

SPSO decision report



Case: 202305765, Ayrshire and Arran NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment given to their partner (A) while in hospital, which they believe led to A's death. In response to the complaint, the board acknowledged and apologised that communication with C had not been effective. However, A had been aware of the severity of their diagnosis and prognosis and was able to make their own decisions and all communication had been with them.

We took independent advice from a consultant in acute and general medicine. We found that, while significant parts of A's care and treatment had been reasonable, there was a delay in the diagnosis and initiation of cancer treatment. In terms of the Scottish referral guidelines for suspected cancer, patients referred via the urgent suspected cancer pathway should receive their first treatment within 62 days of receipt of the referral, which did not happen in this case.

We also found that there were unacceptable delays in relation to acting upon the results of the PET scan and a delay in A's subsequent diagnosis. In addition, we found that at the time of A's death a morbidity and mortality meeting (M&M) had not taken place. However, the board confirmed that a new M&M process had been implemented so that all deaths were reviewed through this process. We upheld the complaint.

During our investigation, we identified issues with the board's handling of the complaint. We made a recommendation to the board to support improvement of their complaint handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

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

- Patients should be treated in line with relevant cancer referral guidelines. Scans should be carried out and reported within a reasonable time frame.

In relation to complaints handling, we recommended:

- There should be a formal review and consideration of a robust investigation process when complaints are received so that any potential learning is identified and actions can be considered to reduce the risk of failures in care in the future.

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.