Scottish Parliament Region: Lothian

Case 200501643: Lothian NHS Board

Summary of Investigation

Category

Health: Breast Screening

Overview

The complainant (Ms C) raised a number of concerns in respect of her attendance at the Breast Screening Service for tests and subsequent correspondence relating to her results.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a lack of information at the screening appointment *(not upheld)*;

(b) the discharge letter was unclear *(upheld)*;

(c) the Breast Screening Service failed to fully address Ms C's concerns *(upheld*); and

(d) the Breast Screening Service failed to issue a letter notifying Ms C that she was clear of breast cancer *(not upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) consider reviewing the wording of the discharge letter; and

(ii) review procedures to ensure that telephone calls to the Breast Care Service are responded to appropriately.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 22 September 2005 the Ombudsman received a complaint from a member of the public (referred to in this report as Ms C) which stated that when attending the Breast Screening Service for further tests on 18 July 2005 following a previous unclear mammogram, she was left in a position where medical staff failed to communicate with her and left her feeling alone, concerned and very frightened.

2. In addition, Ms C stated that when she was discharged after her screening, having apparently been told that she was free from breast cancer, she was given a discharge letter which lacked clarity by stating that 'we will be in touch with you in the near future regarding the date of your next mammogram'. She felt that this letter was unclear, so telephoned the Breast Care Nurse for clarification on a number of points. The Breast Care Nurse advised that she could not help as she did not have access to Ms C's clinical records. She suggested that Ms C made an appointment with her consultant, which she did. Unfortunately this appointment was not until 1 September 2005.

3. When Ms C did attend the appointment with the consultant, he produced a copy of a letter apparently sent to Ms C on 4 August 2005 advising that her results were clear and that she showed no signs of cancer. This letter was never received by Ms C.

4. The complaints from Ms C which I have investigated are that:

(a) there was a lack of information at the screening appointment;
(b) the discharge letter was unclear;
(c) the Breast Screening Service failed to fully address Ms C's concerns; and
(d) the Breast Screening Service failed to issue a letter notifying Ms C that she was clear of breast cancer.

Investigation

5. Ms C raised her complaint with the Breast Screening Service on 2 September 2005. This was fully investigated in line with the NHS Complaints Procedure and a formal response from Lothian NHS Board (the Board) was issued on 12 September 2005. On receipt of this response, Ms C requested that the Ombudsman's office review her complaint.

6. I have reviewed correspondence from the complainant and the Board and discussed the complaints with both parties. I have obtained the clinical records and complaints file from the Board and have sought professional advice from an independent clinical adviser (the Adviser). The points in particular which I have asked the Adviser to review relate to whether the communication between the patient and the Breast Screening Service was of an acceptable standard and whether improvements could be made in the way communication takes place.

7. I have set out, for each of the four main headings of Ms C's complaint, my findings of fact and conclusions. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) There was a lack of Information at the Screening Appointment

8. On 13 July 2005 Ms C attended a follow-up review at the Breast Screening Service. She was seen by a senior clinician Dr D. The Adviser considers that given the seniority of the clinician, it is probable that she would have explained the reasons for the review and provided details of the required tests.

9. Ms C attended the clinic with a female friend. She said that after a general introduction she was left sitting with her friend for long periods with no explanation of what was taking place. She felt that the whole experience was impersonal and uninformative.

10. The Board have advised that at the end of the screening Dr D would have discussed the findings with Ms C. It is the Board's normal policy to inform patients that their examination showed no evidence of breast cancer. In addition, this information was provided by letter.

11. The clinical records do not detail what was said to Ms C at the examination. I consider that the Board should consider reviewing what level of information is recorded on the clinical records at the screening appointment. It is appreciated, however, that the intensive nature of the Breast Screening Programme may make such detailed record-keeping difficult, and that cases where abnormalities are found would more fully documented.

(a) Conclusion

12. The Breast Screening Unit is a busy unit where there may not be time for the level of personal contact desired by some patients. Every patient will react to their circumstances differently with some requiring more reassurance than others. On the balance of probabilities I consider it likely that Dr D did provide a satisfactory explanation both before and after the examination. However, there may have been times when Ms C felt that she was not being kept up-to-date with the progress of the examination. From the available information it is not possible to establish whether this was as a result of a lack of communication by the clinical staff or Ms C's expectations of the service. In all the circumstances, I do not uphold the complaint.

(a) Recommendation

13. The Ombudsman makes no recommendations on this complaint.

(b) The discharge letter was unclear

14. At the end of the examination of 13 July 2005, Ms C was provided with a discharge letter. This letter stated that:

> 'no signs of breast cancer were detected at your assessment today.'

15. This clear statement was clouded somewhat by the following paragraph which detailed that all tests would be reviewed by another Consultant Radiologist and further that:

> 'We shall be in touch with you in the near future regarding the date of your next mammogram.'

16. Whilst the letter did clearly state that there were no signs of cancer detected at the assessment, it goes on to say that contact will be made 'in the near future' in respect of the date of the next mammogram appointment.

(b) Conclusion

17. I am of the view that the content of this letter could be misinterpreted. It failed in this case to provide appropriate reassurance, in particular as no follow-up correspondence was received.

18. I have considered the wording of this letter carefully, and from this review I accept that this letter is not as clear as it should be. I have also sought advice from the Adviser who agrees that this letter could be misinterpreted, particularly

if the patient had a heightened sense of anxiety as is often the case. For this reason I uphold the complaint.

(b) Recommendation

19. The Ombudsman recommends that the Board consider reviewing this standard letter with a view to removing any possible ambiguity.

(c) The Breast Screening Service failed to fully address Ms C's concerns

20. The discharge letter issued to Ms C when leaving her examination stated that she should contact one of the Breast Care Nurses should she wish to discuss any aspect of the examination.

21. Ms C has advised me that she telephoned the number detailed on the discharge letter but did not receive any help. As a result of this she then called the Breast Care Nurse at the symptomatic breast service. This is a completely separate system which is on a different geographical site and would not have any direct administrative link with the Breast Screening Service unless and until a patient is diagnosed with cancer. Nurses in this service would not have access to Ms C's file. Ms C stated that the advice provided by the very helpful nurse from the symptomatic breast service was most welcome and supportive. Additionally, however, she claimed that she was told that as the nurse did not have access to her file, she could not comment on Ms C's specific case. She was advised to contact the consultant, who she had employed on a private basis, if she needed specific advice.

22. The Board have responded to Ms C's claims by advising that Ms C would have been provided with the help and advice she required had she telephoned the number detailed on the discharge letter. The Clinical Director of the Breast Screening Service discussed the case with the nurse from the symptomatic breast service who spoke with Ms C. They maintained that Ms C was given as much advice as was possible from the symptomatic service but was also advised that she must telephone the Breast Screening Service on the number she had been provided with to enable her to obtain advice about her individual circumstances.

(c) Conclusion

23. From my examination of the evidence it is clear that the Board originally did not believe that Ms C had contacted the number provided on the discharge

letter. They maintained that had she done so, she would have been provided with advice and support specific to her case.

24. Ms C has subsequently provided evidence that she did contact the number provided on the discharge letter. I do not have evidence of what was said in that telephone call or why Ms C was not given the information she required.

25. I conclude that, on the balance of probabilities, when Ms C telephoned the Breast Screening Service on the number provided she was not given the assistance she required. As a result of this, I uphold the complaint. I can make no judgement as to why this was the case or whether Ms C was subsequently referred back to the telephone number for the Breast Screening Service by the nurse from the symptomatic service. However, had Ms C's original telephone call to the Breast Screening Service been responded to fully, Ms C may have avoided some of the subsequent period of worry.

(c) Recommendation

26. As a result, the Ombudsman recommends that the Board review their procedures to ensure that telephone calls to the Breast Care Service are responded to appropriately.

(d) The Breast Screening Service failed to issue a letter notifying Ms C that she was clear of breast cancer

27. As part of the standard screening programme procedures, a letter was issued to Ms C on 4 August 2005 with a copy sent to her consultant, advising that her review showed no evidence of breast cancer and that she would be invited back for her next screening in approximately three years. This letter was never received by Ms C although the consultant did receive the copy.

(d) Conclusion

28. It is clearly very unfortunate that Ms C did not receive this letter. This only added to her anxiety. I am unable to establish what happened to the original letter to Ms C. I am satisfied that the Board do not bear responsibility for its loss. Ms C has stated that she believes that a more rigorous procedure should be in place to ensure receipt of such results. Given the volume of correspondence issued by an NHS Board, I do not consider that this would be a reasonable use of resources. I consider the issue of examination results in this case to be acceptable. As a result I do not uphold this aspect of the complaint.

(d) Recommendation

29. The Ombudsman makes no recommendation on this complaint.

20 June 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	Lothian NHS Board
The Adviser	Independent clinical adviser to the Ombudsman
Dr D	Senior Clinician