Scottish Parliament Region: Mid Scotland and Fife

Case 201303189: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; oncology

Overview

The complainant (Mr C) raised concerns about the time it took to diagnose Mr A with liver cancer.

Specific complaint and conclusion

The complaint which has been investigated is that there was an avoidable delay in diagnosing that Mr A was suffering from liver cancer (*upheld*).

Redress and recommendations

The Ombudsman recommends that: Fife NHS Board (the Board):	*Completion date*
(i) review their processes for communicating abnormal results to include referral to an appropriate lead clinician in the hospital as well as the referring doctor in light of the Medical Adviser's comments; and	24 October 2014
(ii) apologise for the failures identified.	24 October 2014

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

Main Investigation Report

Introduction

1. On 20 May 2011, Mr A underwent a magnetic resonance imaging (MRI) scan. The findings of the scan suggested that Mr A had liver cancer and the radiologist recommended that Mr A be referred to a specialist centre for further investigation and treatment. The results of the scan was sent to Mr A's general practitioner (GP), who assumed that a hospital specialist would follow up. However, the hospital specialist did not receive the results and discharged Mr A from his care. Mr A asked his GP about the MRI scan in January 2012 and it then became clear that the findings of the scan had not been acted on. A second MRI scan was performed on 19 March 2012, which showed that Mr A had an inoperable cancer tumour. Mr A died on 1 October 2012. Mr C complained about the delay in the result of the MRI scan carried out in 20 May 2011 being acted on.

2. The complaint from Mr C which I have investigated is that there was an avoidable delay in diagnosing that Mr A was suffering from liver cancer.

3. Mr A[1] complained to Fife NHS Board (the Board) on 7 June 2012. The Board responded on 3 September 2012, 10 October 2012 and 22 August 2013. Mr A's sister, Mrs D, was unhappy with their response and Mr C brought her complaint to us on 17 October 2013.

Investigation

4. During the course of the investigation of this complaint, my complaints reviewer obtained and examined a copy of Mr A's medical records and the Board's complaint file. She obtained advice from an adviser to the Ombudsman on the clinical aspects of the complaint who specialises in oncology (the Medical Adviser).

5. 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.

Clinical background

[1]Mr A died a few months after raising his complaint with the Board and Mr C took the complaint forward on behalf of Mr A's sister, Mrs D.

6. On 8 February 2011, Mr A's GP referred him to Queen Margaret Hospital (the Hospital) for an ultrasound scan of his abdomen, which was carried out on 1 March 2011. The scan showed a potential cancerous lesion in the liver and the radiologist (who undertook the scan) recommended further investigation and arranged a computerised tomography (CT) scan. The GP was notified of the findings and he referred Mr A to a consultant physician and gastroenterologist (Consultant 1) at the Hospital. In the meantime, the CT scan suggested that the liver lesion was more likely to be benign (non-cancerous). However, an MRI scan was recommended by the radiology department who directly arranged this. Consultant 1, who was aware of plans for an MRI scan, saw Mr A on 28 March 2011 and discharged him on the basis of the CT scan findings. The findings of the MRI scan undertaken on 20 May 2011 suggested that the lesion was very likely to be liver cancer and the radiologist recommended referral to a specialist centre for further investigation treatment. The findings were sent to Mr A's GP, but not Consultant 1, who had discharged Mr A. Instead, the findings were sent to another general physician and gastroenterologist (Consultant 2) who had seen Mr A, but who had since left the Board. In January 2012, Mr A asked his GP about the results of the MRI scan and the GP referred Mr A back to the hospital for further investigation. A second MRI scan was performed on 19 March 2012 which showed that Mr A had an inoperable cancer tumour. Mr A died on 1 October 2012.

Complaint: There was an avoidable delay in diagnosing that Mr A was suffering from liver cancer

7. Mr C specifically complained about the delay in the result of the MRI scan carried out on 20 May 2011 being acted on. For ten months, Mr A heard nothing about the results and received no treatment. By the time a second MRI scan was performed, Mr A only had a short while to live. Mr C was extremely concerned that no action was taken on the first MRI scan.

Board response

8. The Board apologised for the significant delay in following up the result of the MRI scan of 20 May 2011 saying it appeared there had been a complex miscommunication between the Board's diagnostic services, the secondary care specialists and general practice.[2]

[2] I am not investigating the GP practice, but I have included this information to provide a full picture of what happened.

9. The Board explained that on 8 February 2011 the GP made an electronic referral to radiology and an ultrasound scan was arranged for 1 March 2011. In March 2011, the GP also made a referral to Consultant 1, who arranged an appointment for 28 March 2011. An ultrasound scan was performed on 1 March 2011 which identified a liver abnormality prompting further investigation. The GP was notified of the findings. An urgent appointment was made for a CT scan, which was undertaken on 10 March 2011. However, the results of this scan raised doubt about the abnormality previously noted and a further MRI scan was requested by the radiology department. The GP was again notified of the outcome. On 28 March 2011, Mr A was seen by Consultant 1. Consultant 1 was aware of the previous scan findings and the proposed further investigation and he planned to conduct a colonoscopy to investigate Mr A with a view to discharging him from the clinic. Consultant 1 told the GP that he would be updated following the MRI scan.

10. The Board continued that the MRI scan of 20 May 2011 again revealed a suspicion of a cancerous mass on the liver. The radiologist who reported the MRI scan suggested referral to hospital specialists. A report was sent to the GP as he was the initial referrer to consider what further action was required. (The Board also noted that all results were available to the GP electronically.) It was then that a substantial delay occurred and the referral to hospital specialists was not made until January 2012. Generally it was considered that when a clinician referred a patient for a test, the responsibility for acting on the result rested with the referrer. The situation became complex when a member of diagnostic staff (the radiologist) recommended further tests to be carried out. In the past what used to happen was that the results were sent to the referrer (in this case the GP) to speak to the patient and arrange further tests. Generally, this led to a delay and some patients were not referred for further tests. The pathway was simplified so that if a radiologist felt further investigations were appropriate they would arrange the tests themselves and send the report to the original referrer who was expected to decide on any follow up. Copies of the reports were also sent to the last secondary care clinician that saw the patient. In Mr A's case, the MRI scan was reported to the GP on 30 May 2011 and suggested referral to hospital specialists. Referrals to hospital specialists would normally be arranged by the secondary care clinicians and the GP assumed the result would be picked up by the secondary care physician to whom Mr A had been referred to. However, the report was actually copied to the secondary care physician who last saw Mr A (Consultant 2) who subsequently left the Board. Consultant 1 had already seen Mr A and had referred him back to the

GP advising him that the MRI scan result would be available in due course and he assumed the GP would arrange follow up action. While the Board acknowledged the unacceptable delay in the referral process, and apologised, they said that clinically surgery would not have been an option with an earlier diagnosis in view of Mr A's other significant health concerns.

11. The Medical Director reviewed the case and said that while there was a system to send a report to the referrer, this could be strengthened by sending a duplicate report to the lead specialist in the area (so if radiologists reported an abnormal result, it would now automatically be copied to the clinical lead).

12. In response to the Board's request for comments, Mr A's GP said he received the result of the 20 May 2011 MRI scan, but that it would be usual practice at that time for GPs to assume the referring clinician would deal with the result. In this instance, the radiologists had requested the further investigation and recommended referral to specialists for further assessment. The GP had assumed that the referral would be made by secondary care, particularly as he believed he could not make the referral himself. When the GP was subsequently informed by Mr A about the lack of follow up in January 2012, he contacted Consultant 1 by letter and this led to the request for a repeat scan which took place on 19 March 2012.

Advice obtained

13. The Medical Adviser said that the delay in diagnosis was not reasonable, although it was the result of complex miscommunication rather than the fault of any individual. The Medical Adviser explained that it was difficult to identify one individual who should have assumed responsibility for following up the abnormal results of the MRI scan of 20 May 2011 because of the complexities of the case. British Medical Association guidance recommended that the clinician who ordered tests was responsible for receiving and acting upon the results. In this case, the GP requested the original ultrasound scan, but did not request the subsequent CT and MRI scans, which were arranged directly by the radiology department. This was with the best of intentions to speed further investigation. By the time the scans had been performed, Mr A had been referred to a hospital specialist on the basis of the ultrasound findings and the GP assumed, not unreasonably, that any further action would be taken by the hospital. Unfortunately, the hospital specialist, Consultant 1, was not sent a copy of the MRI scan report and, therefore, did not act on it.

14. My complaints reviewer asked the Medical Adviser if surgery would have been an option had the diagnosis had been made earlier. In response, the Medical Adviser said that while he could not say definitively, it was his view that it was highly unlikely Mr A would have been fit enough to be considered for surgery even if the findings of the MRI scan of 20 May 2011 had been acted on immediately given his complex medical history, which included chronic obstructive airways disease, diabetes, heart disease and previous deep-vein thrombosis that required treatment with medication. However, it was possible that alternative palliative treatment (aimed at controlling the tumour and improving the symptoms) could have been offered at an earlier stage and may have been better tolerated by Mr A, and which may have led to a small extension in survival although realistically this would only be a matter of months.

15. My complaints reviewer also asked the Medical Adviser about the robustness of the changes the Board had considered making to the system to ensure that there would be no recurrence. In response, the Medical Adviser said that the Board considered instituting a system whereby reports of significant findings on scans were copied to an appropriate clinician in the hospital who has an interest in managing the particular condition concerned, and who would assume responsibility for ensuring that appropriate action has been taken. Had this system been in place, it would almost certainly have avoided the problems experienced by Mr A. However, the Board should also consider extending this to referring patients to the responsible multi-disciplinary team. A plan could then be agreed by all parties involved and this system of ensuring review by the whole team (rather than a single individual lead clinician) would be more robust.

16. In response to the draft report, the Board said that direct referral from radiology into the multi-disciplinary team meetings was not feasible for a number of reasons and outlined the current system for communicating critical, urgent and unexpected significant radiological findings. The Medical Adviser considered the Board's response and said that it was reasonable in the circumstances. In relation the current system of reporting, however, the Medical Adviser said it was important to ensure that reports of significant unexpected findings on scans were copied to an appropriate lead clinician within the hospital with an interest in the condition concerned who would then take responsibility for ensuring that appropriate action would be taken. This would ensure that the problem caused by the delay in this case was not repeated.

Conclusion

17. Mr C complained that there was an unreasonable delay in diagnosing Mr A with liver cancer. The advice I have accepted is that the delay in diagnosis was not reasonable and that the reasons for this were complex. The Board acknowledged the failing, apologised and made changes to the system of reporting abnormal results. The Medical Adviser said that while it was unlikely the only potential curative treatment for Mr A's condition, surgery, was feasible, palliative treatment at an earlier stage may have made a difference to him in the last few months of his life. The delay in the diagnosis was unacceptable and, potentially, impacted adversely on the end of life care Mr A received. Clearly, this has been extremely distressing for the family and I cannot imagine what Mr A went through because of the delay. I uphold the complaint. I am also recommending that the Board consider the Medical Adviser's comments to ensure that their system for communicating abnormal results is as robust as it can be so that this does not happen again.

Recommendations

18. I recommend that the Board:	*Completion date*
(i) review their processes for communicating abnormal results to include referral to an appropriate lead clinician in the hospital as well as the referring doctor in light of the Medical Adviser's comment; and	24 October 2014
(ii) apologise for the failures identified.	24 October 2014

19. 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 A	the aggrieved
MRI	magnetic resonance imaging
Mr C	the complainant
Mrs D	sister of the aggrieved
the Board	Fife NHS Board
Medical Adviser	one of the Ombudsman's advisers who specialises in oncology
the Hospital	Queen Margaret Hospital
CT scan	computerised tomography scan
Consultant 1	a general physician and gastroenterologist at the hospital
Consultant 2	a general physician and gastroenterologist at the hospital

Annex 2

Glossary of terms

chronic obstructive airways disease	a disease affecting the lungs
deep-vein thrombosis	a blood clot in one of the deep veins in the body
diabetes	a condition that causes an individual's blood sugar level to become too high