Scottish Parliament Region: Central Scotland

Case 201203086: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Diagnosis; cancer; communication

Overview

The complainant (Mr C) raised concerns about delays by NHS Lanarkshire (the Board) in diagnosing his lung cancer and about the way that the diagnosis was communicated to him. Mr C had been attending the Neurology Department at Monklands Hospital (Hospital 1), when a Computerised Tomography (CT) scan at Southern General Hospital in May 2012 showed a suspected nodule in his lung. A second CT scan was requested in June 2012, but Mr C was not told about the suspected nodule in his lung. On 14 August 2012 Mr C was attending his GP Practice about another matter, when he was informed that the May CT scan had shown a possible diagnosis of cancer. There were repeated delays in arranging the second CT scan and Mr C did not undergo this CT scan until 7 September 2012 at Hairmyres Hospital, despite both he and his GP pursuing the matter. Following the second CT scan, Mr C was not seen by the Neurology department until 18 September 2012, when he was told it was almost certain that he had cancer. He was then seen by a respiratory consultant on 3 October 2012, and a biopsy was carried out on 4 October 2012. It was confirmed to Mr C that he had cancer of the lung on 15 October 2012.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to carry out appropriate tests in order to diagnose Mr C's condition within a reasonable timescale (upheld); and

(b) the Board failed to keep Mr C reasonably informed about the results of his tests (upheld).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) confirm when the order-comms system will be fully operational in all the hospitals they are responsible	4 December 2013

	for;	
(ii)	provide evidence that they have reviewed with the clinical staff involved why no report of the failures identified in this report was made on the Datix system;	18 December 2013
(iii)	provide evidence that they have carried out a Critical Incident Review;	18 December 2013
(iv)	review the arrangements for providing cover for absent staff to ensure that urgent test results are reviewed timeously;	18 December 2013
(v)	review the procedures within the Radiology Department at Hospital1 to ensure that urgent test requests are identified and treated appropriately to avoid undue delay to patients;	18 December 2013
(vi)	provide evidence that clinical staff have been reminded of the importance of effective communication with patients, especially when there may have been changes to their diagnosis; and	18 December 2013
(vii)	apologise in writing for the failures identified in this report.	4 December 2013

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

Main Investigation Report

Introduction

1. Mr C has raised concerns about the delays by NHS Lanarkshire (the Board) in diagnosing his lung cancer and the way that the diagnosis was communicated to him. Mr C had been receiving treatment from the Neurological Department at Monklands Hospital (Hospital 1) under the care of a visiting Consultant Neurologist (Consultant 1). On 2 May 2012 Mr C was referred for a Computerised Tomography (CT) scan of his head and chest at the Southern General Hospital (Hospital 2). The results of the CT scan showed a suspected lung nodule and in June 2012 Mr C was referred for a second CT scan at Hospital 1.

2. Mr C was contacted by letter on 16 July 2012 by Hospital 1, advising him that he needed to undergo blood tests prior to the second CT scan. Mr C had to undergo three blood tests, as the results were not initially deemed satisfactory. These tests were taken at his GP Practice and the final results were dispatched on 7 August 2012. Mr C telephoned Hospital 1, due to the time elapsed, but was assured that a CT scan would still be requested.

3. Mr C attended his GP's Practice on 14 August 2012 on a different matter and was informed during the appointment that the May CT scan had shown a possible nodule in his lung. Mr C's GP telephoned Hospital 1 on 22 August 2012, as no date for the second CT scan had been provided. Mr C said that his GP telephoned the hospital twice, and he had also contacted them. He was informed that the Radiology Department had not matched the blood test results to the CT scan request and had consequently rejected the request. Mr C was told that the Consultant 1 only worked one day a week at Hospital 1 and that she was on holiday, and would return to work on 27 August 2012. Mr C was assured that an appointment would be made for him at Hairmyres Hospital (Hospital 3).

4. The Neurology Department at Hospital 1 contacted the Radiology Department at Hospital 3. The Radiology Department informed them that the request for a second CT scan had been rejected as they were unable to see the results of Mr C's previous scans on the Hospital 1's IT system.

5. Mr C made a formal complaint to the Board on 31 August 2012 by letter. The letter was acknowledged by the Board on 4 September 2012. Mr C

received his second CT scan on 7 September 2013. On 18 September 2013 Mr C was informed that he had cancer and that his treatment would be taken over by the Department of Respiratory Medicine.

6. In their response to Mr C's formal complaint on 3 October 2012, the Board acknowledged that delays had occurred and apologised for these. They said that these would in part be addressed by the implementation of Order Comms and electronic reporting systems, which would produce an audit trail of investigations. GPs would also be able to view this system. At the time of investigation, however, technical difficulties had prevented this system from being implemented by Hospital 1 or Hospital 3.

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

(a) the Board failed to carry out appropriate tests in order to diagnose Mr C's condition within a reasonable timescale; and

(b) the Board failed to keep Mr C reasonably informed about the results of his tests.

Investigation

8. Investigation of the complaint involved reviewing the information received from Mr C and the Board's medical records for Mr C. My complaints reviewer also obtained advice from an independent medical adviser who is a consultant in Respiratory Medicine (the Adviser).

9. 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.

(a) The Board failed to carry out appropriate tests in order to diagnose Mr C's condition within a reasonable timescale

10. Mr C was attending the Neurology Department at Hospital 1 in April 2012. He was referred for a CT scan of his head to Hospital 2, with the first CT scan taking place on 2 May 2012. The CT scan showed a possible nodule in Mr C's lung. Consultant 1 wrote to his GP on 25 May 2012 following her review of his first CT scan. The first CT scan report was verified on 26 June 2012 at Hospital 2, recommending review by a general radiologist. Consultant 1 wrote again to his GP on 12 July 2012 noting this finding and advising that a second CT scan of Mr C's chest had been arranged. The request for the second CT scan was received by the Radiology Department on 11 July 2012.

11. Mr C was contacted on 16 July 2012 by Hospital 1, advising him that he needed to attend his GP Practice to have blood samples taken. It took three attempts for Mr C to provide satisfactory samples did this and these were dispatched on 7 August 2012. Mr C was not informed by Consultant 1 why he required a second CT scan. He did telephone Hospital 1, as he was concerned as to the length of time it had taken him to provide blood samples; he was, however, assured that the second CT scan would proceed.

12. On 14 August 2012 Mr C attended his GP Practice about another matter. During the course of his appointment he was informed that the CT scan in May had shown a possible nodule on his lung, which could indicate that he was suffering from cancer. Mr C said that he was shocked and upset by this news, especially as three months had elapsed since the first CT scan was carried out. Mr C's GP called Hospital 1 on 22 August 2012 as Mr C was still awaiting an appointment for his second CT scan.

13. Following this telephone call, the Neurology Department at Hospital 1 contacted the Radiology Department at Hospital 1. They were informed by the Radiology Department that the request had been rejected, as the results of Mr C's previous CT scan could not be seen on the internal IT systems. On 23 August 2012, when Mr C telephoned the Neurology Department, he was informed that the request for the second CT scan had been rejected, but that the Neurology Department had not been informed of this.

14. Consultant 1 was not based at Hospital 1 and only attended it once a week. On 27 August 2012, when she was next at Hospital 1, she filled out a new scan request card. Mr C contacted Hospital 1 again on 31 August 2012 as he had still to receive an appointment for a second CT scan. The Neurology Department then contacted the Radiology Departments at Hospital 1 and Hospital 3, but was informed that neither had received a scan request. Mr C then made a formal complaint in writing on 31 August 2012.

15. On 3 September 2012, the Neurology Department again checked with the Radiology Departments at Hospital 1 and Hospital 3, but the request had not been received by either department. Mr C was not informed the second appointment request card had gone missing. A further scan request was faxed to Hospital 3 on 4 September 2012 and delivered by hand to the Radiology Department at Hospital 1 and faxed to the Radiology Department at Hospital 3.

On 5 September 2012 Mr C was given an appointment for a second CT scan on 7 September 2012 at Hospital 3. Mr C was informed by Consultant 1 that it was likely he had cancer on 18 September 2012. This diagnosis was confirmed following a biopsy on 15 October 2012, some four months after the second CT scan was first requested.

16. The Board responded formally to Mr C's complaint on 3 October 2012. They acknowledged that there had been an unacceptable delay in arranging Mr C's second CT scan and apologised for this. The Board explained that the initial delay had been caused by Radiology staff being unable to access the blood test results supplied by Mr C. Once staff had the blood test results, the request had been rejected following a review by a consultant radiologist (Consultant 2), as there was no record of any previous CT scan having taken place within the Health Board's region. Consultant 2 had undertaken this review in order to ensure that Mr C was not exposed to radiation unnecessarily. Consultant 2 had also been considering whether the test could be carried out at Mr C's local hospital (to avoid him having to travel). The Board said that staff were now able to access blood test results electronically. The Board said they appreciated that this was a distressing time for Mr C and that they regretted any deficiencies in their service which had added to this distress.

17. Mr C rejected the Board's response as he did not consider that it addressed all the fallings he had experienced. He also felt that the letter failed to show sufficient understanding of the traumatic nature of his experience, or the strain that the episode had placed on his family.

Advice Received

18. The Adviser said there were a series of failings which contributed to the unacceptable delay in arranging Mr C's second CT scan. In the Adviser's opinion, Mr C should have been referred to respiratory physicians on 10 July 2012 when his neurology consultant reviewed his CT report, which indicated a possible nodule on Mr C's lung. The failure to do this meant that Mr C was not seen by a respiratory physician until 1 October 2012, contributing to the delay in his diagnosis.

19. The Adviser said that the records showed confusion and mismanagement in the Radiology Department at Hospital 1. The Radiology Department should have had in place a system for highlighting any suspected cancer findings on CT scans directly to the patient's GP or a chest physician. This would reduce

unnecessary delays. The Adviser went on to say that specifically, the 10 July request for the second CT scan for Mr C should not have been rejected even once the two week period for return of his blood test results had expired. He said that the request form should have been assessed on its merits and the seriousness of the suspected condition should have been considered by the Radiology Department. Given that the request was made for a suspected cancer diagnosis, some effort should have been made to contact Mr C, his GP or Consultant 1 to arrange a fresh blood test as a matter of urgency. Rejecting the request effectively ensured there would be an additional delay, as a new request card would have to be completed and submitted.

20. The Adviser then said the rejection of the second CT scan request card on the basis that no recent imaging was available on Hospital 1's internal computer system was unacceptable, particularly given the request was for a suspected cancer. The Adviser said the Radiology Departments at Hospitals 1, 2 and 3 should have robust systems of communication and synchronisation of radiology request forms specifically designed to avoid this type of delay.

21. In addition the Adviser commented that the CT report of 21 May 2012 had a note on it saying it should have been assessed by a general radiologist. There was no evidence that this assessment was ever carried out. He said that the reporting Radiologist should have taken the initiative to ask his colleague to assess it further and report it with an addendum. The Adviser noted that it was six weeks before Consultant 1 reviewed the CT report on 10 July 2012 and requested a second CT scan.

22. Overall the Adviser said there were a string of failures on the part of the Health Board and specifically on the part of the Radiology Department at Hospital 1 in diagnosing Mr C's cancer. He said that the CT scan had been the appropriate test to confirm the status of the nodule and surrounding lung tissue. He said that Consultant 1 only attended Hospital 1 once a week, and during the period Mr C was awaiting the second CT scan she was on leave for a two week period, the Board should have in place procedures to ensure high risk patient's CT scan results were reviewed in her absence by a colleague of appropriate seniority.

23. The Adviser described the delays from the Radiology department at Hospital 1 as ‘inordinate’, caused by inadequate systems and management and a lack of co-ordination in dealing with imaging requests. Specifically there was

no robust plan for distinguishing between urgent and routine requests, or for identifying and prioritising possible cancer patients.

24. The Adviser believed that there had been an unacceptable delay of four months in Mr C's diagnosis. The Adviser went on to say that although he noted that the Board had repeatedly apologised they had not investigated what he considered a major failure as either a critical incident, or a serious adverse event and as such he could not be confident that adequate steps had been taken to ensure that a similar incident could not occur again.

(a) Conclusion

25. The Advice I have received is that there were unacceptable delays in arranging the second CT scan for Mr C. I note the Board have accepted this and that they have offered apologies for these delays. It is though a matter of concern that despite the clear difficulties that the card based scan request system has caused in this case, at the time of the investigation the electronic systems intended to replace this request system had not been introduced, due to technical difficulties. In addition the Board has not conducted a Serious Incident Review into the delay in diagnosing Mr C's cancer, although the Adviser described it as a major failure. The Board have advised that as the delays were not recorded on the Datix system, they had not been reported as a serious clinical incident. The Board do not appear to have considered whether the delays should have been recorded on the Datix system, which I consider a failure on the part of their investigation into the complaint.

26. After Mr C was first suspected of having cancer, his case should have been considered a priority. In the event a combination of failures and inadequate systems resulted in a four month delay in diagnosing Mr C's cancer. In view of these failings I uphold the complaint.

(a) Recommendations

27. I recommend that the Board:	*Completion date*
(i) confirm as a matter of urgency when the order-comms system will be fully operational in all the hospitals they are responsible for and in the meantime ensure that the card based system in use for appointment requests is adequate;	4 December 2013
(ii) provide evidence that they have reviewed with the	18 December 2013

	clinical staff involved why no report of the failures identified in this report was made on the Datix system;	
(iii)	confirm that they have carried out a Critical Incident Review;	18 December 2013
(iv)	review the arrangements for providing cover for staff to ensure that urgent test results are reviewed timeously; and	18 December 2013
(v)	review the procedures within the Radiology Department at Hospital 1 to ensure that urgent test requests are identified and treated appropriately to avoid undue delay to patients.	18 December 2013

(b) The Board failed to keep Mr C reasonably informed about the results of his tests

28. Mr C's CT scan on 21 May 2012 showed a possible nodule in his lung. Mr C was not informed of this and discovered that he might be suffering from a cancer of the lung at an appointment at his GP Practice on 14 August 2012. Consultant 1 had written to Mr C's GP on 12 July 2012 advising the GP of the results of the first CT scan and advising that a second CT scan had been arranged.

29. In addition Mr C has complained that even once he had had the second CT scan on 7 September 2012, he did not receive an appointment with Consultant 1 until he telephoned the Consultant's her on 17 September 2012.

30. The Board said that Consultant 1 did not wish to discuss Mr C's possible cancer diagnosis with him until she had received the results of the second CT scan. Unfortunately as the second CT scan was delayed, Mr C discovered the results of the first CT scan following a conversation with his GP. The Board said they had not apologised to Mr C for this incident, as although he mentioned it in his letter of complaint to the Board, they did not consider it to be the substantive matter he was complaining about.

31. The Board said that Consultant 1 attended Hospital 1 one day per week, during which time she reviewed all test results from the preceding week. She would have held her next clinic following the scan on 7 September 2012 on the 10 September 2012. She was, however, on study leave and, therefore, the first

opportunity to review the results was on 18 September 2012. Mr C was, therefore, contacted and invited to attend the clinic that afternoon.

32. I asked the Adviser who was responsible in their opinion for informing Mr C about the results of the first CT scan in May given the implications that the scan's result had for his diagnosis and treatment. The Adviser said that Consultant 1's responsibilities were set out in the General Medical Council guidance on Good Medical Practice – Good Communication:

> 'to communicate effectively you must:
>
> a) Listen to patients, ask for and respect their views about their health and respond to their concerns and preferences
>
> b) Share with patients in a way they can understand, the information they want or need to know about their condition, its likely progression and the treatment options available to them, including associated risks and uncertainties
>
> c) Respond to patients' questions and keep them informed about the progress of their care
>
> d) Make sure that patients are informed about how information is shared within teams and among those who will be providing their care.'

The Adviser said that the responsibility, therefore, rested with Consultant 1 to inform him of changes in his diagnosis and treatment. When a new investigation was requested, it should have been communicated to the patient by letter or telephone, so that it was not a surprise or a source of worry to the patient.

(b) Conclusion

33. The advice I have received is that the responsibility for informing Mr C lay with Consultant 1. Clearly this did not happen, even when it was apparent that the second CT scan had been delayed. Mr C should have been informed at the same time as his GP, to allow him to process the information and prepare himself and his family for the likely diagnosis of cancer.

34. The evidence presented does not contradict Mr C's assertion that he was not contacted prior to the clinic on 18 September 2012 and that it was only due to his telephone conversation with Consultant 1's secretary that he was booked into this clinic. There are no appointment letters, which I would expect to see on file, nor is there evidence that it was explained to Mr C that Consultant 1 would not be able to see him on 10 September 2012 as she was absent.

35. It is clear that the standard of communication with Mr C was not of an acceptable standard. The failure to communicate appropriately with him added to the distress and uncertainty that he and his family experienced. Although I accept the Board did not consider this part of his original complaint, it should be acknowledged and the Board should take steps to ensure that the importance of timely communication with patients is emphasised to staff. I uphold this complaint.

(b) Recommendations

36. I recommend that the Board:	*Completion date*
(i) provide evidence that clinical staff have been reminded of the importance of effective communication with patients, especially when there may have been changes to their diagnosis; and	18 December 2013
(ii) apologise in writing for the failures identified in this report.	4 December 2013

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	NHS Lanarkshire Health Board
Hospital 1	Monklands Hospital
Consultant 1	Visting Consultant Neurologist at Monklands Hospital
CT	Computerised Tomography
Hospital 2	Southern General Hospital
GP	General Practitioner
Hospital 3	Hairmyres Hospital
The Adviser	Consultant in Respiratory Medicine
Consultant 2	Consultant Radiologist at Monklands Hospital

Glossary of terms

computerised tomography (CT) scan	a scan using x-rays and a computer to create detailed images of the inside of the human body
Critical Incident Review	a process for reviewing incidents that cause or could cause unintended harm to a patient as a result of the healthcare provided to them, to prevent their reoccurrence
Datix system	a computerised system for reporting and recording incidents affecting patient safety
General Medical Council	the body which registers doctors, allowing them to practice in the United Kingdom. Promotes and upholds standards for the medical profession
neurology	medical specialism dealing with disorders of the nervous system
nodule	a spot on the lung three centimetres or less in diameter. May be malignant (cancerous)
Order-Comms	electronic system allowing doctors to request tests make referrals and review test results
radiology	medical speciality in the use of imaging to diagnose and treat diseases in the human body
respiratory medicine consultant	a doctor specialising in diseases of the respiratory system, including the lungs

Annex 3

List of legislation and policies considered

General Medical Council, Guidance for Doctors, *Good Medical Practice, section 22, Good communication*