SPSO decision report

Case: **202401263, A Medical Practice in the Highland NHS Board area**
Sector: Health
Subject: Delays in diagnosis / treatment
Decision: upheld, recommendations

Summary

C complained about the care and treatment the practice provided to their late spouse (A). After experiencing steady unexplained weight loss, A had contacted the practice. A was diagnosed with diabetes and prescribed medication for this. Symptoms continued over the following months, and A queried the possibility of pancreatic cancer with the GP. This was not immediately followed up by the GP.

A continued to experience symptoms and the GP sent an urgent referral to gastroenterology (specialists in disorders of the stomach and intestine). The following month, the GP sent a new urgent suspicion of cancer referral after blood tests showed a change in A's liver function. Following a CT scan, A was diagnosed with pancreatic cancer. They died around six weeks after their diagnosis.

C complained that there was an unreasonable delay in recognising that A's specific symptoms indicated they may have had pancreatic cancer. They also complained that there was an unreasonable delay in referring A to appropriate secondary care for further investigation.

We took independent advice from a GP. We found that relevant guidance was clear that A had red flag symptoms for pancreatic cancer from their initial presentation. From this point until the urgent suspicion of cancer referral, there were missed opportunities to recognise the significance of A's symptoms and refer them onward for further investigation. Given this, we upheld both of these complaints.

C also complained that the practice failed to provide reasonable input into A's palliative care following their terminal diagnosis. We found that there was a lack of proactive planning and communication on the part of the practice. Therefore, we upheld this complaint.

Finally, C complained that there was an unreasonable reliance on telephone consultations. We accepted that telephone consultations are an important part of delivering a GP service. However, in A's case, we concluded that face-to-face appointments may have resulted in less delay in diagnosis and a better quality of end-of-life care. On balance, we upheld this complaint.

Although we upheld all of C's complaints, we did note that the practice had responded constructively to the concerns raised and our enquiries. We asked the practice to apologise to C but made no further recommendations given the action already taken.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable delay in recognising that A's specific symptoms indicated they may have had pancreatic cancer and referring A to appropriate secondary care for further investigation. Apologise to C for the unreasonable standard of end-of-life and palliative care input provided to A.

Apologise to C for the unreasonable reliance on telephone consultations in their interactions with A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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.