Scottish Parliament Region: Glasgow

Case 200701522: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) was concerned that he had to wait two years for an operation to remove a benign acoustic neuroma (a tumour which develops on the eighth cranial/hearing nerve), which he felt was an unacceptable amount of time. He was also concerned that no follow-up or review had been conducted within those two years.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C had to wait two years for an operation to remove a benign acoustic neuroma (*upheld*); and

(b) Mr C was seen only once by a consultant, in October 2005, and received no follow-up or review of his condition after that (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C for their failure to arrange his surgery in a reasonable timescale and for the anxiety and distress this will have caused; and

(ii) apologise to Mr C for their failure to arrange a review of his condition and for the anxiety and distress this will have caused.

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

Main Investigation Report

Introduction

1. On 31 August 2007, the Ombudsman received a complaint from a man, referred to in this report as Mr C, about the amount of time he had to wait for an operation to have a benign acoustic neuroma removed. Mr C was also concerned that he had received no follow-up or review after seeing a consultant (the Consultant) at the Southern General Hospital (Hospital 1) in October 2005.

2. The complaints from Mr C which I have investigated are that:

(a) Mr C had to wait two years for an operation to remove a benign acoustic neuroma; and

(b) Mr C was seen only once by the Consultant, in October 2005, and received no follow-up or review of his condition after that.

Investigation

3. The investigation of this complaint involved obtaining and reading the complaint correspondence between Mr C and Greater Glasgow and Clyde NHS Board (the Board). I also obtained copies of Mr C's clinical records. Regarding the clinical aspects of the complaint, I sought the advice of one of the Ombudsman's medical advisers (the Adviser).

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

Background

5. On 10 October 2005, Mr C attended Hospital 1 and saw the Consultant, who confirmed that Mr C had an acoustic neuroma. The Consultant suggested that the best course of action would be to have a period of initial interval imaging and that, only if this revealed significant growth, would they proceed to surgery. However, Mr C wished to have the acoustic neuroma surgically removed and the Consultant, who felt this was not an unreasonable option, put him on a waiting list to have the operation.

6. On 4 January 2006, Mr C emailed the Consultant saying that he had been told to expect an operation within three to six months of the consultation on 10 October 2005 and that he needed to know the exact date. The Consultant replied on 6 January 2006 stating that Mr C's memory must have been mistaken

as it was very unlikely that he would have said that waiting times were between three and six months. The Consultant said that waiting times were more in the region of six months to a year and could be even more than that. He said he was sorry that he could not give Mr C any more information.

7. On 26 June 2006, Mr C's general practitioner (the GP) wrote to the Consultant stating that she had signed Mr C off work because of increasing dizziness, poor balance and daily left-side headaches. The GP asked, given Mr C's anxiety about these new features, that his position on the waiting list be reviewed. The Consultant replied on 14 July 2006 stating that he had been trying to negotiate extra theatre sessions in order to deal with cases similar to Mr C's who had been on the waiting list a long time. He said that he had some success in this but had still not secured enough theatre time to make the waiting list an acceptable length. He said that Mr C was getting fairly near the top of the list and that he hoped to perform the surgery within the following three months or so.

8. On 2 November 2006, the GP wrote to the Consultant again explaining that Mr C's condition was deteriorating. The GP asked for an indication of the likely timescale for Mr C's admission.

9. On 24 November 2006, the Consultant wrote to Hospital 1's General Manager explaining that Mr C had been on the waiting list for over a year and that, while he recognised that efforts had been put into trying to find temporary arrangements to deal with the waiting times, he felt strongly that there had to be some long-term solution to the continuing problem. Mr C asked for a meeting to discuss the situation (the documents I have seen do not indicate whether a meeting took place or what its outcome was).

10. On 30 March 2007, a consultant anaesthetist (the Anaesthetist) at Royal Alexandra Hospital (which Mr C was attending for a laparoscopic cholecystectomy – an operation to remove the gall bladder) wrote to the surgeon who was due to carry out the operation stating that he was concerned about Mr C's symptoms of worsening balance and possible slurring of speech. The Anaesthetist said that Mr C had not had any imaging since his initial diagnosis 18 months previously and that he had, therefore, arranged for him to have another Magnetic Resonance Imaging (MRI) scan to exclude any significant increase in the size of the acoustic neuroma. The letter was copied to the Consultant.

11. On 11 April 2007, the Consultant wrote to the Anaesthetist saying that Mr C had been on the waiting list since October 2005 to have the acoustic neuroma removed but that, for a number of reasons, there had been quite a significant delay in patients like Mr C having their surgery carried out. The Consultant said he would be very interested to know if the follow-up MRI scan revealed any significant increase in the size of the acoustic neuroma.

12. On 19 April 2007, the Anaesthetist wrote to the Consultant enclosing a copy of the MRI scan report. This indicated that the acoustic neuroma was slightly bigger than on the previous MRI scan.

13. On 22 May 2007, Mr C's MSP (the MSP) wrote to the Board's Chief Executive on Mr C's behalf complaining about the delay in arranging his surgery. The Board sent an acknowledgment on 25 May 2007. On 11 June 2007, the MSP wrote to the Board enclosing a consent form signed by Mr C which authorised the MSP to pursue a complaint on his behalf. On 14 June 2007, the Board acknowledged receipt of this form.

14. On 10 July 2007, the Board wrote to the MSP stating that the investigation of her concerns was not yet complete. They apologised for the delay and said they would keep the MSP updated on progress.

15. On 13 July 2007, the Consultant wrote to Mr C stating that he was aware of his concerns about the long wait he had experienced despite the fact that a further MRI scan had indicated the acoustic neuroma was growing in size. The Consultant said he was very frustrated about the lack of any progress in obtaining adequate theatre time for cases like Mr C's. He said that although temporary solutions had been found for some individual patients, no long-term solutions had been found.

16. On 14 August 2007, Mr C's MSP wrote to the Consultant, enclosing her letter to the Board dated 22 May 2007, asking whether the reason for the lack of theatre time available was financial and why Mr C had not been examined or had any follow-up since his first examination at Hospital 1 in October 2005.

17. On 17 August 2007, the Consultant wrote to Mr C explaining that he had received copies of the MRI scan. He said these showed a slight but significant increase in the size of the acoustic neuroma. The Consultant said he was no

further forward in arranging for the operation to be carried out at Hospital 1 and, therefore, he had contacted colleagues in other neurosurgical units in Scotland. He said that a colleague in Edinburgh had agreed to have Mr C admitted to the Western General Hospital (Hospital 2). The Consultant asked Mr C whether he would be happy with that arrangement.

18. Also on 17 August 2007, the Consultant wrote to Mr C's MSP stating that he had been doing the type of operation Mr C was due to have for 25 years in collaboration with one of his neurosurgical colleagues. He said that since his colleague had retired, the service Hospital 1 had been able to offer had significantly deteriorated. He said the fundamental problem was lack of access to staffed theatres to do difficult and complex cases. He explained that he had made himself available at any time to go to theatre to do these cases, but despite numerous meetings with all levels of management there did not seem to be any permanent solution to the problem. In commenting on a draft of this report, the Board said that their neurosurgical colleagues did not agree with the Consultant's view that the service offered by Hospital 1 had deteriorated.

19. In the same letter, the Consultant said he felt pessimistic about the possibility of there being a local solution to the problem. He explained, as at paragraph 17 above, that he was in the process of arranging for Mr C to have his operation at Hospital 2. He said he was sorry that things had reached that stage at Hospital 1 but he felt that, from Mr C's point of view, this was the only way forward.

20. On 22 August 2007, the Board wrote to the MSP stating that their investigation was not yet complete and that, as it had exceeded 40 working days, she could now refer the complaint to the Ombudsman. On 30 August 2007, the MSP wrote to the Board stating that the complaint would be referred to the Ombudsman. On 5 October 2007, the Board wrote to the MSP apologising for the delay in responding to her concerns, which they said was entirely due to having to wait for a date for Mr C's surgery to finally be scheduled. The Board explained that, with the surgery Mr C was due to have, there were clinical difficulties and complications involved in arranging dates. They said the surgery involved a multi-disciplinary approach between Otology (the branch of medicine relating to the ear) and Neurosurgery (surgical treatment of diseases or disorders of the brain and nervous system). They said that surgery time was normally in excess of 12 hours and that patients required neurosurgery intensive care facilities post-operatively. They said such cases

required a sophisticated level of scheduling to ensure that all elements of surgical input and post-operative care were in place. The Board said, however, that they had now arranged for Mr C's surgery to be carried out on 11 October 2007. Mr C, during a telephone conversation on 24 October 2007, told me that he had gone ahead with the operation and that the acoustic neuroma had been successfully removed.

(a) Mr C had to wait two years for an operation to remove a benign acoustic neuroma

21. In response to my investigation, the Board said they recognised there were significant omissions in Mr C's clinical care. They said that, as a result, they had been changing their service to improve the delivery of care to patients with similar conditions.

22. The Board explained that patients who presented with acoustic neuromas were initially investigated by a neuro-otologist and that MRI scans were taken to determine the size of a tumour. They said patients with tumours had their diagnoses discussed and those patients with small or medium sized tumours were told that, usually, surgical treatment was only considered if the tumour was seen to be growing on MRI scans taken at intervals.

23. The Board explained that Mr C had his tumour diagnosed by his local service in Paisley prior to his referral to the neuro-otology service. They said that when he attended Hospital 1 for his first visit, the Consultant recalled that Mr C had already extensively researched his condition and treatment options on the internet. The Consultant reported that Mr C was strongly of the opinion that he wished surgery for his acoustic neuroma. The Board said the Consultant discussed this with a consultant neurosurgeon (the Neurosurgeon). The Neurosurgeon advised that there was no need for neurosurgical involvement at the time, given the clinical presentation and the size of the tumour. The Board explained that the Consultant, therefore, planned to operate on Mr C himself. The Board said, however, that due to a combination of pressure on neurosurgical operating lists (which were the lists the Consultant had access to), the availability of post-surgical support and the Consultant's own availability, it was not possible to carry out the operation until October 2007.

24. The Board told me that the Consultant had several other patients who had been referred to him with small or medium sized tumours, some of whom had been listed for surgery. They said that, following Mr C's complaint, all patients

in the Consultant's care were undergoing a case note review by another neuro-otologist to ensure that the MRI scans were up-to-date and that the surveillance programme was being properly maintained. They explained that follow-up MRI scans, other investigations and surgery would be arranged following this review where appropriate.

25. The Board said it was recognised that a multi-disciplinary approach to tumour management was the most appropriate way to manage patients such as Mr C. They said that, to that end, a regular meeting was being instituted between the Consultant, the other neuro-otologist he worked with and the Neurosurgeon. They said that all existing and new patients would be reviewed at this meeting, which would streamline the admission process for those requiring surgery. They said that patients with small and medium sized tumours would be monitored on an annual basis and that an MRI scan would be taken at an annual clinic visit.

26. The Board said that all new patients and those who had received their annual surveillance visit would be reviewed at the monthly multi-disciplinary team meeting at which treatment options for patients would be agreed. Patients would subsequently be seen within three to four weeks of the meeting. The Board said that if the agreed course of treatment was surgery this would be arranged within the appropriate timescale for their clinical urgency and, in any event, within 18 weeks, in line with the national waiting time guarantee. The Board said this new process would ensure that acoustic neuromas were managed via a multi-disciplinary approach and to an agreed treatment protocol. They said the approach was used for many other tumour sites as clinical evidence showed that it resulted in better outcomes for patients.

27. The Board explained that the length of time a patient would have to wait, varied, based on their clinical condition. They said that most acoustic neuromas did not grow, or grew very slowly, but that a smaller number were either larger or grew more rapidly and, therefore, had greater clinical urgency. The Board said it was intended that all patients would be treated within the 18 weeks guarantee.

28. The Board said that patients were not routinely given written information about waiting times, but that this information would be given during consultations. They said that, in Mr C's case, the Consultant regretted that the waiting time information he gave him was inaccurate.

29. I asked the Adviser for his comments on the Board's response, as I wanted to know whether it was reasonable from a clinical perspective. The Adviser's comments are summarised at paragraphs 30 and 31 below.

30. The Adviser said the Board acknowledged that the waiting time was too long and explained that the delay was due to a logistical issue. He said they had recognised that this led to inadequate waiting times and had explained how they were going to prevent a reoccurrence and how they would ensure that surgery was received within 18 weeks.

31. The Adviser said that conditions that required collaborative surgery between different specialties could result in excessive delays for patients. He said that this in no way excused what was an unacceptable delay in treating Mr C, but that he considered that the Board had recognised why the delay had happened and put systems in place to ensure the same thing did not happen again. The Adviser considered that the Board had taken an honest approach to the complaint and that the new system the Board had put in place was a reasonable one.

(a) Conclusion

32. The Board have acknowledged that it took longer than it should for Mr C to have his surgery. As a result of Mr C's complaint, the Board have changed their system for managing patients in order to ensure that those on a waiting list for surgery, receive it in 18 weeks. The Adviser has told me that the system the Board has put in place is reasonable and should ensure that the problems identified here do not occur again in future.

33. In light of the above, I find that there was an unreasonable delay in Mr C's surgery being arranged in this case. Consequently, I uphold the complaint.

34. I am satisfied that the changes to the Board's system adequately address the problems identified in this report and will ensure they are not repeated in future. The only matter outstanding in terms of redress is dealt with in the recommendation at paragraph 35 below.

(a) Recommendation

35. The Ombudsman recommends that the Board apologise to Mr C for their failure to arrange his surgery in a reasonable timescale and for the anxiety and distress this will have caused.

(b) Mr C was seen only once by the Consultant, in October 2005, and received no follow-up or review of his condition after that

36. The Board said there was no written guidance which detailed when, and how often, patients should be reviewed pending surgery. They said that other departments in the UK adopted the surveillance programme (detailed at paragraph 26 above) to determine whether patients required surgery. The Board said that patients with small tumours would only be offered surgery if the size of the tumour increased significantly. They said that as all patients who were listed for surgery would, in future, have it done within 18 weeks, the issue of scans being required pending surgery would no longer exist.

37. The Board said that, in Mr C's case, it would have been good practice for him to have a follow-up MRI scan one year after the initial consultation to assess the growth of his tumour. The Board said that the Consultant did not conform to best practice and regretted that he did not arrange a follow-up MRI scan for Mr C. The Board also acknowledged that the letters from Mr C's GP should have prompted a further review. In addition, the Board acknowledged that the findings of the MRI scan in April 2007 should have prompted a further follow-up and that the Consultant regretted that had not been offered at the time. The Board acknowledged that it took longer to arrange surgery than it should have done.

38. I asked the Adviser for his comments regarding this point of complaint. He said the Board had acknowledged that a follow-up should have been arranged. He said that the new system put in place by the Board to manage patients would ensure that this error would not occur again in future.

(b) Conclusion

39. The Board have acknowledged that Mr C should have had a follow-up after one year; that letters from Mr C's GP should have prompted a follow-up; and that scans taken at Hospital 2, which showed that Mr C's acoustic neuroma had grown, should have prompted a review. The Adviser agrees that a review or follow-up should have occurred. He considers that the new system put in

place by the Board will help to ensure that the problem Mr C encountered will not occur again.

40. In light of the above, it is clear that the Board failed to carry out a review of Mr C's condition. Consequently, I uphold the complaint.

41. As at paragraph 34 above, I am satisfied that the changes to the Board's system that have been introduced will address the problems identified in this report and will ensure they are not repeated. The only outstanding matter in terms of redress is dealt with in the recommendation at paragraph 42 below.

(b) Recommendation

42. The Ombudsman recommends that the Board apologise to Mr C for their failure to arrange a review of his condition and for the anxiety and distress this will have caused.

43. 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.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Consultant	A consultant responsible for Mr C's care and treatment
Hospital 1	Southern General Hospital
The Board	Glasgow and Clyde NHS Board
The Adviser	One of the Ombudsman's medical advisers
The GP	Mr C's general practitioner
The Anaesthetist	An anaesthetist at Royal Alexandra Hospital
MRI	Magnetic Resonance Imaging
The MSP	Mr C's MSP
Hospital 2	Western General Hospital, Edinburgh
The Neurosurgeon	A neurosurgeon at Southern General Hospital

Annex 2

Glossary of terms

Acoustic neuroma	A tumour which develops on the eight cranial/hearing nerve
Laparoscopic Cholecystecomy	An operation to remove the gall bladder
MRI scan	A Magnetic Resonance Imaging scan
Neurosurgery	Surgical treatment of diseases or disorders of the brain and nervous system
Otology	The branch of medicine dealing with the ear