assessed by doctors when presenting with new or worsening symptoms, with reference to the relevant guidance and that staff are aware that consideration should be given to CA125 testing in accordance with relevant guidance.
- When a relevant adverse event occurs, the practice should promptly carry out a SEA in accordance with the framework. This should include investigating the cause, and identify and evidence any potential

learning with involvement from those affected and sharing with them the outcomes.

In relation to complaints handling, we recommended:

- Relevant staff should be aware of the requirements of the complaints handling procedures. Complaints handling staff should clarify and confirm the complaint with C before their investigation, feel confident in managing expectations with regard to meetings, and be clear in what will be discussed and the outcomes to be shared. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at <https://www.spsa.org.uk/training-courses>.

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.