Scottish Parliament Region: Central Scotland

Cases 200600429 & 200601152: Lanarkshire NHS Board and a Medical Practice, Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology; referral, follow-up

Health: General Practitioner; referral, follow-up

Overview

A MSP (Ms C) raised a number of concerns about the referral process that her constituent (Mr A) had been through after he was diagnosed with cancer. Specifically, she raised concerns that Mr A's GP Practice (the Practice) had failed to identify that Mr A had not been informed of his referral to Oncology and that Lanarkshire NHS Board (the Board) failed to properly administer Mr A's referral and follow-up when he failed to attend the appointment. Mr A died during the course of this complaint and his wife (Mrs A) continued to pursue the complaint on his behalf.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to properly administer Mr A's referral to the Medical Oncology Unit and to follow-up when Mr A did not attend his appointment *(upheld)*;

(b) the Board did not respond appropriately to Mr A's complaint about their failings *(upheld*); and

(c) the Practice failed to identify that Mr A was not aware of his referral to the Medical Oncology Unit (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr A's family for their failure to properly administer his referral; and

(ii) confirm to her that they have gained assurance that the new referral system functions properly.

The Board have accepted the recommendations and will act on them

accordingly.

Main Investigation Report

Introduction

1. On 8 May 2006, the Ombudsman received a complaint from Ms C on behalf of Mr A. She complained that Mr A had not been properly referred to the Medical Oncology Unit at Hairmyres Hospital (the Hospital) by Lanarkshire NHS Board (the Board) and that Mr A's GP Practice (the Practice) had failed to identify that Mr A was not aware of the referral.

2. Mr A complained to the Board on 22 March 2006 that, following tests in 2005, he was not informed that cancerous cells had been detected until 1 March 2006. When he subsequently attended for further tests, a tumour was discovered. He complained that, because of the delay, his chances of survival had been diminished.

3. The Board responded on 19 April 2006. They explained that the referral letter had been typed late and that there was no evidence that it had been sent. The letter also contained an overview of Mr A's clinical history and expressions of regret. It explained that a formal review of practices was underway to ensure that measures were taken to prevent a similar situation from arising again.

4. Ms C wrote to the Chief Executive of the Board (the Chief Executive) on 8 May 2006 and received a response on 31 May 2006. The Chief Executive explained that the practices in place were being formally reviewed towards ensuring that measures were taken to prevent a similar situation from arising again. The Chief Executive explained that, as the Ombudsman had decided to investigate this complaint, they would leave any further investigation up to her at this stage.

5. Mr A also complained to the Practice on 22 March 2006. He complained that the Practice had failed to follow-up on the letter referring Mr A to the Oncology Unit, which had been copied to them. The Practice responded on 3 April 2006. They explained that it was not normal practice to follow-up whether hospitals have carried out arrangements as planned and that they did not feel the Practice bore any responsibility for the Hospital's failing.

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

(a) the Board failed to properly administer Mr A's referral to the Medical Oncology Unit and to follow-up when Mr A did not attend his appointment;

(b) the Board did not respond appropriately to Mr A's complaint about their failings; and
(c) the Practice failed to identify that Mr A was not aware of his referral to the Medical Oncology Unit.

Investigation

7. My investigation of this complaint is based on correspondence between Mr A, Ms C, the Board and the Practice; the Board's complaints file on this matter and Mr A's medical records. During the course of my investigation, I met Ms C and Mrs A, and asked for advice from the Ombudsman's medical adviser (the Adviser).

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C, Mrs A, the Board and the Practice were given an opportunity to comment on a draft of this report.

(a) The Board failed to properly administer Mr A's referral to the Medical Oncology Unit and to follow-up when Mr A did not attend his appointment

9. Mr A attended the Hospital in May 2005 and saw a consultant thoracic surgeon (Consultant 1) for an endoscopy. This showed some inflamed mucosa so a biopsy was taken. Mr A had had oesophageal cancer previously and the biopsy confirmed that Mr A had a recurrence of this carcinoma. When Consultant 1 received the histology report, he made a note that Mr A should be admitted on 15 June 2005 to see a consultant in the Medical Oncology Unit (Consultant 2) on 16 June 2005. A referral letter was dictated but was not typed until 27 June 2005 and there is no evidence it was ever sent.

10. In March 2006, after he had been contacted by the Practice, Consultant 1 became aware that Mr A had not received any further treatment from Consultant 2. He promptly re-admitted Mr A for a further endoscopy. At this stage, the tumour had increased significantly and a CT scan of the chest confirmed enlarged lymph nodes, which can be a sign of cancer. Mr A was then referred verbally to Consultant 2 who agreed to see him the next day, 9 March 2006. The brain scan carried out on that day showed multiple brain metastases.

11. Ms C complained about the delay from when Mr A was found to have cancer to when he received treatment for this. Mr A had the endoscopy at the end of May 2005 during which the biopsy was taken, the result of which was

available in June 2005 prompting a request for admission which did not occur until March 2006. Ms C complained that, by the time Mr A received treatment, the cancer had already spread to other parts of his body and it was too late. Mr A died in May 2006.

12. During the investigation of Mr A's original complaint by the Board, it became clear that there had been a significant breakdown in communication between the Thoracic Unit and the Medical Oncology Unit. This was due to a combination of factors which the Board considered warranted further investigation and resolution. The Associate Medical Director of the Board (the Associate Medical Director) was, therefore, asked to undertake a formal review of the processes and systems involved.

13. The Board's investigation concluded that a significant contributory factor had been rapid and unexpected breakdown in the secretarial arrangements for the Thoracic Unit. Consultant 1 had the same thoracic secretary (the Secretary) for over ten years and a clear understanding and working relationship was well established which provided a high level of service to Consultant 1 and his patients. Unfortunately, the Secretary was on long term sick leave at the time this incident occurred and subsequently retired. She was replaced temporarily by various administrative co-ordinators while a new thoracic secretary was recruited. Consultant 1's typing was also distributed to other individuals within the Hospital. The administrative co-ordinators were only providing a typing service and were not aware of how the Thoracic Unit functioned on a day-to-day basis. Normally, the thoracic secretary would have been responsible for arranging for Mr A to come into the ward, however, the administrative co-ordinators did not do this. The individual who typed the letter was also not sufficiently aware of the processes and this resulted in the referral not being followed up correctly as it should have been.

14. The Board's investigation also showed that the letter of referral was finally typed on 27 June 2005. The follow-up did not take place principally due to the fact that the letter of referral was typed after the proposed admission date, and the fact that no error was noted at that stage. The investigation showed that Consultant 2 did not appear to have received the letter of 27 June 2005 and this further contributed to the problem.

15. Prior to my decision to formally investigate this complaint, the Board informed me that based on the Associate Medical Director's investigation, an

action plan had been drawn up and a number of changes made. Consultant 1 now has an established thoracic secretary employed on a permanent basis and a number of relief staff have been recruited and are available to provide cover to all Units within the Hospital during periods of annual leave or sick leave. All relief staff are fully trained and are shown the detailed systems and protocols within the Clinical Unit prior to starting work there.

16. The Board informed me that they had also reviewed in detail the protocol for referring a patient from the Thoracic Unit to the Medical Oncology Unit. It has been agreed that when the thoracic secretary types a referral letter, a standard pro-forma will also be completed and the thoracic secretary will now physically take the referral letter to the Medical Oncology Unit and hand the letter to the appropriate person. This will be recorded on the copy of the referral letter which is kept in the case note. The thoracic and oncology secretaries are in close proximity to each other and this will not cause any unnecessary delay in the system. In addition, the thoracic secretary will also email a copy of the referral letter to Consultant 2's secretary. This should guarantee that the referral has been logged at both ends and should eliminate the possibility of the referral letter being lost and not followed up as happened in the case of Mr A.

17. In addition, if the patient has to attend the Hospital as an in-patient, the thoracic secretary will notify the Thoracic Ward and the patient of the time and date of this attendance, and the ward will subsequently confirm whether or not the patient attended on that day. If the patient has to attend the hospital as an out-patient, the thoracic secretary will arrange an out-patient clinic appointment and notify the patient accordingly. The Out-patient Department will then subsequently confirm whether the patient has attended or not.

18. The Board also informed me that this incident was reported to the Clinical Risk Committee and Acute Divisional Clinical Board so that lessons might be learned for other specialities across the Acute Services Division. The revised protocol will also be issued as a standardised referral protocol across all specialities as appropriate.

19. The Adviser stated that the new procedures should make the recurrence of this chain of events much less likely in the future.

(a) Conclusion

20. It is worrying that the referral process was so dependent on one individual and that it broke down in her absence. The Board have acknowledged that there were significant failings in the referral process. This had tragic consequences for Mr A and his family. The Board have carried out a thorough investigation into the failings in the process and have taken action to change the process. The action taken by the Board to ensure that the referral process functions correctly is appropriate and I commend the Board for this action. However, given the seriousness of the failings in this case, I uphold the complaint.

(a) Recommendation

21. The Ombudsman recommends that the Board apologise to Mr A's family for their failure to properly administer Mr A's referral and also that they confirm to the Ombudsman that they have gained assurance that the new referral system functions properly.

(b) The Board did not respond appropriately to Mr A's complaint about their failings

22. In her complaint to the Ombudsman, Ms C was concerned about the scant apology offered by the General Manager of the Hospital (the General Manager).

23. The General Manager responded to Mr A's complaint on 19 April 2006. He stated that he 'was sincerely sorry to learn that Mr A had not been followed up.' His letter provided a factual background to Mr A's complaint and explained why Mr A's follow-up appointment was not made and that a formal review of practices was underway in order to take any corrective action. The General Manager went on to state that he regretted that Mr A was not followed-up appropriately following his appointment.

(b) Conclusion

24. The Board have acknowledged that there were significant failings in the way Mr A's referral was handled. This had serious consequences for Mr A as it meant that the treatment for his cancer was delayed by nine months. Mr A unfortunately died shortly after this. Further to this complaint, the Board carried out a detailed investigation and review of the procedures and produced an action plan in order to ensure measures were taken to prevent a similar situation from arising again. I commend the Board for this action. Given the repercussions of their failings on Mr A, it would have been appropriate for the

Board to provide a sincere apology to Mr A. This was not done. For these reasons, I uphold this complaint.

(b) Recommendation

25. The Ombudsman's recommendation under this complaint is covered by the recommendation under complaint (a) that the Board apologise to Mr A's family for their failure to properly administer Mr A's referral.

(c) The Practice failed to identify that Mr A was not aware of his referral to the Medical Oncology Unit

26. Mr A complained that the Practice failed to identify that he was not aware of the results of the tests carried out in May 2005 and of his referral to the Medical Oncology Unit, despite the fact that he had made enquiries of the Practice about these after the date he was scheduled to attend his referral appointment at the Hospital.

27. Mr A attended the Practice and saw a GP (GP 1) on 27 June 2005. Mr A's notes record that no letter had been received at that stage and Mr A was told to telephone back in a week. Mrs A and Ms C told me that Mr A telephoned the Practice a week after the appointment on 4 July 2005; the letter had still not been received at this time. The Practice did not receive the copy of Consultant 1's referral letter to the Medical Oncology Unit until 7 July 2005. Another GP (GP 2) saw the letter and initialled it without further action. Nothing further happened until Mr A presented much later to the Practice on 1 March 2006. At this point, it was realised that there had been a failure and the Practice contacted the Hospital.

28. The Adviser has informed me that the endoscopy and its follow-up were very much hospital care and the Hospital were responsible for follow-up and implementing care plans. When GP 1 saw Mr A on 27 June 2005, he made a reasonable plan for the patient to telephone back and the Adviser has stated that there are no grounds for criticism here. He informed me that the practicalities of communication with hospitals and delayed letters mean that GPs are not able to follow-up all such first enquiries.

29. The Adviser said that the delayed letter copied to the Practice was for information only and no action by the Practice was called for. In these circumstances, the Adviser concluded that it was reasonable for the Practice to

file this letter on the assumption that the appointment had occurred; and that the failure was at the Hospital end.

(c) Conclusion

30. When Mr A attended the Practice on 27 June 2005, the Practice had not yet received the copy of the referral letter from Consultant 1 and so were not aware that Mr A had been referred to the Medical Oncology Unit. Whilst it is unfortunate that the Hospital's failing was not noticed, it is not normal practice for GP Practices to follow-up on letters of referral as such referrals are the responsibility of the hospital. I, therefore, do not uphold this complaint.

18 July 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant, Mr A's MSP
Mr A	The aggrieved
The Hospital	Hairmyres Hospital
The Board	Lanarkshire NHS Board
The Practice	The GP Practice which Mr A attended
The Chief Executive	The Chief Executive of Lanarkshire NHS Board
The Adviser	The Ombudsman's medical adviser
Consultant 1	A consultant thoracic surgeon
Consultant 2	A consultant oncologist
The Associate Medical Director	The Associate Medical Director of Lanarkshire NHS Board
The Secretary	Consultant 1's secretary
The General Manager	The General Manager of the Hospital
GP 1	A General Practitioner at the Practice
GP 2	A General Practitioner at the Practice

Annex 2

Glossary of terms

Carcinoma	A cancer of the tissue that covers the internal and external surfaces of the body
CT Scan	A specialised form of x-ray examination that produces cross-sectional images of the body
Endoscopy	Visual examination of the interior of the body using a fibre optic instrument
Histology	The study of cells and tissue on the microscopic level
Metastases	The spread of tumour cells from one part of the body to another unrelated part of the body by the way of the bloodstream or lymphatic system
Mucosa	A mucous membrane that lines hollow organs or body cavities
Thoracic	Pertaining to the chest