SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case ref: 201402286, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals; clinical treatment / diagnosis

Summary
Mr A had an operation in May 2011 to remove half of his large bowel due to a malignant tumour. In May 2012, Mr A had a follow-up appointment and his GP was contacted to say that blood tests had been taken, a scan was to be arranged, and that Mr A would be seen again in six months. Mr A had his scan in July 2012. No action was taken by the board as a result of the scan test, and Mr A did not have another appointment until September 2013. It was at this appointment that he learned that the results from the July 2012 scan indicated that it was likely that cancer had spread to his liver and one of his lungs. At this point a second scan was arranged, but there were further delays at this point in obtaining a scan. Mr A's daughter (Mrs C) had to contact the board a number of times to get an appointment for her father. She complained to the board but was not satisfied with their response, and so complained to my office. Mr A began chemotherapy in late 2013, and died in August 2014.

As part of my investigation I took independent advice from a consultant physician and a consultant oncologist.

On Mrs C's first complaint about the delay in assessing her father's test results, I found that a combination of errors and inadequate systems resulted in a failure to assess and refer Mr A for treatment of his cancer. My physician adviser noted that the board had not more thoroughly investigated the handling of the test and scan results in their response to Mrs C. Given that neither set of results had been handled correctly, the adviser was concerned that this reflected a more general failure of results gathering / scrutiny by the board. Whilst some changes to test result handling procedures have been made by the board since the time period under investigation in this case (as a result of a recommendation in a previous SPSO case 201305802), further action will be required to fully address the concerns outlined in my investigation. My adviser was also concerned to note that the board's response to Mrs C's complaint did not reflect on their role in regard to the long period between follow-up appointments. I am therefore concerned that this situation could arise again.

The delays in arranging a second scan were also unacceptable. Whilst the board accepted that Mrs C had to make an unreasonable number of calls to chase an appointment, they have not apologised for this. My advisers both noted that, given the circumstances surrounding the initial delay in communicating the scan results to Mr A, it was not reasonable to leave Mr A and his family waiting again for the second scan. The board had also not apologised to Mrs C for the second delay, and I am very critical of this.

Mrs C had noted that when her father saw the cancer specialist after the second scan, he was told that even if the July 2012 scan result had been picked up earlier, he would not have been offered further surgery and that starting chemotherapy at an earlier stage would have been unlikely to make any difference to his prognosis. However, the advice I received from my oncology adviser was that Mr A received very poor care: even if there was no treatment to cure his cancer at that time, being told of the results more than a year prior to when he actually found out would have given him and his family more time to know that he was terminally ill and to plan accordingly.

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	apologise to Mrs C for the delay in acting on the spread of cancer reported in July 2012;	19 August 2015
(ii)	ensure this case is raised with the Registrar and Consultant 1 for discussion at their annual appraisals;	19 August 2015
(iii)	review the process for the booking of out-patient clinic appointments;	16 September 2015
(iv)	take steps to ensure all laboratory staff are fully aware of the process for dealing with referrals without appropriate requesting clinician details;	16 September 2015
(v)	ensure radiology staff have a robust system in place for notifying referring clinicians of urgent and unexpected results;	16 September 2015
(vi)	consider the introduction of a safeguard whereby the radiology department copy unexpected results of malignancy direct to the relevant multi-disciplinary team;	16 September 2015
(vii)	report on the outcome of the ongoing Board level	30 September 2015

	review of the tracking of test results in both paper and electronic formats and the role of individuals who order tests and report their results;	
(viii)	apologise to Mrs C for the delays in arranging the follow-up scan; and	19 August 2015
(ix)	ensure that all administrative and medical staff involved in this complaint are aware of the findings of this investigation.	19 August 2015

Introduction

1. Mrs C complained to the Ombudsman about the care and treatment that her father (Mr A) received from Lanarkshire NHS Board (the Board). Mr A had undergone an extended right hemicolectomy (an operation to remove half of the large bowel) for a malignant tumour in May 2011. Following a review by oncology, it was decided that there would be a surgical follow-up, rather than treatments such as chemotherapy. The complaints from Mrs C I have investigated are that:

(a) there was an unreasonable delay in assessing Mr A's computerised tomography (CT) scan conducted on 10 July 2012; (*upheld*); and

(b) there were unreasonable delays in obtaining an appointment for Mr A's follow-up CT scan (September and October 2013); (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer considered all the information provided by Mrs C and the Board. Independent advice was also obtained from a consultant physician (Adviser 1) and a consultant oncologist (Adviser 2). In this case, we have decided to issue a public report on Mrs C's complaint given the significant personal injustice suffered by Mr A. It was also considered that there was evidence of systematic failure in results reporting systems which required further investigation.

3. 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

4. In May 2011, Mr A underwent an extended right hemicolectomy for a malignant tumour. Following a review by oncology, it was decided that there would be a surgical follow-up and no chemotherapy due to an existing cardiac condition.

5. Mr A was seen by a consultant colorectal surgeon (Consultant 1) in an out-patient clinic in July 2011 and he was subsequently seen by a surgical trainee (the Registrar) at his next out-patient appointment on 17 May 2012. A CT scan was requested following this appointment to assess Mr A's condition and routine blood test were also carried out as part of the standard procedure for colorectal cancer patients.

6. A letter was sent to Mr A's GP dated 21 May 2012 stating that the Registrar had arranged routine blood tests and a follow-up CT scan of the chest, abdomen and pelvis. This correspondence also advised that Mr A would be reviewed again in six months. Although Mr A was meant to be seen again for a further follow-up, no appointment was booked onto the system.

7. A CT scan was carried out on 10 July 2012 which indicated it was likely that cancer had spread to Mr A's liver and also to the right lung. The radiology report states that a consultant radiologist (Consultant 2) would arrange for the results to be brought to the attention of the referrer by telephone. Consultant 1 was noted as the referring clinician. No action was taken by the Board as a result of the CT scan result from 10 July 2012. Consultant 1 has advised that it has been their practice for the last three years to sign and date all the results they see and states that as this report has not been signed/initialled, they never saw the result. The blood tests that were carried out following Mr A's out-patient appointment of 17 May 2012 were also not reviewed by any clinician. The referring consultant's name is recorded as 'unknown' on the results whilst the clinical details were noted to be 'illegible'.

8. Mr A was next seen by Consultant 1 at the out-patient clinic on 19 September 2013, over a year after the CT scan identified malignancy. At this time Consultant 1 explained the results of the scan and a referral was made to a consultant oncologist (Consultant 3) for consideration of palliative chemotherapy. Consultant 1 was also to arranged for Mr A to have a further CT scan.

9. Mrs C advised us that on 1 October 2013, she contacted Consultant 1's secretary as she had a number of questions and Mr A had not yet received the CT scan appointment. She was advised that a call back would be arranged. Mrs C advised that she called the secretary again on 4 October 2013 as she had not heard anything. During this call Mrs C was apparently advised that they could not locate Mr A's notes and that a doctor would call her once they had been reviewed. Mrs C said that on 7 October 2013, she called again and was advised that the notes had been located and that the doctor would call her back once there had been an opportunity to review them. Mrs C advised that on 8 October 2013, she spoke with a doctor and explained her concerns. She said that the doctor advised her that Consultant 1 had requested the CT scan but that nothing had been booked. Mrs C advised us that she told the doctor how unhappy she was with this and stated that they should call her back by

9 October 2013, at the latest, with a date for the scan. Mrs C was advised on 9 October 2013 that the scan had been arranged and that they would receive the date by post.

10. The further CT scan was carried out on 25 October 2013. Mr A's case was discussed by the multi-disciplinary team and he saw Consultant 3 on 1 November 2013 regarding his treatment. Consultant 3 advised him that he would never have been a candidate for liver surgery even if the if the July 2012 CT scan had been picked up earlier. Consultant 3 explained that his survival in July 2012 would have been quoted at around six to nine months without treatment and 12 to 18 months with treatment. They considered that having chemotherapy at an earlier stage would have been unlikely to made any difference to his prognosis. Consent was given for chemotherapy and this treatment was started thereafter.

11. Mrs C wrote to her MSP to ask for his assistance in making her complaint on 28 October 2013. There was a delay to the Board's complaint investigation proceeding due to missing information and consent issues. These matters were resolved on 20 January 2014 and the Board investigated Mrs C's concerns. A final response was provided on 25 March 2014.

12. Mrs C was dissatisfied with the Board's response and decided to bring her complaints to the Ombudsman. Sadly, Mr C died a short time later on 5 August 2014.

(a) There was an unreasonable delay in assessing Mr A's CT scan conducted on 10 July 2012

Concerns raised by Mrs C

13. Mrs C complained that Mr A went for a CT scan on 10 July 2012 as part of his surgical follow-up. She said she understood that there was meant to be an appointment every six months to one year but that none was received. Mrs C advised she had to chase the Board regarding his next appointment which took place in September 2013. Mrs C complained that Mr A was informed at that appointment that his cancer had spread, over a year after the CT scan had taken place.

The Board's response

14. In their final response to this complaint, the Board advised that the CT scan carried out on 10 July 2012 showed the spread of cancer and

confirmed that Consultant 1 had not received or reviewed Mr A's scan results. They advised that this was unacceptable and had identified a weakness within their systems. The Board went on to advise that the implementation of their electronic radiology reporting system in May 2013 ensured that the referring doctor must access the system to sign off the radiology report and, therefore, such an error should not happen again.

15. The Board said that Consultant 1 had not seen the scan result of July 2012 due to a failure in communication between departments but that the new radiology reporting system should prevent such errors in future. They also advised that the radiology department had reviewed their practice and now recorded the doctor with whom they have discussed reports. The Board went on to inform Mrs C that in reviewing the out-patient follow-up, there was a gap of over a year in Mr A coming back to the clinic. They said that it was unclear why an earlier appointment was not made in May 2012 and that had this happened, it may have brought the lack of review of the July 2012 scan to light.

16. In response to enquiries during the investigation of this complaint, the Board advised that the blood samples taken for testing on 17 May 2012 had not included the referring clinician's name. This resulted in the results not being directed to any specific person and checks of the electronic system show that they were not accessed a clinician. No paper copy was placed in Mr A's file and so no audit trail exists to show that these were reviewed.

17. They also advised that Consultant 2 was unable to recall Mr A's case due to the passage of time. Consultant 2 advised that the level of urgency in acting on the scan findings would not have been immediate but considered that the referring clinician should have been made aware of the result within two weeks at the most.

18. The Board described the process of their new electronic radiology reporting system (Order Comms) and how this clarifies accountability as the requesting clinician is responsible for follow-up action on investigations. They advised that under the new system, the Registrar would not have had the correct privileges to request and sign off on a CT scan and, therefore, this would have appeared in Consultant 1's work list. The Board explained that they had recently issued further guidance to all consultants that should they find a result has been entered onto their work list in error, it is their responsibility to ensure that it is redirected to the correct clinician. They went on to advise that

each clinical team should have an agreed hierarchy for authorisation/sign off of results and that each directorate team, should have a process for regularly reviewing lists of results that are coded as 'not signed off'.

19. The Board acknowledged that there had been a breakdown in the process of review for Mr A's out-patient clinic results (both the CT scan and blood tests) and that there were a number of possible safeguards that should have been in place (but were not). They went on advise that laboratory staff should have taken steps to identify the referring clinician for the blood results by using Mr A's Community Health Index number and the sample date before forwarding the result to the Directorate Support Manager. The Board explained that the letter issued following Mr A's out-patient appointment on 17 May 2012 should not have been verified by the Registrar or Consultant 1 without highlighting that results were outstanding and that a follow-up appointment had been made. Finally, the Board advised that a regular review file with 'pending' actions like Mr A's outstanding results should have been held to ensure that no issues were overlooked by Consultant 1 or the administrative support team.

20. The Board said that a risk assessment was carried out prior to the implementation of the Order Comms system and that this was continually re-evaluated in the context of changing working practices. They advised that Mr A's case had highlighted that consultant staff need further clarification regarding their professional responsibilities and that clinical administrative teams needed absolute clarity on supporting workflows. The Board advised that a working group had been established to agree assurance processes for the receipt, acknowledgement, action and safeguards required for all clinical investigation regardless of whether electronic or paper systems were in place.

21. The Board advised that the radiology department arranges for urgent or unexpected findings to be brought to the attention of the referring clinician by asking a radiology secretary to telephone the referrer's team, usually the clinician's secretary. They clarified that the radiology secretary now records the fact that this telephone call has been made by making an entry in a dedicated folder. The Board advised that direct discussion with the referring doctor is undertaken when an emergency situation is detected.

Medical advice

22. Adviser 1 was asked to comment on whether it was appropriate that no follow-up appointment was booked for Mr A. Adviser 1 said that the plan was

for an appointment to be made for Mr A to be seen again but that this did not occur. He advised that this fell below a level Mr A could expect and was unreasonable as a result. Adviser 1 commented that the exact circumstances of this were unclear but that the Board's view was that Mr A was expected to make an appointment as he left the out-patient clinic. He explained that this is often done by the clinician giving the patient a slip of paper with instructions for the reception staff with nursing staff on hand to direct this process. Adviser 1 noted that there was no information about the nature of the conversation between Mr A and the Registrar so this was now very difficult to judge.

23. Adviser 1 went on to explain that there is some onus on the patient to organise their own appointment in a case such as this. However, some responsibility for making the appointment and informing the patient of when the appointment occurs also lies with the out-patient clinic staff. Adviser 1 said that it could be possible that Mr A had not understood in the surroundings of a busy clinic that there were differences between his follow-up scan and follow-up appointment. He considered that if Mr A was told that the scan appointment would be sent out to him, he may have assumed that this also applied to the out-patient clinic appointment. Adviser 1 said that when patients are receiving information about complex arrangements such as this, clinic staff should help them understand and make sure the correct arrangements are in place before they leave the clinic area.

24. Adviser 1 found that the clinic letter issued following the appointment of 17 May 2012 stated that Mr A would be seen again in six months. He noted that the Board response was unclear why an appointment was not made. Adviser 1 commented that having considered Consultant 1's submission on the complaint, he found that Consultant 1 had misinterpreted this aspect as they had stated 'from the registrar's letter it is clear Mr A was asked to make an appointment for six months'. He advised that this was not the case and that the Registrar had in fact said 'He will be reviewed again by the general surgeons in six months'.

25. Adviser 1 found that there had been no specific investigation of this by the Board or any review of the usual clinic procedures. He advised that the Board had not addressed this aspect of the complaint in sufficient detail and that there had been no meaningful reflection on their own role in this. Consequently, Adviser 1 considered that it was likely that this situation could arise again.

26. In relation to the scan report, Adviser 1 noted it was clear that Consultant 2 thought there were abnormalities which indicated that cancer had returned and spread to other organs. Adviser 1 said that the report contained information that, given the serious nature of the findings, would be brought to the attention of the referrer by telephone. He went on to say that this is in keeping with the guidance from the Royal College of Radiologists which states:

> '1. There should be effective and timely communication of imaging reports. There are situations where “routine” methods of communication of imaging reports to clinician are inadequate (4). … Imaging findings that suggest serious pathology, e.g. likely malignancy that are thought to be unsuspected should be communicated in a manner that reasonably ensures timely treatment.'

27. He went on to advise that the safeguard of the radiology department informing the referring clinician directly appeared to have failed in this case. Adviser 1 found that there was no note of any telephone call made to Consultant 1's team. Although Consultant 2 believed that this call would have been made as part of normal practice after identifying urgent or unexpected findings, Consultant 2 was unable to recall Mr A's case due to the passage of time.

28. Adviser 1 commented that as the clinician responsible for Mr A's care, Consultant 1 had a duty of care with regard to the CT scan, even though they had not organised it directly. He advised that the paper trail of the scan report (where it went and when) is lacking and noted that Consultant 1 described not having seen the report before as it was their practice to initial reports when they are seen and this report bore no signature. He advised that it was unclear how this paper report had come to be filed in Mr A's notes without having been seen by a clinician or if it had in fact been seen and the abnormalities gone un-noted. Adviser 1 considered that on balance, the radiology report was so clear in its findings, it was unlikely that this would have been filed without action by medical staff if it had been seen by them. He went on to say that he was concerned that the Board had not investigated this aspect of Mrs C's complaint in more detail. Taking into account that there was also no signature on the blood test results, Adviser 1 was concerned that the failure of the Board to note the CT scan result reflected a more general failure of results gathering/scrutiny. One of the blood tests that was carried out following the 17 May 2012 out-patient appointment was to check the Carcino Embryonic Antigen (CEA) level which can be raised in bowel cancer. Adviser 1 found that this was reported to be mildly abnormal

(Mr A's level was six micrograms per litre whereas the normal range is zero to five). He said that in contrast, the CT scan result showed a clear recurrence of cancer, however, like the scan result the CEA level result was not checked by clinicians and was presumably a failure of the same systems.

29. Adviser 1 said that given the limitations of the paper based system of results that was in place at the time, it would have been better had Consultant 1 had a system in place to track tests and other investigations that had been ordered. He noted that there was no description of any such system and that Consultant 1 appeared to rely solely on the paper results arriving. Adviser 1 found that the fact that the paper CT scan report had apparently not arrived with Consultant 1 to be a failure of the 'postal' system used at that time but he considered that there should have been a safeguard mechanism in place to prevent this delay becoming too long.

30. Adviser 1 was concerned that three stages of the process had all failed in this case, namely the radiology department communicating the result to Consultant 1's team, the paper result delivery system and Consultant 1/the Registrar seeking out the result. He went on to advise that the clinical investigation process was investigated by the Board without sufficient scrutiny and with an undue level of reassurance placed on the new Order Comms process.

31. Overall, Adviser 1 highlighted a number of specific concerns following his consideration of this case. He advised that steps had not been taken by the Registrar to ensure that a follow-up appointment was made for Mr A and the results of the CT scan reviewed. He also noted that the clinic letter issued following the 17 May 2012 appointment had not been approved until a month after it was ready on the system (18 June 2012) rather than within a few days as it should have been. Adviser 1 commented that the Registrar did not appear to have been involved in the complaint investigation and was concerned by this given the errors that stemmed from the clinic appointment. He considered that as a trainee, there were educational issues that should have been discussed with the Registrar.

32. Adviser 1 was concerned that Consultant 1 had not initiated a review of this case when it became apparent that the CT result had been missed. He advised that the General Medical Council (GMC) guidance 'Good Medical Practice' has a section on safety and quality which states:

'…23 To help keep patients safe you must: …
…b contribute to adverse event recognition.'

Adviser 1 found the delay in noting the CT scan result to be an adverse event and advised that he was concerned that Consultant 1 did not take any action at the time to investigate it. He was also concerned that Consultant 1 had not indicated that the complaint and learning from it would be included in their annual appraisal.

33. Additionally, Adviser 1 was concerned that Consultant 1 did not provide a formal apology at the time the error was discovered. He explained that 'Good Medical Practice' states:

'If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if this is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.'

Adviser 1 considered that Mr A had suffered distress and harm from a delayed diagnosis but that the overall impression given by Consultant 1 was that this had not altered his prognosis. He advised that Consultant 1 did not offer sufficient apology or redress at the time.

34. Adviser 1 found that it was very poor care for Mr A that he did not receive an earlier diagnosis of the spread of his cancer as he should have. He advised that better care would have been a review of his scan in August 2012 to inform him of the results and discuss the implications. Adviser 1 considered that, even if there was no curative treatment that could have been offered at that time, it would have given Mr A more time to know that he was terminally ill and plan accordingly. He was concerned that the Board failed to provide a reasonable level of care to Mr A and found that their investigation was both superficial and overconfident in its conclusions about future patient safety.

35. Adviser 2 was asked to comment on Mr A's prognosis following the CT scan result of July 2012. He explained that in July 2012 there was evidence of the spread of cancer to both lobes of the liver and at least six nodules in the lung. Adviser 2 considered that in this situation liver surgery would be unlikely to be considered as the cancer had already spread and the procedure would not be curative. He found that given the presence of cancer in both the liver and lung, curative treatment would not have been possible even if the CT scan

result had been acted on sooner. Adviser 2 referred to clinical trial evidence that in colorectal cancer patients with metastatic disease (the spread of cancer) but without symptoms, there is no advantage to embarking on palliative chemotherapy immediately, rather than waiting until symptoms develop and beginning treatment then. He advised that the overall survival time for patients using both these strategies is the same. Adviser 2 commented that this suggested that the delay in starting Mr A's chemotherapy would have made little difference to the overall outcome.

36. Adviser 2, went on to note that when Mr A was seen in the oncology clinic on 1 November 2013, he was not considered to be well enough to receive combination chemotherapy and was given a single agent instead. Adviser 2 considered that if the result of the July 2012 scan had been identified earlier, it was possible that Mr A may have been able to receive the combination treatment which has a higher response rate, leading to longer duration of survival. Adviser 2 was clear, however, that even if this combined treatment had been given, a superior outcome was not guaranteed and a cure would not have been possible.

(a) Decision

37. It is clear that there was a complete failure to act appropriately on the results of the CT scan of 10 July 2012 and the advice I have received is that Mr A's care in this regard fell below a level he could reasonably expect. While Mr A's prognosis may not have been changed by earlier treatment, it is unacceptable that no action was taken at that time in relation to the spread of cancer. I note the advice that this could have given Mr A more time to know that he was terminally ill and plan accordingly.

38. The Board have recognised the failure in this case given that Consultant 1 did not review the results of Mr A's CT scan. I am critical that while there has been an acknowledgement of their failing, the Board do not appear to have made any meaningful apology to Mrs C or her family for this, either at the time the error was identified or later when her MSP brought the complaint to the Board.

39. The advice I have received is that this is not in keeping with the relevant GMC guidance which indicates that a formal apology should have been offered by Consultant 1 in September 2013 and an adverse event review started. The Board's own policy and procedure for handling and learning from feedback,

comments, concerns and complaints is clear that an apology will be offered where appropriate:

> '4.3.13 Report of the investigation
> …The report will include:
> …• an apology where things have gone wrong
> …'

The Board should have included an apology in their written response to Mrs C's complaint in March 2014. While I appreciate this was issued to the MSP rather than directly to Mrs C, I can see no justifiable reason why an apology for this significant error was not included.

40. Furthermore, although there has been acknowledgement of the error, I am not satisfied that the issues which led to the delay in identifying the report of malignancy (cancer) were reasonably investigated at the time. The advice I have received is that there were a number of processes that failed in this case around both radiology and laboratory results reporting.

41. In terms of the CT scan result, I note that there has been a significant level of reliance placed on the new electronic system to prevent errors such as this occurring in future. The Board have advised that a working group has been established to agree assurance processes for the receipt, acknowledgement, action and safeguards required for all clinical investigation regardless of whether electronic or paper based systems are in place. I understand that this is related to a recommendation made to the Board under the SPSO case reference 201305802 as a result of their failure to take appropriate, timely action on an abnormal blood result. Following my investigation of that complaint, I recommended that a Board level review was conducted of the role of individuals who order tests and report their results, and the tracking of test results in both paper and electronic formats. In the course of carrying out this recommendation, the Board have advised that the development and implementation of a quality assurance framework is a more complex task than was originally appreciated and will take several months. They are continuing to work on this important project and will be providing a further update by the end of September 2015.

42. I note that the radiology department have now amended their practice so that the details of calls notifying the referring clinician of urgent or unexpected results are noted. Due to the passage of time, it has not been possible to

determine exactly where the failing in the telephoning of the CT scan result arose in Mr A's case. What is clear is that there was a significant error either by the radiology department in not drawing the result to the attention of Consultant 1 or on the part of Consultant 1's team in failing to take appropriate action as a result of the call.

43. The Board did not identify any issue with the reporting of Mr A's blood test results during their own investigation of Mrs C's complaint. Enquiries made during my investigation uncovered that the results of Mr A's blood tests were not reviewed by a doctor. I acknowledge the Board's reference to potential safeguards that could have prevented Mr A's CT scan/blood test results from being missed and highlighted the fact that a further appointment had not been made. Mr A was without any follow-up by the Board for over a year. The advice I have received is that while there is some onus on the patient to make the necessary appointments, the Board also have some responsibility for ensuring out-patient appointments are booked. Insufficient consideration was given to this area during the Board's original investigation of Mrs C's complaint and I am concerned by the advice received that this situation could arise again.

44. It is clear that Mr A should have received timely follow up action after the CT scan of 10 July 2012 was reported by the radiology department. A combination of errors and inadequate systems resulted in a failure to assess and refer Mr A for treatment of his cancer. I find that this was unreasonable. While I expect that issues surrounding the blood test and CT scan results will be considered to some extent by the Board as part of their ongoing review of the ordering and tracking of tests, further action will also be required to fully address my concerns. In view of these findings, I uphold this complaint.

(a) Recommendations

45. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the delay in acting on the spread of cancer reported in July 2012;	19 August 2015
(ii) ensure this case is raised with the Registrar and Consultant 1 for discussion at their annual appraisals;	19 August 2015
(iii) review the process for the booking of out-patient clinic appointments;	16 September 2015
(iv) take steps to ensure all laboratory staff are fully	16 September 2015

	aware of the process for dealing with referrals without appropriate requesting clinician details;	
(v)	ensure radiology staff have a robust system in place for notifying referring clinicians of urgent and unexpected results;	16 September 2015
(vi)	consider the introduction of a safeguard whereby the radiology department copy unexpected results of malignancy direct to the relevant multi-disciplinary team; and	16 September 2015
(vii)	report on the outcome of the ongoing Board level review of the tracking of test results in both paper and electronic formats and the role of individuals who order tests and report their results.	30 September 2015

(b) There were unreasonable delays in obtaining an appointment for Mr A's follow-up CT scan (September and October 2013)

Concerns raised by Mrs C

46. Mrs C complained that Mr A was informed that a further CT scan would be necessary, she had to make repeated calls to Consultant 1's administrative team to chase this up before being told on 9 October 2013 that an appointment had been booked. Mrs C felt it was unreasonable to have to follow-up with the hospital in this manner, especially for other people who, who unlike Mr A, have no family to help them.

The Board's response

47. The Board advised that they had carried out a detailed examination of the events and agreed that it was unacceptable that Mrs C had to make a number of calls to the department. They advised that this had been addressed this with the relevant staff.

48. In response to further enquiries made during the investigation, the Board advised that the process for dealing with patient/relative enquiries had been discussed with the secretarial staff involved at the time and that they were also advised that they must follow the set procedure. This had not occurred in Mrs C's case and the Board advised that it had been emphasised to the secretarial staff that they are the link between the patient/relative and the medical staff. They were also advised that their responsibility is to provide clear concise updates when managing telephone enquiries.

Medical advice

49. Adviser 1 noted that Mr A had been seen by Consultant 1 on 19 September 2013 at which point a further CT scan was discussed. Mrs C then telephoned Consultant 1's team on 1 October 2013 as Mr A had received no information about the further scan. Adviser 1 found that it had taken nine days from the first contact by Mrs C for staff to confirm that the scan request was underway. He advised that given the previous delay, and the anxiety that further delays could have caused, he was concerned that more effort had not been made in this case. Adviser 1 said that a delay of a few days might be reasonable in normal circumstances but this was a case where there had already been a significant delay and a serious diagnosis. He considered that better care for Mr A would have been to ensure that the scan process followed on this occasion was more organised and secure.

50. Adviser 2 commented that the CT scan had been requested following the out-patient appointment of 19 September 2013 and was performed on 25 October 2013, a wait of well over a month. He advised that in the circumstances of the previous scan having been abnormal but not acted on, and the inevitable anxiety this would have caused, he considered it reasonable to expect that a further scan would be performed and a clinic appointment arranged to discuss the results within two to three weeks. Adviser 2 said that while this would not have affected the overall outcome, the wait had clearly caused considerable avoidable anxiety.

(b) Decision

51. The Board have accepted that Mrs C had to make an unreasonable number of calls to chase the further scan appointment but as with the previous complaint, they have not offered an apology to Mrs C. Once again, I am critical of this. A full apology should have been provided in the Board's response to Mrs C's complaints in line with their complaints handling policy.

52. The advice I have received is that it was not reasonable to leave Mr A and his family waiting again after such a significant delay having already occurred in his care and treatment. I appreciate that Consultant 1 and the secretarial team would not have been responsible for allocating the scan appointment but after the previous errors in Mr A's care, more should have been done to expedite the process and keep the family updated. Advice has indicated that Mr A should have had a further CT scan and been seen at an out-patient clinic appointment within two to three weeks. Instead, after being told on 19 September 2013 that

the Board had failed to act on the results of his previous scan, Mr A had to wait over a month to be seen.

53. I note that the Board have taken steps to address the involvement of Consultant 1's administrative team and that those staff have been reminded that they act as the link to the medical team.

54. Providing Mrs C with timely, accurate advice and expediting the scan process as much as possible could have relieved the family's anxiety at what would have been a very difficult time for them. This did not happen and in view of these findings, I uphold this complaint.

(b) Recommendations

55. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the delays in arranging the follow-up scan; and	19 August 2015
(ii) ensure that all administrative and medical staff involved in this complaint are aware of the findings of this investigation.	19 August 2015

56. 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 dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved
the Board	Lanarkshire NHS Board
CT scan	computerised tomography scan
Adviser 1	a consultant physician
Adviser 2	a consultant oncologist
Consultant 1	a consultant colorectal surgeon
the Registrar	a surgical trainee
Consultant 2	a consultant radiologist
Consultant 3	a consultant oncologist
MSP	Member of the Scottish Parliament
CEA	Carcino Embryonic Antigen
GMC	General Medical Council

Annex 2

Glossary of terms

Carcino Embryonic Antigen (CEA) level	a test of carcino embryonic antigen levels that can be useful in identifying colon cancer
chemotherapy	a treatment where medicine is used to kill cancerous cells
computerised tomography (CT) scan	a scan that uses x-rays and a computer to create detailed images of the inside of the body
extended right hemicolectomy	an operation to remove half of the large bowel
General Medical Council	the body that registers doctors allowing them to practice in the United Kingdom. Promotes and upholds standards for the medical profession
metastatic disease	the spread of cancer
Order Comms	electronic system allowing doctors to request test, make referrals and review test results
palliative chemotherapy	chemotherapy used to relieve the symptoms and slow it down where a cure is not possible
Royal College of Radiologists	a representative body which produces resources which are reviewed and updated regularly to ensure that they are consistent with current standards of practice and developments radiology and oncology

Annex 3

List of legislation and policies considered

General Medical Council, Guidance for Doctors, Good Medical Practice

NHS Lanarkshire Policy and Procedure for Handling and Learning from Feedback, Comments, Concerns and Complaints

SIGN Guidelines for Colorectal (Bowel) Cancer

The Royal College of Radiologists, Standards for the communication of critical, urgent and unexpected significant radiological findings

The Royal College of Radiologists, Good practice guide for clinical radiologists