SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201708494, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary
Mrs C complained about the care and treatment that her late husband (Mr A) received from Grampian NHS Board (the Board). Following his GP referral to the Board, Mr A was diagnosed with kidney cancer. He had surgery to remove part of his kidney, which appeared to have removed all of the cancer. However, around two years later, it was found that Mr A's kidney cancer had returned. He was referred for further surgery to remove the rest of his kidney, which was then cancelled. When Mr A attended oncology (cancer specialists) to discuss other treatment options, he was told his cancer was terminal and it had spread more widely than previously identified. Sadly, Mr A died early the next year.

Mrs C complained about a delay in first diagnosing and treating Mr A's kidney cancer. She also complained about a delay in diagnosing and treating Mr A's kidney cancer when it returned and spread to other areas of his body. Mrs C raised particular concerns that there was a delay in advising them of the seriousness of Mr A's condition.

We took independent advice from a consultant urologist and a consultant radiologist, which we accepted. We found that there was an unreasonable delay in diagnosing Mr A's kidney cancer, as his first GP referral was not actioned by the Board. We found there was also an unreasonable delay in diagnosing that Mr A's kidney cancer had returned and spread. This was due, in part, to a series of failings in interpreting the results of Mr A's scans. We also found significant failings in the communication with Mr A about his condition and its seriousness.

Mrs C was also unhappy with how the Board dealt with her complaint. We found that there was an unreasonable delay in dealing with Mrs C's complaint. We also found the Board failed to thoroughly investigate or address all of Mrs C's concerns. We were very concerned that the Board's review failed to identify or acknowledge the significant failings in their communication with Mr A and his family.

We upheld Mrs C's complaints. We made a number of recommendations to address the issues identified. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are

asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	• The Board unreasonably delayed in diagnosing Mr A's kidney cancer; • The Board unreasonably delayed in diagnosing Mr A's kidney cancer had returned and spread; • The communication with Mr A about his condition was unreasonable; and • The Board's complaints handling was unreasonable	Apologise to Mrs C for the unreasonable delays in Mr A's care and treatment; the failure to communicate reasonably with Mr A about his condition and the failings in the Board's complaints handling	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance By: 22 April 2019

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board's cancer treatment times, for both the partial nephrectomy and radical nephrectomy, exceeded the national targets	In similar cases, patients should receive treatment within 62 days of the referral and within 31 days from the decision to treat, as per the national targets	• Evidence that the findings of this investigation have been fed back to the relevant clinicians in a supportive way that promotes learning • Evidence of the steps being taken to reduce waiting times for treatment and better meet the national targets By: 20 May 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	There were multiple instances where clinically significant abnormalities were missed when CT scans were reported and reviewed	Radiological findings should be accurately reported as far as possible	• Evidence that the findings of this investigation have been fed back to the relevant radiologists in a supportive way that promotes learning • Confirmation that the individual radiologist(s) will discuss this case at their next appraisal By: 20 May 2019
(a)	The multidisciplinary team (MDT) did not review and/or identify the errors in the reporting of Mr A's CT scans	There should be systems and safeguards in place to ensure: • the MDT actively review CT scan imaging, including, where appropriate, a re-assessment by a radiologist and a comparison with older imaging And • the radiologist is resourced, with the time, technology and support, to do this before the MDT for all cases and to issue addenda afterwards if required	Evidence of the systems in place to ensure that CT scan imaging is reviewed appropriately before MDTs and how this will provide necessary safeguards By: 20 May 2019
(a)	The MDT referred Mr A for a radical nephrectomy when it was not technically feasible	Systems should be in place to ensure the surgeon (for patients due to undergo complex or major surgery), inputs to the MDT on whether the surgery being considered or recommended by the MDT is technically feasible	Evidence that the Board has reviewed and where appropriate amended its approach, to ensure the views of operating surgeons on technical feasibility are considered. By: 20 May 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	There was a delay in carrying out the imaging requested by the MDT to investigate the extent of Mr A's cancer	Systems should be in place to ensure requests for imaging by the MDT are followed up with an urgent imaging request and an automatic MDT review as soon as the imaging has been completed	Evidence that the Board has reviewed the MDT approach and supporting processes to ensure that any imaging requested by the MDT is carried out within an appropriate timescale By: 20 May 2019
(a)	The consultant urological surgeon's communication with Mr A about his condition was unreasonable	Patients should be given prompt, clear, realistic and honest information about their condition, its seriousness and the likely chance of success from any treatment options	• Evidence that the findings of this investigation have been fed back to the individual consultant urological surgeon in a supportive way that promotes learning. • Confirmation that the individual consultant urological surgeon will discuss this case at their next appraisal. • An explanation about how this will inform wider learning in the Board By: 20 May 2019
(a)	There were errors in CT scan reports by the private company used by the Board for radiology outsourcing	Radiological findings should be accurately reported	Confirmation that the Board has a system in place to feedback reporting discrepancies to any private radiology companies they use for outsourcing work By: 20 May 2019

We are asking Grampian NHS Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	There was an unreasonable delay in the Board's complaints investigation, partly because they tried to arrange a meeting with Mrs C before issuing a formal response to her concerns	Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here: www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs	Evidence that the outcome of this investigation has been fed back to staff in a supportive manner which encourages learning, and that all staff are aware of and understand the complaints handling procedure By: 20 May 2019
(b)	The Board's own complaints investigation did not identify or address all of the failings in the care provided to Mr A	The Board's complaints handling system should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement	Evidence that the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here By: 20 May 2019

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board told us they have improved the pathway for GP referrals	The Board should have a clear reliable pathway for both electronic and paper referrals	Details of the current referral pathway for electronic and paper GP referrals and how they are actioned By: 22 April 2019
(b)	The Board told us that they discussed the errors in the CT scan reporting at a radiology discrepancy meeting	As far as possible, radiological findings should be accurately reported	• Evidence that this case has been discussed at the departmental radiological 'learning from discrepancies' meeting. • Confirmation that in discussing these errors, the CT scan imaging was examined and compared with earlier CT scans By: 22 April 2019

Feedback

Points to note:

Adviser 2 explained that it would have been best practice for the reporting radiologist to make a direct referral to the MDT in 2014. However, they might not have been aware of the local process to do so because they were working remotely for a private company. The Board might wish to make private companies aware of the local process for radiologists to make direct MDT referrals.

Adviser 1 noted that Mr A waited four weeks to be told about his kidney cancer, after his diagnosis was confirmed by the January 2014 CT scan and his treatment was discussed by the MDT. The Board might wish to consider if it is possible to streamline this process so patients are offered earlier urology appointments in similar circumstances.

Adviser 1 considered that the Board could have written to Mr A about the histology findings at the same time as they wrote to his GP. The Board might wish to consider copying patients into these types of GP letters in future.

Adviser 2 commented that the use of standardised CT protocols would make it easier to compare any follow-up CT scans with previous CT scans. The Board might wish to carry out a review of CT protocols to ensure that optimum diagnostic quality imaging is obtained across the whole range of clinical scenarios or possible pathologies.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to me about a delay in diagnosing and treating her late husband (Mr A)'s renal cell carcinoma (a type of kidney cancer), which later returned and spread to other areas of his body. Mrs C was also unhappy with how the Board dealt with her complaint.

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

(a) the Board unreasonably delayed in diagnosing and treating Mr A's cancer (*upheld*); and

(b) the Board failed to handle Mrs C's complaint appropriately (*upheld*).

Investigation

3. I and my complaints reviewer considered all the information provided by Mrs C and the Board. This included Mr A's relevant medical records and the Board's complaints file. We also obtained independent advice from a consultant urologist (Adviser 1) and a consultant radiologist (Adviser 2) on the clinical aspects of the complaint.

4. I have decided to issue a public report on Mrs C's complaint. This reflects both my deep concerns about the systemic failings identified in Mr A's care and treatment; and the significant personal injustice, to both Mr A and to his family.

5. When responding to Mrs C's complaint, the Board acknowledged there were failings in aspects of Mr A's care. However, a number of significant failings, in particular regarding the communication with Mr A and his family about his condition were not acknowledged. In publishing this report my aim is to ensure that there is lasting learning and improvement arising from the systemic medical and communication failures my investigation identified in Mr A’s case.

6. 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.

Background

7. In November 2013, Mr A had an ultrasound scan that showed a lesion in his right kidney. His GP sent the Board an urgent referral letter by fax, under the suspicion of cancer. It was not actioned by the Board. At the end of December 2013, the GP sent them a further copy of the referral letter.

8. In late January 2014, the Board referred Mr A for a CT scan. It confirmed that Mr A had a lesion in his right kidney, which could be cancer. His treatment was discussed at a multidisciplinary team meeting (MDT) the next month. They decided to refer Mr A for surgery, specifically a partial nephrectomy (the surgical removal of part of his right kidney).

9. At the end of March 2014, Mr A was admitted to hospital to prepare him for the surgery.

10. At the beginning of April 2014, Mr A had the partial nephrectomy. Tissue samples were taken from the kidney tumour and from the body fat next to it. When the histology findings were issued (a report on the microscopic appearance of tissue), they confirmed that it was cancer and that it had been completely removed.

11. In May 2014, the MDT discussed the histology findings. The Board then wrote to Mr A's GP explaining the partial nephrectomy was successful.

12. In late June 2014, Mr A attended a urology appointment with the Board. He was told that his kidney cancer had been completely removed.

13. In late August 2015, Mr A had a CT scan as follow-up, which did not report anything of concern.

14. However, in late February 2016, Mr A had an ultrasound scan that showed a possible lesion in his right kidney. At that time, Mr A was undergoing separate management for a lung condition. The consultant at the chest clinic wrote to urology to draw their attention to the concerning ultrasound scan findings. Urology referred Mr A to the MDT. They did not consider the ultrasound scan suggested his cancer had returned. However, the MDT referred him for a triple phase CT scan (an enhanced CT scan technique) to investigate his condition further.

15. In April 2016, Mr A had his triple phase CT scan. It reported areas of concern around his right kidney, which suggested that his cancer had returned. In light of the findings, Mr A's CT scan from August 2015 was reviewed. It was noted that the kidney cancer had been visible in the imaging taken in August 2015 but it had not been identified or reported at that time.

16. In June 2016, Mr A had a CT scan of his abdomen, which reported no areas of concern in his chest and pelvis. In June 2016, the MDT again discussed his

treatment. They recommended referring Mr A for further surgery, specifically a radical nephrectomy (the surgical removal of the rest of his right kidney).

17. In early August 2016, Mr A was admitted to hospital to prepare him for the radical nephrectomy. The evening before it was due to take place, it was cancelled. The consultant urological surgeon had reviewed Mr A's CT scans and decided it would not be possible to safely remove all of the cancer. Mr A was referred for an up-to-date CT scan and to the MDT for a discussion in mid-August 2016.

18. The MDT referred Mr A to oncology to discuss potential treatment options. Mr A attended his oncology appointment in September 2016. He was told that systemic treatment alone would not cure his cancer. Also, that it might not be possible to shrink the cancer, with systemic treatment, to a size where it could be surgically removed. Shortly afterwards, Mr A was told that the cancer had spread more widely than had previously been identified, as it was in his chest and pelvis.

19. Mr A then underwent systemic treatment for his cancer. However, the cancer progressed further into his spine causing compression to his spinal cord (squeezing of the spinal cord), which left him paralysed from the chest down.

20. Mr A's condition continued to worsen and in March 2017, sadly, Mr A died at home.

(a) the Board unreasonably delayed in diagnosing and treating Mr A's cancer

Concerns raised by Mrs C

21. Mrs C complained about delays in diagnosing and treating her husband's cancer. She was concerned that after his GP referral in November 2013, Mr A waited two months for a urology appointment. Mrs C complained that after Mr A's partial nephrectomy, he waited nine weeks for the histology findings.

22. Mrs C complained that the August 2015 CT scan was interpreted incorrectly, as it reported nothing of concern. However, a later review found that it had shown a lesion in Mr A's right kidney, which had been missed. Mrs C was concerned that the consultant urological surgeon did not look at that August 2015 CT scan themselves and had relied on the radiologist's report.

23. When it appeared that Mr A's kidney cancer had returned in April 2016, Mrs C said they were not told how serious his condition was. In addition, Mrs C complained that there was an unreasonable delay in scheduling Mr A's radical nephrectomy. She said there should have been more urgency, given how aggressive his cancer was.

Mrs C was concerned that the radical nephrectomy was then cancelled the night before. She was particularly concerned that the decision to cancel it was not based on any new information but on the results of previous investigations.

24. As Mr A's cancer had returned in August 2015 and he was referred to oncology in August 2016, Mrs C complained that he went 12 months without any treatment. Mrs C considered this was an unreasonable delay. In addition, she felt that urology had downplayed the seriousness of Mr A's condition when he was referred to oncology. Mrs C explained they were told that systemic treatment could shrink Mr A's tumours and surgery could still be an option. However, when Mr A attended oncology, they were told that his cancer was terminal. Mrs C said that Mr A had continued to work full time and they were denied the opportunity to decide how to spend Mr A's final months together as a family. In particular, they would have liked to travel abroad before his condition worsened.

The Board's response

25. The Board acknowledged that there was an unacceptable delay when Mr A was referred to the Board by his GP in November 2013. They explained it was unclear why the GP referral was not actioned sooner and they apologised to Mrs C for this delay. The Board said the timescales for responding to GP referrals has now improved significantly, as all GP referrals are received electronically through a single portal and are vetted daily. The Board explained that referrals to the MDT also take less time, as it is done electronically and patients are now added to the MDT list before their scans have been carried out.

26. The Board stated that after Mr A's partial nephrectomy, his GP was advised of the histology findings around four weeks after their issue. The Board acknowledged this was a delay and explained they had now introduced an electronic system to highlight these types of important pending reports. The Board said it is usual to tell the patient the histology findings during their next clinic appointment, which normally takes place six weeks after surgery.

27. The Board said that from 2015 onwards, they diligently followed up Mr A with regular imaging. They explained that his August 2015 CT scan did not report anything of concern. However, the Board noted, during their April 2016 review, that it had shown evidence that Mr A's cancer had returned and spread to the area around his kidney. The Board acknowledged that Mr A was not told that his kidney cancer had returned and spread until late July 2016.

28. The Board commented that Mr A's cancer was aggressive, as it progressed quite rapidly between 2015 and 2016. They said that in retrospect, the June 2016 CT scan had shown evidence of Mr A's cancer having spread to his chest. However, the Board said this was missed by the reporting radiologist and by the MDT at that time.

29. The Board confirmed that Mr A's radical nephrectomy was cancelled the evening before it was scheduled to take place. They explained it was cancelled after the consultant urological surgeon had reviewed Mr A's CT scans. They noted that Mr A had cancer in a lymph node behind his inferior vena cava so surgery would not have completely and safely removed the cancer. The Board said the consultant urological surgeon was unsure if they had reviewed Mr A's CT scans at an earlier point or not.

30. The Board said it is unusual for kidney cancer to return to multiple different areas of the body, as happened here. They said that it can happen if the tumour bursts during surgery, causing a spill of cancer cells. However, the Board said they had reviewed the histology findings following Mr A's partial nephrectomy and they were reassuring. The Board said the histology findings confirmed that the tumour was removed completely and that it had been intact.

31. The Board said that when Mr A's radical nephrectomy was cancelled, they had only identified cancer in his kidney and lymph node. They had not realised it had spread to other parts of Mr A's body. The Board explained that they later found that the cancer in Mr A's rib was visible in his August 2016 CT scan and this had been missed. The Board said that Mr A was told by the consultant urological surgeon that systemic treatment might reduce his cancer and make surgery possible. The Board acknowledged that it might not have been possible to cure Mr A's cancer with surgery but they considered it could have significantly improved his quality of life. The Board commented that the consultant urological surgeon was unaware of how much Mr A's cancer had spread and it would have been unkind to tell Mr A he was terminally ill.

32. The Board explained that when Mr A attended his oncology appointment in September 2016, they had identified the cancer that had spread to his chest. The Board said that shortly afterwards, cancer was also identified in Mr A's pelvis.

33. The Board described the delay in diagnosing Mr A's widespread cancer as a grave error. However, they said they believed that Mr A's outcome would have been the same, even with an earlier diagnosis of widespread cancer and an earlier referral to oncology. The Board said that action has been taken as a result of Mrs C's

complaint, as Mr A's CT scans were discussed at a radiology discrepancy meeting. They also referred to the improvements they have made to their electronic system for processing GP referrals and MDT referrals, as outlined above.

Medical advice: Referral to urology

34. In late November 2013, Mr A was urgently referred to the Board, as his GP suspected he had cancer. No action was taken in response to this initial referral, which was a delay the Board accepted and apologised for. We considered that on the face of it, this was an unreasonable delay so we sought advice about it. Adviser 1's view, was that this was an unreasonable delay in Mr A's treatment. Adviser 1 directed us to the Scottish Cancer Referral Guidelines, which are the relevant national guidelines for cancer treatment (see Annex 2). Adviser 1 explained that under these guidelines, the Board should have urgently responded so they could carry out Mr A's treatment within 62 days of his GP referral.

35. Adviser 1 noted that the GP sent the Board a further referral in late December 2013. Around a week later, the Board asked the GP to arrange up-to-date blood tests. Mr A had the blood tests in early January 2014 and the results were forwarded on to the Board. The Board referred Mr A for an urgent CT scan, which was carried out in late January 2014. Adviser 1 noted there had been some delay in arranging this CT scan because of the wait for the blood tests. However, Adviser 1 told us that the action taken by the Board, in response to the second GP referral, was reasonable.

Medical advice: January 2014 CT scan

36. We asked Adviser 2 about the interpretation of the January 2014 CT scan, which had been outsourced to a private company by the Board. Adviser 2 said the CT scan report confirmed there was cancer in Mr A's right kidney. Adviser 2 told us that given the diagnosis, it should have recommended referring Mr A to the MDT. Adviser 2 explained that this is set out in the relevant European Association of Urology Guidelines on Renal Cancer (see Appendix 2). Adviser 2 considered it was unreasonable that that the CT scan report did not recommend making a referral to the MDT.

37. Adviser 2 said it would have been best practice for the reporting radiologist to make the referral to the MDT directly. However, Adviser 2 explained that as the reporting radiologist was working remotely for a private company, they probably were not aware of the local process to do this. I note that Adviser 2 commented that the Board might wish to make private companies aware of the local process so their radiologists can make direct MDT referrals in future.

38. After a referral by urology, Mr A's treatment was discussed by the MDT ten days after the January 2014 CT scan report was issued. Adviser 1 confirmed this was a reasonable timeframe. Therefore, the omission in the January 2014 CT scan report did not affect Mr A's care and treatment.

Medical advice: February 2014 MDT

39. Adviser 1 confirmed that given the nature of Mr A's kidney tumour, it was appropriate that the February 2014 MDT recommended a partial nephrectomy. Adviser 1 explained that this allows for some of the kidney to be preserved and maximises the overall remaining kidney function. In addition, Adviser 1 confirmed that it is equally possible to cure cancer with a partial nephrectomy as with a radical nephrectomy.

40. Adviser 1 noted that Mr A was seen by urology to discuss the treatment recommendation, within two weeks of the MDT. Adviser 1 confirmed this was a reasonable timescale. However, Adviser 1 noted it meant that Mr A had to wait four weeks to be told about his January 2014 CT scan results, which confirmed his diagnosis of kidney cancer.

41. Adviser 1 suggested to us that the Board might wish to consider shortening this timescale by offering patients an earlier clinic appointment.

Medical advice: April 2014 partial nephrectomy

42. Adviser 1 explained that a partial nephrectomy is surgically more complex and less common than a radical nephrectomy. Therefore, Adviser 1 considered it was appropriate Mr A was referred to the Board's consultant urological surgeon with the most expertise in carrying it out.

43. Adviser 1 explained that Mr A's partial nephrectomy took place in early April 2014, which was 127 days after his initial GP referral. Adviser 1 noted this was more than twice the 62 day target from referral to treatment for cancer, as mentioned above. In addition, Adviser 1 drew our attention to the national target of 31 days to carry out cancer treatment once the decision to treat has been made. Adviser 1 explained that as Mr A's partial nephrectomy was carried out 50 days after the treatment decision, this target was breached by 19 days. Adviser 1 said the delay might have been caused by local service pressures and might have been due to Mr A requiring a referral to a specific consultant urological surgeon. However, Adviser 1 commented that it was unclear if any efforts were made by the Board to fast-track Mr A's partial nephrectomy, given their initial failure to respond to his GP referral.

44. Adviser 1's view was that taking four months to treat Mr A's kidney cancer, after his initial GP referral, was an unreasonable delay.

Medical advice: Histology findings

45. Adviser 1 noted Mrs C's concerns that Mr A waited around nine weeks to be told the histology findings after his partial nephrectomy. Adviser 1 explained that it usually takes two to three weeks to process the tissue samples. Adviser 1 said it might take a further one to two weeks for the Board to prepare and send a letter setting out the histology findings.

46. If no immediate medical intervention is required, Adviser 1 considered it would be reasonable to take around six weeks to issue histology findings and possibly longer, if there was a particular reason for any delay. Adviser 1 noted that the Board had written to Mr A's GP with the histology findings in late May 2014 but only told Mr A at his appointment a month after that. Adviser 1 commented that the Board should have told Mr A the histology findings at the same time as his GP, as it was their responsibility to do so and not his GP's. Therefore, Adviser 1 considered the time taken to advise Mr A of the histology findings was unreasonable.

47. Adviser 1 noted that the Board considered the outcome of Mr A's partial nephrectomy was highly favourable.

48. Adviser 1 told us that after any surgery to treat kidney cancer, there is a risk the cancer will come back to the remaining kidney tissue or to the surrounding tissue. They stated there is also a chance the cancer will have spread to other areas of the body and told us that if kidney cancer spreads, it is usually to the lymph nodes or lungs. Adviser 1 explained that the risk of cancer returning can be estimated by examining the characteristics of the kidney tumour and using specific prediction tools.

49. Adviser 1 confirmed that for Mr A, there was a very good chance (over 90%) that his kidney cancer would have been cured by the partial nephrectomy. Therefore, Adviser 1 confirmed it was appropriate that the Board advised Mr A and his GP that it was a very positive outcome.

50. However, Adviser 1 went on to explain that there was a potential area of concern in relation to these histology findings. Adviser 1 noted that the kidney tumour and surrounding fat had been submitted as separate specimens for histology testing. Adviser 1 explained there was evidence that the kidney tumour had extended into that fat. Adviser 1 said that the fat might have been divided from the tumour after Mr A's partial nephrectomy. However, Adviser 1 said that if it was

separated during the partial nephrectomy, there was a chance that cancerous cells had spilled into Mr A's surgical wound. Adviser 1 explained that this would have increased the risk of Mr A's cancer returning, by perhaps around 10%.

51. Adviser 1 said that the way Mr A's cancer returned would be consistent with a cancer spill during the partial nephrectomy. However, Adviser 1 confirmed it was not certain this had happened and the surgical note did not mention that the kidney tumour was divided during the partial nephrectomy.

Medical advice: August 2015 CT scan

52. We asked Adviser 1 about Mr A's follow-up care after his partial nephrectomy. Adviser 1 again referred us to the European Association of Urology Guidelines on Renal Cancer. Adviser 1 explained that according to the guidelines, frequent scanning to check if kidney cancer has returned is unnecessary and there is no evidence that it improves people's outlook. Adviser 1 said it is recommended in the guidelines that a patient is followed up six months after they have treatment for kidney cancer. There should then be an annual follow-up for the next three years, with bi-annual follow-up after that.

53. Adviser 1 explained that after Mr A's partial nephrectomy in April 2014, he had various follow-up that included CT scans, ultrasound scans and x-rays. In particular, Adviser 1 noted that Mr A had an ultrasound scan in May 2015 and a CT scan in August 2015. Adviser 1 confirmed that after his partial nephrectomy, Mr A's follow-up care was reasonable.

54. We asked Adviser 2 about the reporting of Mr A's August 2015 CT scan. Adviser 2 noted that this was outsourced to a private company. Adviser 2 explained it did not report the visible evidence of Mr A's kidney cancer having returned and spread to the area surrounding the kidney. Therefore, Adviser 2 said that in their view, the August 2015 CT scan report was unreasonable.

55. Adviser 2 told us that the imaging also showed a small mass in Mr A's stomach wall, suggestive of cancer. This was also not reported, although, Adviser 2 explained it was quite subtle and could have been easily overlooked.

56. Adviser 1 noted Mrs C's concern that in August 2015, the consultant urological surgeon relied on the CT scan report and did not check the imaging themselves. However, Adviser 1 confirmed this was reasonable. Adviser 1 explained that urologists are only trained to evaluate CT scans to a level that is necessary to carry

out surgery and deal with any complications from surgery. Adviser 1 explained that radiologists are specialists in carrying out in depth evaluations of imaging.

57. In addition, Adviser 1 told us that radiologists usually have more sophisticated technology that enables them to consider more detailed imaging. Adviser 1 confirmed that urologists would not be expected to check on work by radiologists. Adviser 1 said that in practice, urologists usually rely on a radiologist's report of a CT scan and base their care management decisions on this, particularly if no abnormality is reported. Adviser 1 explained that urologists would usually only be expected to review certain CT scan images and that would be for reasons like assessing a patient's suitability for surgery, preparing to carry out surgery or discussing the findings of CT scans with patients.

58. Adviser 1 explained that Mr A had a chest x-ray in December 2015, which identified nothing of concern. As a result, Adviser 1 considered it was reasonable the Board planned a routine follow-up of Mr A in February 2016.

Medical advice: February 2016 ultrasound scan and MDT

59. Adviser 1 explained that the February 2016 ultrasound scan showed an area of concern in Mr A's right kidney. Mr A was referred to the MDT, who discussed his condition in March 2016. Adviser 1 noted the MDT referral was typed and sent 19 days after it was dictated by urology, which in their view was an avoidable delay in Mr A's treatment.

60. Adviser 1 also noted Mrs C's concerns that a consultant at the chest clinic had needed to write to urology to highlight these concerning results. However, Adviser 1 confirmed that by that point, urology had already referred Mr A to the MDT and no further action was required.

61. Adviser 1 explained that the March 2016 MDT did not identify the evidence of Mr A's cancer having returned in the August 2015 CT scan report. Both Adviser 1 and Adviser 2 told us that the March 2016 MDT should have re-assessed Mr A's previous CT scans and identified this.

62. Adviser 1 explained that the March 2016 MDT decided to refer Mr A for a triple phase CT scan. Adviser 1 confirmed that was appropriate, as further imaging was needed to clarify his diagnosis. Adviser 1 said this was a predictable outcome of the MDT discussion, as the ultrasound scan was not diagnostic and only raised a suspicion of his cancer having returned. Therefore, it was Adviser 1's view that

urology could have arranged the triple phase CT scan so the MDT would have the results for their discussion.

63. Adviser 1 said that doing this in advance could have reduced the time it took to diagnose Mr A's returned kidney cancer by around three weeks.

Medical advice: April 2016 triple phase CT scan

64. Adviser 2 noted that Mr A had the triple phase CT scan in late April 2016, around three weeks after the MDT. Adviser 2 confirmed this was a reasonable timescale and that it was reported promptly.

65. Adviser 2 explained that the triple phase CT scan involved taking repeated images of Mr A's abdomen, using a contrast and different timing delays to show blood flow. Adviser 2 explained that images were also taken of Mr A's chest and lungs but none were taken of his pelvis. Adviser 2 noted that the triple phase CT scan report recommended *'completion CT staging of the lungs'*. Adviser 2 said this suggested that the reporting radiologist had not reviewed the images of Mr A's chest.

66. Adviser 2 said they would have expected Mr A's pelvis and chest to have been fully examined. However, the Board explained that chest and pelvis imaging had not been requested by the MDT, as they did not consider the February 2016 ultrasound scan results were consistent with Mr A's cancer having returned. Adviser 1 told us this was a reasonable explanation for the MDT decision. However, Adviser 1 commented that if the failing in the reporting of the August 2015 CT scan had been identified by the MDT, as it should have been, the MDT would have requested chest and pelvis imaging also.

67. Adviser 2 explained that the triple phase CT scan report accurately reported evidence of Mr A's cancer having returned to his kidney and the surrounding area. Adviser 2 said it was not clear from the imaging if there was cancer specifically within the lymph node but Adviser 2 considered that was likely. Adviser 2 explained there was evidence of cancer spread to other areas of Mr A's body in the imaging that was not reported. Specifically, there was a small area of damage to Mr A's left third rib; to his spine; and a solid mass in the right muscles of Mr A's stomach wall. Adviser 2 said this stomach wall mass had increased since the August 2015 CT scan and it was likely to be cancer. Adviser 2 said it was unreasonable that these three areas of abnormality were not included in the triple phase CT scan report.

68. Adviser 2 noted that following the triple phase CT scan, the August 2015 CT scan imaging was reviewed again. The review was carried out by the private

company who prepared the August 2015 CT scan report. Adviser 2 said the evidence of kidney cancer was noted at that time and they added an addendum (note) to the August 2015 CT scan report confirming this. Adviser 2 confirmed it was appropriate that an addendum was added to it. However, Adviser 2 said that the August 2015 CT scan should have been compared with the April 2016 triple phase CT scan in that imaging review. If this was done, Adviser 2 explained that the abnormalities, which were missed in the April 2016 triple phase CT scan report, should have been identified. Adviser 2 stated it was unreasonable that the April 2016 triple phase CT scan was not included in this imaging review or if it was, that the abnormalities were missed again.

69. Adviser 1 explained that in mid-June 2016, an additional CT scan was requested of Mr A's chest and pelvis to establish the full extent of his cancer. Adviser 2 explained that the June 2016 CT scan report failed to identify abnormalities that suggested the cancer had spread to Mr A's bones. Specifically, Adviser 2 explained there was an abnormality visible in Mr A's left third rib, which had enlarged since the August 2015 CT scan. Also, there were new areas of abnormality in Mr A's spine and in his pelvis. Adviser 2 told us that the June 2016 CT scan report was unreasonable, as these abnormalities should have been identified and reported.

70. In addition, Adviser 1 told us that there was a significant delay in completing the imaging to investigate Mr A's condition following the March 2016 MDT. Adviser 1 noted it took 24 days to carry out the April 2016 triple phase CT scan and a further 48 days to carry out his June 2016 chest and pelvis CT scan. Adviser 1 said taking nearly three months to clarify Mr A's diagnosis of cancer was unreasonable. Adviser 1 confirmed that the timescale exceeded the national target of six weeks to complete these kinds of key diagnostic tests (see Appendix 2).

Medical advice: Referral for surgery (radical nephrectomy)

71. Adviser 1 told us that when the imaging was completed, the MDT had a further discussion in late June 2016. Adviser 1 noted there was a gap of 84 days between this MDT and the previous one. Adviser 1 considered this was an unreasonably long timescale, which was partly due to the time it took to complete Mr A's imaging. Adviser 1 explained that the June 2016 MDT recommended referring Mr A for a radical nephrectomy. Adviser 1 explained that this would have involved removing Mr A's remaining kidney and the surrounding fat. Adviser 1 confirmed that usually kidney cancer cannot be cured with systemic treatment and surgery offers the best chance of curing it.

72. However, Adviser 1 explained that the MDT recommendation of surgery was incorrect for Mr A for two reasons:

(i) Operability: Mr A's largest tumour was lying immediately next to and behind his inferior vena cava, without any tissues between the inferior vena cava and the tumour. Mr A's cancer might have started to grow into the inferior vena cava and there was no safety margin of healthy tissues around the tumour to fully remove it. This meant there was a high risk of major bleeding during surgery and a low chance of curing his cancer.

(ii) Presence of widespread cancer: The June 2016 CT scan showed that the cancer had spread to Mr A's rib and pelvis. This was missed by the reporting radiology and by the June 2016 MDT. Given Mr A's widespread cancer, there was no chance that surgery would have cured him. Also, Mr A did not have any symptoms from his kidney cancer that surgery could have alleviated.

73. Adviser 1 explained that the June 2016 MDT should have referred Mr A to oncology to discuss systemic treatment. In addition, Adviser 2 commented that this was a missed opportunity for the MDT to identify the errors in the reporting of Mr A's April 2016 and June 2016 CT scans. Adviser 2 considered these errors should have been identified, as these CT scans would have been available to the June 2016 MDT to review.

74. Adviser 1 noted that when Mr A attended a urology appointment in late July 2016, he was told that his cancer had returned. As this diagnosis was based on the April 2016 triple phase CT, Adviser 1 told us that Mr A should have been seen by urology to advise him of the diagnosis earlier. Adviser 1 said that ideally, Mr A would have been seen shortly after the April 2016 triple phase CT scan. Adviser 1 considered this would have allowed urology to explain to Mr A that they would carry out further CT scans, as his cancer might have spread. Adviser 1 said that the role of surgery could also have been discussed with Mr A.

75. Adviser 1 said that as Mr A was not told his cancer had returned until three months after it was diagnosed, this was a prolonged and unreasonable delay. Adviser 1 stated that given the seriousness of the diagnosis, such a long delay was completely unacceptable.

July 2016 urology appointment

76. We asked Adviser 1 about the communication with Mr A about his condition, when he attended his July 2016 urology appointment. Adviser 1 noted Mrs C's concerns that they were not told about the seriousness of his condition and as a result, Mr A had continued to work full time.

77. Adviser 1 explained that as discussed above, Mr A's initial kidney cancer had a very good chance of being cured. Adviser 1 said that for any cancer that returns, the outlook will be much worse. Adviser 1 explained that for cancer that returns in or around the kidney, the chance of curing it with surgery is probably around 50%. In addition, Adviser 1 told us that the surgery tends to be more difficult, with a higher risk of complications. Adviser 1 explained that when someone has cancer in a lymph node, the chance of curing it with surgery is significantly reduced. Adviser 1 told us Mr A should have been advised of the limited chance that his cancer would be cured with surgery and about the risk of his cancer spreading. Adviser 1 considered that there was a failure to communicate appropriately with Mr A about the seriousness of his condition during that July 2016 appointment.

78. Adviser 1 explained that Mr A's radical nephrectomy was scheduled for mid- August 2016. Adviser 1 noted this was 51 days after the June 2016 MDT decision on his treatment; this breached the national target to treat Mr A's cancer within 31 days of the decision to treat (as discussed above). Therefore, Adviser 1 stated that this was a further unreasonable delay.

Medical advice: Cancellation of the radical nephrectomy

79. Adviser 1 noted that Mr A was admitted to hospital in July 2016, as he had blood in his urine. Adviser 1 said it was appropriate they did not carry out the radical nephrectomy during that admission, as Mr A needed special preparation for surgery because he was taking blood thinning medication. Also, Adviser 1 confirmed that bringing the date forward would not have improved its likelihood of success. Adviser 1 explained that Mr A was admitted to hospital again in early August 2016 to prepare him for the radical nephrectomy, which was scheduled to take place six days later.

80. Adviser 1 noted the radical nephrectomy was cancelled by the consultant urological surgeon, the evening before they were due to carry it out. Adviser 1 confirmed that the decision to cancel the radical nephrectomy was appropriate, for the operability reasons discussed above. However, Adviser 1 said that for a complex and/or major surgery of this type, the MDT should have had a process in place so that the operating surgeon would check the surgery recommended by the MDT was technically feasible.

81. As Mr A's radical nephrectomy was only cancelled the evening before, Adviser 1 said this suggested it was the first time the consultant urological surgeon had reviewed the CT scans. Adviser 1 considered this was unreasonable. Adviser 1 noted that the decision to cancel the radical nephrectomy was based on the April

2016 triple phase CT scan. Adviser 1 noted that the MDT had recommended the radical nephrectomy in June 2016 and Mr A was admitted to hospital to prepare him for surgery in early August 2016. Adviser 1 said that during that interval, there were numerous opportunities for the consultant urological surgeon to review the CT scan imaging. For example, when the MDT recommended the radical nephrectomy or when it was discussed with Mr A at his July 2016 appointment. Adviser 1 told us the consultant urological surgeon should have reviewed the CT scans on at least one occasion before Mr A was admitted to hospital for the radical nephrectomy.

Medical advice: August 2016 CT scan

82. Adviser 1 explained that when the radical nephrectomy was cancelled in August 2016, Mr A was referred for a further CT scan and for a further MDT discussion. Adviser 1 confirmed it was reasonable that a further CT scan was arranged, as it was nearly four months since his previous kidney CT scan. Adviser 1 also confirmed it was reasonable there was a further MDT discussion, given a decision had been made not to proceed with MDT's previous recommendation of a radical nephrectomy.

83. We asked Adviser 2 about the interpretation of the August 2016 CT scan. Adviser 2 explained that it was a CT scan of Mr A's chest, abdomen and pelvis. Adviser 2 said it accurately reported a mass in Mr A's stomach wall, which had increased in size. However, Adviser 2 said it also showed lesions in Mr A's rib, pelvis and spine, which were not reported. Adviser 2 explained that these lesions had increased in size since the previous CT scan and they were consistent with cancer. Adviser 2 said that the failure to report these lesions was unreasonable. Adviser 2 explained that the evidence of cancer in Mr A's spine showed there was a risk of his spinal cord compressing. Adviser 2 said it was unreasonable that this risk was not included in the August 2016 CT scan report.

84. We asked Adviser 2 about an addendum added to the August 2016 CT scan report a month later. Adviser 2 explained it was added as the cancer in Mr A's rib had been identified by a chest physician, who was treating Mr A's unrelated condition. Adviser 2 said it was reasonable that this addendum was added. Adviser 2 said it would have been best practice to have added an addendum to the June 2016 CT scan report also, although it would not have been of any practical clinical benefit. However, Adviser 2 said that the information in the addendum to the August 2016 CT scan was unreasonable, as it failed to mention there was visible evidence of cancer in Mr A's spine and the risk of spinal cord compression, which had also been missed in the August 2016 CT scan report.

85. Adviser 1 explained that the August 2016 MDT decided to refer Mr A to oncology to consider systemic treatment, which was appropriate. However, Adviser 2 commented that the August 2016 MDT was a further missed opportunity to identify the failings in the reporting of Mr A's previous CT scans. Adviser 2 said that all of the 2016 CT scans would have been available to the August 2016 MDT to review.

Medical advice: CT scan reporting errors

86. Adviser 2 explained that the failure to report the abnormalities in Mr A's CT scans, as outlined above, would be considered to be perceptual errors or 'under readings'. Adviser 2 said these errors tend to happen because of multiple psychophysiological factors; such as how alert the observer was; how tired they were; how long they spent looking at the CT scans; and any factors that distracted them from doing the task. Adviser 2 explained that radiologists will make occasional errors in reporting CT scan imaging and unfortunately, that is unavoidable.

87. Adviser 2 suggested the Board's main focus should be on minimising the impact any external factors are having on the interpretation of CT scans. For example, ensuring they have ergonomically well-designed computer reporting workstations, suitable work conditions (e.g. comfortable temperature, suitable lighting, lack of noise), and minimal interruptions such as enquiries from other clinical staff or issues with their IT systems. Adviser 2 said that if there is any issue with the IT systems malfunctioning, this should be reported through the Board's clinical governance mechanisms. Adviser 2 considered that an overly high workload for the reporting radiologists could also be a contributing factor to this number of perceptual errors.

Medical advice: Oncology referral

88. Adviser 1 said that following the August 2016 MDT discussion, Mr A was referred promptly to oncology. Mr A attended his oncology appointment in early September 2016, which Adviser 1 confirmed was a reasonable timeframe. However, Adviser 1 commented that the oncology referral could have been made earlier that month, when the decision was made to cancel Mr A's radical nephrectomy.

89. We asked Adviser 1 about the impact the delays were likely to have had on Mr A's condition and outlook.

90. Adviser 1 said that the initial delay in treating Mr A's kidney cancer in 2013/2014 was unlikely to have had any long-term negative impact on him.

91. Adviser 1 noted that in August 2015, there was evidence that Mr A's cancer had returned and spread to his stomach wall. Given the extent his cancer had spread by that point, Adviser 1 explained that any further surgery would not have cured him and it was unlikely to have significantly prolonged his life.

92. Adviser 1 explained that when the Board identified that Mr A's kidney cancer had returned and spread in April 2016, the delay in referring him to oncology for systemic treatment was unlikely to have made a difference to his outcome. Adviser 1 explained that according to the European Urology Association Guidelines on Renal Cancer, there is no evidence that an earlier diagnosis of widespread cancer improves the chance of survival. Adviser 1 also noted it was the oncologist's opinion that systemic treatment was unlikely to shrink Mr A's kidney tumour to the extent that they could carry out any further surgery. As a result, Adviser 1 considered that the delay in diagnosing and treating Mr A's kidney cancer was unlikely to have affected his long-term outcome.

(a) Decision

93. The basis on which we reach decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. I do not apply hindsight when determining a complaint.

94. The advice I have received and I accept is that when Mr A was first referred to the Board by his GP in November 2013:

- there was an unreasonable delay in diagnosing Mr A's kidney cancer, as the first GP referral was either lost or it was not actioned appropriately;
- there was an unreasonable delay in treating Mr A's kidney cancer, as his partial nephrectomy took place 127 days after his GP referral. This was more than double the national target to carry out cancer treatment within 62 days of the GP referral. The target to carry out Mr A's treatment within 31 days of the treatment decision being made was also breached by 19 days; and
- the Board unreasonably delayed in telling Mr A about the successful outcome of his partial nephrectomy, as he was only advised of the histology findings a month after they were issued to his GP.

95. The advice I received and I accept in relation to Mr A's kidney cancer returning is that:

- the August 2015 CT scan report was unreasonable, as it failed to report evidence of Mr A's kidney cancer having returned and spread to the area around his kidney;

- after the February 2016 ultrasound scan showed an area of concern in Mr A's kidney, there was an avoidable delay in referring him to the MDT;
- the March 2016 MDT failed to re-assess Mr A's August 2015 CT scan and/or identify the failing in how it was reported, either of which would be unreasonable;
- after the March 2016 MDT, there was a significant delay in carrying out the CT scans required to investigate Mr A's condition;
- the April 2016 triple phase CT scan unreasonably failed to report evidence of cancer spread to Mr A's rib, spine and stomach;
- when radiology reviewed the August 2015 CT scan, they failed to compare it to the April 2016 triple phase CT scan or they again missed the abnormalities in April 2016 triple phase CT scan, either of which would be unreasonable;
- the June 2016 CT scan was unreasonable as it failed to report evidence of cancer spread to Mr A's rib, spine and pelvis;
- the June 2016 MDT recommended a radical nephrectomy to treat Mr A which was incorrect, as the position of the largest tumour next to his inferior vena cava meant that the risk of surgery was high and the chance of curing his cancer was low;
- the June 2016 MDT unreasonably failed to identify the evidence of Mr A's cancer having spread, which was visible in the April 2016 CT scan and June 2016 CT scan;
- the June 2016 MDT should have had a process in place so that the consultant urological surgeon, who was due to carry out this complex surgery, checked that surgery would be technically feasible;
- Mr A was told that his cancer had returned in July 2016, three months after it was diagnosed in the April 2016 triple phase CT scan. This was a completely unacceptable delay, particularly given the seriousness of the diagnosis;
- Mr A should have been told there was a limited chance of successfully curing his cancer with a radical nephrectomy and a risk that the cancer would spread;
- there was an unreasonable delay in scheduling Mr A's radical nephrectomy, as it was due to take place 51 days after the MDT decision, which breached the national treatment target of 31 days;
- the consultant urological surgeon, who was due to carry out the radical nephrectomy, should have reviewed Mr A's CT scans before he was admitted to hospital to prepare him for the surgery;
- the August 2016 CT scan report was unreasonable as it failed to report the evidence of cancer spread to Mr A's rib, pelvis and spine. It also failed to report the risk of spinal cord compression, as a result of this cancer spread;

- when the August 2016 CT scan was reviewed by radiology a month later, the evidence of cancer spread to Mr A's spine and the risk of spinal cord compression was missed again, which was unreasonable; and
- the August 2016 MDT unreasonably failed to review and/or identify the failings in the reporting of the April 2016, June 2016 and August 2016 CT scans.

96. In light of these failings, I consider there was an unreasonable delay in diagnosing and treating Mr A's kidney cancer. There was also an unreasonable delay in diagnosing and treating his cancer, after it returned to his kidney and spread. I am particularly concerned with the systemic nature of these failings, given the numerous occasions that abnormalities were overlooked in Mr A's CT scans, when they were first reported and in subsequent reviews.

97. I am also deeply concerned with the nature of the communication with Mr A and his family about his condition and its seriousness. There was a significant delay in telling Mr A his kidney cancer had returned and a failure to clearly advise Mr A there was a limited chance his cancer would be cured with surgery and about the risk of his cancer spreading. This poor communication was particularly painful for his family. It denied them the opportunity to make meaningful life choices such as travelling and spending more time together, before Mr A's condition worsened.

98. In light of the failings identified, I uphold this complaint. My recommendations for action by the Board are set out below.

(b) the Board failed to handle Mrs C's complaint appropriately

Concerns raised by Mrs C

99. Mrs C complained that she was not properly updated during the Board's investigation of her complaint. Mrs C said there was an extremely lengthy delay of over 19 weeks before the response was issued. Mrs C told us that some of her concerns were answered by the Board. However, she felt that many of their answers were evasive, overly complicated and failed to offer her any real clarity about what happened.

The Board's response

100. The Board said they apologised unreservedly to Mrs C for the length of their complaints investigation. The Board explained they had offered to meet with Mrs C to discuss the response during their investigation, which she declined.

(b) Decision

101. I have significant concerns about the Board's complaints handling. I appreciate that this was a complex complaint and Mrs C, understandably, raised many issues of concern. Given the nature of the complaint, I appreciate why the Board's complaints investigation might have exceeded the 20 working day target set out in the NHS complaints handling process.

102. However, Mrs C waited almost four months for a response to her complaint, which was a significant delay. The decision to try to arrange a meeting with Mrs C and clinical staff appears to have largely contributed to this. I consider it would have been preferable if the Board had offered to meet with Mrs C after they issued a written response to her concerns and not during their investigation. Particularly given the complexity of the complaint, I consider this approach would have allowed Mrs C to first consider the Board's response and if she later wished to meet with clinical staff, she could have asked them to explain the aspects of the response she found to be overly complicated or unclear.

103. In addition, the NHS complaints handling process advises that a response to a complaint should:

- address all the issues raised and demonstrate that each element has been fully and fairly investigated; and
- include an apology where things have gone wrong.

104. I consider the Board failed to demonstrate they had investigated all the concerns raised by Mrs C. For example, they did not explain why the wrong recommendation was made by the MDT to refer Mr A for a radical nephrectomy or why the failings in the CT scan reports were not identified earlier.

105. I am very concerned that the Board did not identify or acknowledge the significant failings in their communication with Mr A and his family about his condition and outlook. For example, the Board did not acknowledge the significant delay in telling Mr A that his cancer had returned in 2016. They also did not acknowledge the failure to advise Mr A of the limited chance of successfully curing his cancer with surgery at that time or to explain the possibility of his cancer spreading. Instead of acknowledging the failure to clearly explain to Mr A his cancer might not be cured and that it might spread, the Board commented that it would have been unkind to tell Mr A he was terminally ill. It was inappropriate and unreasonable for the Board to make this judgement, given the importance of respecting a patient's right to be informed and to make decisions about their own care and treatment. As I have

determined under complaint (a), the Board should have informed Mr A of the terminal nature of his illness.

106. I note that the only learning or improvements the Board mentioned were improvements to their electronic record and referral system. I do not consider the action outlined was sufficient to give Mrs C reassurance that similar failings and delays would be avoided in future.

107. Although the Board acknowledged several failings in Mr A's care, the only apology they offered to Mrs C was for the delay in responding to the initial GP referral and in completing their complaints investigation. Given the issues she raised and the extent of the failings, this is wholly unacceptable and does not persuade me the Board gave reasonable thought to the feelings of a family going through such a difficult time.

108. Taking all of this into consideration, I uphold this complaint. My recommendations for action by the Board are set out below.

Recommendations

Learning from complaints
The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	• The Board unreasonably delayed in diagnosing Mr A's kidney cancer; • The Board unreasonably delayed in diagnosing Mr A's kidney cancer had returned and spread; • The communication with Mr A about his condition was unreasonable; and • The Board's complaints handling was unreasonable	Apologise to Mrs C for the unreasonable delays in Mr A's care and treatment; the failure to communicate reasonably with Mr A about his condition and the failings in the Board's complaints handling	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance By: 22 April 2019

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board's cancer treatment times, for both the partial nephrectomy and radical nephrectomy, exceeded the national targets	In similar cases, patients should receive treatment within 62 days of the referral and within 31 days from the decision to treat, as per the national targets	• Evidence that the findings of this investigation have been fed back to the relevant clinicians in a supportive way that promotes learning

			• Evidence of the steps being taken to reduce waiting times for treatment and better meet the national targets By: 20 May 2019
(a)	There were multiple instances where clinically significant abnormalities were missed when CT scans were reported and reviewed	Radiological findings should be accurately reported as far as possible	• Evidence that the findings of this investigation have been fed back to the relevant radiologists in a supportive way that promotes learning • Confirmation that the individual radiologist(s) will discuss this case at their next appraisal By: 20 May 2019
(a)	The multidisciplinary team (MDT) did not review and/or identify the errors in the reporting of Mr A's CT scans	There should be systems and safeguards in place to ensure: • the MDT actively review CT scan imaging, including, where appropriate, a re-assessment by a radiologist and a comparison with older imaging And • the radiologist is resourced, with the time, technology and support, to do this before the MDT for all cases and to issue addenda afterwards if required	Evidence of the systems in place to ensure that CT scan imaging is reviewed appropriately before MDTs and how this will provide necessary safeguards By: 20 May 2019
(a)	The MDT referred Mr A for a radical nephrectomy when it was not technically feasible	Systems should be in place to ensure the surgeon (for patients due to undergo complex or major surgery), inputs to the MDT on whether the surgery being considered or recommended by the MDT is technically feasible	Evidence that the Board has reviewed and where appropriate amended its approach, to ensure the views of operating surgeons on technical feasibility are considered. By: 20 May 2019

(a)	There was a delay in carrying out the imaging requested by the MDT to investigate the extent of Mr A's cancer	Systems should be in place to ensure requests for imaging by the MDT are followed up with an urgent imaging request and an automatic MDT review as soon as the imaging has been completed	Evidence that the Board has reviewed the MDT approach and supporting processes to ensure that any imaging requested by the MDT is carried out within an appropriate timescale By: 20 May 2019
(a)	The consultant urological surgeon's communication with Mr A about his condition was unreasonable	Patients should be given prompt, clear, realistic and honest information about their condition, its seriousness and the likely chance of success from any treatment options	• Evidence that the findings of this investigation have been fed back to the individual consultant urological surgeon in a supportive way that promotes learning. • Confirmation that the individual consultant urological surgeon will discuss this case at their next appraisal. • An explanation about how this will inform wider learning in the Board By: 20 May 2019
(a)	There were errors in CT scan reports by the private company used by the Board for radiology outsourcing	Radiological findings should be accurately reported	Confirmation that the Board has a system in place to feedback reporting discrepancies to any private radiology companies they use for outsourcing work By: 20 May 2019

We are asking Grampian NHS Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	There was an unreasonable delay in the Board's complaints investigation, partly because they tried to arrange a meeting with Mrs C before issuing a formal response to her concerns	Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here: www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs	Evidence that the outcome of this investigation has been fed back to staff in a supportive manner which encourages learning, and that all staff are aware of and understand the complaints handling procedure By: 20 May 2019
(b)	The Board's own complaints investigation did not identify or address all of the failings in the care provided to Mr A	The Board's complaints handling system should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement	Evidence that the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here By: 20 May 2019

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board told us they have improved the pathway for GP referrals	The Board should have a clear reliable pathway for both electronic and paper referrals	Details of the current referral pathway for electronic and paper GP referrals and how they are actioned By: 22 April 2019
(b)	The Board told us that they discussed the errors in the CT scan reporting at a radiology discrepancy meeting	As far as possible, radiological findings should be accurately reported	• Evidence that this case has been discussed at the departmental radiological 'learning from discrepancies' meeting. • Confirmation that in discussing these errors, the CT scan imaging was examined and compared with earlier CT scans By: 22 April 2019

Feedback

Points to note:

Adviser 2 explained that it would have been best practice for the reporting radiologist to make a direct referral to the MDT in 2014. However, they might not have been aware of the local process to do so because they were working remotely for a private company. The Board might wish to make private companies aware of the local process for radiologists to make direct MDT referrals.

Adviser 1 noted that Mr A waited four weeks to be told about his kidney cancer, after his diagnosis was confirmed by the January 2014 CT scan and his treatment was discussed by the MDT. The Board might wish to consider if it is possible to streamline this process so patients are offered earlier urology appointments in similar circumstances.

Adviser 1 considered that the Board could have written to Mr A about the histology findings at the same time as they wrote to his GP. The Board might wish to consider copying patients into these types of GP letters in future.

Adviser 2 commented that the use of standardised CT protocols would make it easier to compare any follow-up CT scans with previous CT scans. The Board might wish to carry out a review of CT protocols to ensure that optimum diagnostic quality imaging is obtained across the whole range of clinical scenarios or possible pathologies.

Terms used in the report **Annex 1**

Addendum	a note added later
Adviser 1	a consultant urologist who provided medical advice on Mr A's care and treatment
Adviser 2	a consultant radiologist who provided medical advice on Mr A's care and treatment
CT scan	a CT scan uses x-rays and a computer to create detailed images of the inside of the body
Histology findings	a report on the microscopic appearance of tissue
Inferior vena cava	the major vein in the abdomen
Lesion	an area of damage
Lymph node	glands that drain lymph, a clear body fluid running through the tissues
MDT	multidisciplinary team meeting
Mr A	the aggrieved
Mrs C	the complainant and wife of Mr A
Oncology	cancer specialists
Partial nephrectomy	the surgical removal of part of the kidney
Radical nephrectomy	the surgical removal of all of the kidney
Radiologist	specialists in medical imaging

Renal cell carcinoma	a type of kidney cancer
Systemic treatment	the use of drugs to treat cancer cells wherever they are in the body
the Board	Grampian NHS Board
Triple phase CT scan	an enhanced CT technique using a contrast and timing delays
Ultrasound scan	a scan that uses sound waves to create images of organs and structures inside the body
Urologist	a clinician who treats disorders of the urinary tract
Urology	a specialty in medicine that deals with problems of the urinary system and the male reproductive system

List of legislation and policies considered **Annex 2**

The Scottish Cancer Referral Guidelines the Scottish Government (2011):

- The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days.
- The maximum wait from decision to treat to first treatment for all patients diagnosed with cancer is 31 days.
- Patients waiting for one of the eight key diagnostic tests and investigations should wait no longer than six weeks.

Suspected Cancer: Recognition and Referral National Institute for Health and Care Excellence Clinical Guideline 12 (June 2015)

Renal Cell Cancer Guidelines European Association of Urology, published yearly

Renal Cancer Clinical Quality Performance Indicator 4 NHS Scotland (updated December 2014)

Cancer Multidisciplinary Team Meetings - Standards for Clinical Radiologists The Royal College of Radiologists (2014)

Standards for Learning from Discrepancies Meetings The Royal College of Radiologists (2014)