SPSO decision report

Case: **202009009, A Medical Practice in the Lothian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to us about the care and treatment that they had received from their GP practice. C told us that the practice had failed to carry out appropriate prostate specific antigen (PSA) testing after they found out that C was at increased risk of prostate cancer genetically. They told us that after an initial test, which was normal, there was a delay of around four years in carrying out a further test, at which time the test showed elevated results and they were subsequently diagnosed with cancer. C considered that this delay had a considerable impact on their prognosis, as their cancer had by that time spread, which they had been told was unlikely to have been the case had they been diagnosed earlier.

C also complained that the practice had failed to appropriately respond to their concerns about this, both in the way that they had investigated the concerns, and the manner in which they had responded, which C had found to be uncaring.

We took independent advice from a GP adviser. We found that the practice had failed to handle C's testing appropriately. In particular, that they unreasonably assessed that regular testing was not required based on guidance intended for those not at increased genetic risk and that they unreasonably failed to seek further advice and clarity from specialist services on the request to consider regular testing. We also noted that when the test was subsequently agreed as part of other blood tests, this was missed in error, and they then failed to identify this had been missed or notify C, leaving them with the impression that this had provided normal results.

Therefore, we upheld C's complaint that their testing had been mishandled.

Our investigation also found that the practice had not responded reasonably to C's concerns, as the Significant Event Analysis (SEA) they carried out was not of a reasonable standard, and they had failed to provide appropriate apologies for the failures that were identified by their own investigations.

On this basis, we also upheld C's complaint that the practice had not responded reasonably to their concerns.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide appropriate PSA testing. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for failing to respond reasonably to their concerns. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The practice should appropriately consider the results of any tests requested to ensure that they are fit for

the purpose they were requested for.
- The practice should ensure that there is clarity around any request received from secondary care services that they choose to accept.
- The practice should provide appropriate screening for any patient at increased risk of developing cancer.

In relation to complaints handling, we recommended:

- All complaints should be processed in line with the Model Complaints Handling Procedure and any apologies offered in complaint responses should meet the terms of the guidance on apology.
- All SEA (Significant Event Analysis) investigations should include an assessment of whether the treatment provided was of a reasonable standard, and a consideration of the root causes of any failings identified.

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.