SPSO decision report

Case: **201702683, Golden Jubilee National Hospital**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Decision: upheld, recommendations

Summary

Mr C had a scan at the Golden Jubilee National Hospital. A mass was discovered on his lung, which could have been either a spread of his existing bowel cancer or a new lung cancer. His consultant arranged some tests to help determine which it was, but because they were busy, they asked another consultant to carry out the tests. Both consultants thought that the other would be responsible for Mr C's ongoing care, so neither of them wrote a discharge letter. While Mr C attended a follow up appointment at the second consultant's clinic, he saw another doctor who referred him back to the first consultant, instead of to the multi-disciplinary team (MDT), which is what should have happened. The first consultant did not see the referral.

Mr C and his GP both tried to contact the first consultant to find out what was happening, but it is not clear whether Mr C's phone messages were passed on and his GP's letter was not seen by the first consultant. Eventually, about six months after the scan, Mr C's GP spoke with the first consultant, who then referred Mr C to the MDT for consideration and Mr C was offered palliative radiotherapy. Mr C was told that his cancer was terminal, and he was concerned that the delay may have affected this outcome. He complained to the board about this.

In response to Mr C's complaint, the board accepted that there was an unreasonable delay and a failure to communicate with Mr C about his treatment. They apologised for this and said that they had taken action to prevent this happening again. The board had put in place a new protocol for passing care between two consultants, and a message book to ensure phone messages are recorded and signed off by consultants. The board said that the delay would not have affected the outcome in Mr C's case, although they acknowledged that palliative radiotherapy should have been offered sooner. Mr C remained unhappy and brought his complaints to us.

We took independent advice from a thoracic surgeon (a surgeon who deals with treatment of conditions of the organs inside the chest). We found that the delay in arranging treatment for the mass on Mr C's lung was unreasonable. We upheld this complaint, however we noted that, although Mr C's cancer grew during this time, the delay would not have affected his outcome, as surgery or radical radiotherapy would not have been available even if he had been considered immediately. As the board had already put in place measures to avoid this happening again in the future, we did not make any further recommendations in this regard.

Mr C also complained that the hospital failed to communicate reasonably with him about the arrangements for his treatment. We found that there were failings in communication, including a failure by the first consultant to pick up on two important letters. We upheld this aspect of Mr C's complaint. We noted that the board had already taken some steps to avoid similar failings occuring in the future, however we made a further recommendation regarding mail processes.

Recommendations

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

- Consultants should have robust mail processes in place to ensure that important letters are not missed or overlooked.

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.