Scottish Parliament Region: Mid Scotland and Fife

Case 200602210: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology, delays in appointments

Overview

The complainant (Mrs C) raised a number of concerns that there had been unacceptable delays by Forth Valley NHS Board (the Board) in arranging follow-up for her husband (Mr C) and a consequent failure to provide any treatment for him following his diagnosis of cancer.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) did not arrange timely follow-up to Mr C (*upheld*); and

(b) did not provide Mr C with treatment following his diagnosis of cancer (*not upheld*).

Redress and recommendations

In light of the action taken by the Board the Ombudsman recommends that the Board make a written apology to Mrs C for the delays in arranging the follow-up appointment and requests that they send a copy of the finalised policy on Patient Access to this office.

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

Main Investigation Report

Introduction

1. On 26 October 2006 the Ombudsman received a complaint from Mrs C that Forth Valley NHS Board (the Board) had failed to provide timely or adequate follow-up and treatment to her husband (Mr C) and that this had contributed to his death in March 2006. Mrs C first raised a complaint with the Board on Mr C's behalf on 11 January 2006 and raised further issues through her MSP (MSP 1) in July 2006. A final response was sent to MSP 1 on 4 September 2006. Mrs C was not satisfied with the response and complained to the Ombudsman's office.

2. The complaints which have been investigated are that the Board:

(a) did not arrange timely follow-up to Mr C; and

(b) did not provide Mr C with treatment following his diagnosis of cancer.

Investigation

3. Investigation of this complaint involved reviewing Mr C's clinical records and the Board's complaint file. I have met with Mrs C and I have sought the views of a medical adviser to the Ombudsman (the Adviser). A number of requests for further information were also made of the Board.

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

Medical Background

5. Mr C was diagnosed with an advanced carcinoma in May 2003 which was successfully treated at that time with surgery. Mr C was seen for follow-up and in June 2004 a blood test for CEA levels was found to be normal. A further test on 8 October 2004 showed raised CEA levels and Mr C was advised by letter on 20 October 2004 that he would be sent an appointment for follow-up ahead of the date originally planned. Following a series of events (see complaint (a)) Mr C was not finally seen by a Specialist Registrar until 9 June 2005 when a diagnosis of possible recurrent carcinoma was made. Mr C was seen by a consultant (Consultant 1) on 16 June 2005 and a biopsy taken then revealed suspicious cells, but the diagnosis was not confirmed until a further biopsy was performed on 14 July 2005. Mr and Mrs C met with Consultant 1 and a nurse (Nurse 1) on 25 July 2005 and were told that the cancer had re-occurred and

was inoperable. Mr and Mrs C considered no treatment options were given and they were simply referred to the palliative care team (see complaint (b)).

(a) The Board did not arrange timely follow-up to Mr C

6. Mrs C told me that Mr C had initially received an appointment for follow-up on 20 January 2005 but that shortly after the Christmas holidays they had received a letter cancelling this appointment. A further appointment was sent for 14 April 2005 but this was cancelled because the consultant was not to be available that day. The appointment was finally arranged for 9 June 2005.

7. In their responses to Mrs C and MSP 1 the Board stated that their records indicated that an appointment card for 20 January 2005 had been sent out. The clinic records for that date indicated that Mr C did not attend. The Board could not find any record of the appointment having been cancelled. The Board confirmed that a subsequent appointment was made for 14 April 2005 but was later cancelled as Consultant 1 was on pre-planned study leave at that date. The appointment was re-booked for 9 June 2005.

8. The Board concluded that there had been undesirable delays in Mr C's appointments which may have influenced his later management. The question of the 'cancelled' January 2005 appointment could not be explained but the subsequent delay was unacceptable and had been highlighted to staff in order to raise awareness and review current practices with a view to making necessary changes.

9. I asked the Board to provide computer printouts from the relevant booking systems and asked for further information on any changes that had been made to the booking process in light of this complaint. The computer records do not provide any information which clarifies the 'cancelled' appointment in January 2005. The Board informed me that as a result of their review following this complaint, it had become apparent that as the reason for the appointment was to check the CEA levels, the doctor who reviewed Mr C's records at the clinic on 20 January 2005 should have arranged a more urgent replacement appointment (it appears he simply asked instead for the next available slot which was in April 2005). The Board are now working on a Patient Access Policy which will outline the procedure staff should undertake following the non-attendance of a patient for an out-patient appointment. The new procedure will emphasise that the doctor must decide on the action to be taken and a note made in the medical file. The patient's GP should also be informed. There will

also be a need where there is a rescheduled appointment (as happened in April 2005) for consideration by the doctor of the urgency of review in determining the date for a new appointment.

10. The Adviser said that Mr C's cancer in 2003 was noted to be advanced and the consultant who carried out the surgery at that time considered it to have a poor prognosis. The Adviser considered the original timescale for the follow-up appointment in January 2005 to be reasonable but was critical of the fact that no urgency or priority was given to the re-arranged appointment dates as this would then have been appropriate. The Adviser noted the action being taken by the Board to address this issue would have ensured that there was a clinical review of the urgency of future appointments which he considered would have led to more prompt follow-up after January 2005.

(a) Conclusion

11. I cannot determine what actually occurred in reference to the cancelled January 2005 appointment. In saying this I am not suggesting that Mrs C's recollection of events is incorrect, nor has the Board suggested that they do not accept Mrs C's views. However, there are no records that can assist in explaining the cancellation. Based on the medical advice I have received the original January 2005 appointment was within a reasonable timescale but waiting until June 2005 was not. I note that the Board also conclude that the delays had been excessive in their response to Mrs C. I conclude that more prompt follow-up was needed and should have been arranged and that there was administrative fault in not achieving this. I, therefore, uphold this aspect of this complaint.

(a) Recommendation

12. In light of the action taken by the Board the Ombudsman recommends that the Board make a written apology to Mrs C for the delays in arranging the follow-up appointment. The Ombudsman commends the action the Board has taken to address this issue and requests that they send a copy of the finalised policy on Patient Access to this office.

(b) The Board did not provide Mr C with treatment following his diagnosis of cancer

13. Mrs C told me that when she and Mr C met with Consultant 1 and Nurse 1 on 25 July 2005, Consultant 1 was extremely blunt in breaking the news to them of Mr C's cancer and offered them no options for treatment, simply stating that

there was nothing more he could do and that they could go to the cancer unit in Glasgow if they wanted to. Consultant 1 then asked Nurse 1 to refer Mr C to the local hospice. Mr and Mrs C considered the matter for two days and decided that Mr C was too weak to travel to Glasgow for treatment.

14. In their response to Mrs C the Board stated that Mr C had been offered further treatment including chemotherapy but on considering the matter further Mr C had declined. The letter included an apology from staff if they had not appeared supportive as this was not their intention.

15. The Adviser told me that the medical notes did not contain a great deal of detail about what was discussed at the appointment on 25 July 2005 but that he would not expect them to. In a situation where a cancer is widespread and inoperable, the only treatment that can be offered is chemotherapy and/or radiotherapy, which Mr C declined. In any event such treatment would have been palliative (to reduce symptoms, especially pain) rather than offering a cure.

16. The complaint file contained a statement from Nurse 1 about the appointment in which she stated that a lot of time was spent with the couple and that she had also discussed a chemotherapy consultation with them but this was declined. Nurse 1 also discussed a hospice referral for symptom control.

(b) Conclusion

17. Mrs C found Consultant 1 to be unsympathetic and felt that no treatment options were offered. Clinical staff present at the appointment did not feel that matters were rushed and confirmed that treatment options were discussed, although I note that in this situation these options were limited to chemotherapy and radiotherapy with mention being made of attending the hospital in Glasgow where the specialist centre was. I acknowledge that this was a very difficult meeting at which Mr and Mrs C were given catastrophic news. I cannot resolve a difference in views between Mrs C and staff as to the conduct of the meeting, although I note that staff apologised if they had made Mrs C feel unsupported. The medical advice I have received is that radiotherapy and chemotherapy were the only treatment options the hospital could offer in this case and that the evidence all suggests these were offered. Based on this medical advice I do not uphold this aspect of the complaint.

18. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

19 September 2007

Annex 1

Explanation of abbreviations used

Mrs C	The Complainant
The Board	Forth Valley NHS Board
Mr C	The complainant's late husband (the aggrieved)
MSP 1	Mrs C's MSP
The Adviser	A medical adviser to the Ombudsman
Consultant 1	The Consultant in charge of Mr C'S care who gave his diagnosis to Mr C on 25 July 2005
Nurse 1	The nurse present at the meeting on 25 July 2005

Annex 2

Glossary of terms

Carcinoma	A type of cancer which often spreads to surrounding tissue
CEA levels	A chemical marker in the blood which is indicative of cancer and is used to monitor the progress of the disease