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: Glasgow

Case ref: 201407748, A Medical Practice in the Glasgow and Greater Clyde NHS Board area
Sector: Health
Subject: GP & GP Practices; clinical treatment; diagnosis

Summary
Ms C, who works for the Patient Advice and Support Service, brought the complaint on behalf of Ms A. It concerned the delay in Ms A's son's diagnosis with Hodgkin's Lymphoma (a cancer that develops in the lymphatic system). I decided to issue a public report because of the significant personal injustice suffered by the child and his family in delaying the diagnosis. I was also concerned that this case highlighted a potential systemic failure at the GP practice to recognise a 'red flag' symptom of cancer.

The child was taken to the practice in May 2013 with a painful swelling on the left side of his neck. He was seen by a doctor who took blood for testing and prescribed an antibiotic. The child returned to the practice later that month and was seen by a different doctor. A chest x-ray referral form was completed and a note made that blood tests were to be repeated in one month as some of the earlier results were abnormal. Further antibiotics were prescribed.

However, no appointment was made with the practice for the further blood tests and no chest x-ray appointment was allocated to the child at the local hospital. The child returned to the practice in October 2013 when he was seen again by the first doctor who immediately referred him for a chest x-ray and for further blood tests. Further consultations took place regarding the child's continuing pain and though a referral was made, it was not an urgent referral and the child was advised to wait for a forthcoming appointment in early November. After this appointment and following further investigation, he was diagnosed with Hodgkin's Lymphoma.

I took independent medical advice on this complaint from a GP adviser. They referred to the *Scottish referral guidelines for suspected cancer* and commented that they would expect a doctor to be aware of the significance of a left supraclavicular (above the collarbone) node and its potential as a sign of an underlying cancer. They said it would have been reasonable practice to refer the child at an earlier stage and considered that this delay suggested a lack of

clinical knowledge on the part of the practice doctors. Although it was considered beneficial to carry out blood tests and an x-ray, the adviser said that this should not have delayed the referral being sent when the child first presented with a lump.

This case also highlighted the way referrals were processed by the practice at that time. The practice were unable to say whether the letter requesting an x-ray had been lost at the practice and never posted; lost by Royal Mail; or lost within the records office at the local hospital. They apologised for the delay in the child receiving his x-ray acknowledged that ideally, the referral should have been followed up. They said that there had not been a robust system for following up referrals or test requests.

The practice explained that in order to prevent such incidents happening again, the process had been changed so that the referring doctor now gives the referral letter to the patient and instructs them to go directly to the hospital. They also advised that a register had been introduced on their computer system for the daily recording of all referrals and test requests. They said that this is checked each week and updated with results or other information received, with any entry that has not been actioned for more than two weeks being flagged for immediate attention. They considered that the new system worked well and would prevent a recurrence of the circumstances the child experienced. I asked the adviser about the new system introduced by the practice to monitor referral and test requests and they commended it and agreed that this would adequately address the issue of the chest x-ray request that arose in this case.

I am concerned that the events in this case suggest a gap in the clinical knowledge of both practice doctors who saw the child, as neither identified the significance of the supraclavicular lump. I appreciate that one of the doctors has now retired, but the other continues to practice. It is important that this matter is addressed without further delay as a learning priority, and I made a recommendation about this.

Redress and recommendations

The Ombudsman recommends that the practice:	*Completion date*
(i) issue a written apology for the delays in appropriately referring the child to the board;	20 April 2016
(ii) ensure that the practicing doctor identifies the	4 May 2016

	diagnosis and referral criteria for signs of cancer as a learning priority; and	
(iii)	ensure that this case is discussed at the practicing doctor's next appraisal.	18 May 2016

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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman on behalf of her client (Ms A). Ms A was concerned about the care and treatment provided to her son (Child B) by their GP practice (the Practice) prior to his diagnosis with Hodgkin's Lymphoma (a cancer that develops in the lymphatic system).

2. The complaint from Ms C which I have investigated is that that the Practice unreasonably delayed in diagnosing Child B with Hodgkin's Lymphoma during the period May 2013 to November 2013 (*upheld*).

Investigation

3. In order to investigate Ms C's complaint, my complaints reviewer carefully considered all the information provided by Ms C and the Practice. Independent advice was obtained from a medical adviser specialising in general practice (the Adviser). In this case, we have decided to issue a public report on Ms C's complaint due to the significant personal injustice suffered by Child B and his family in delaying his diagnosis. We were also concerned that this case highlighted a potential systemic failure at the Practice to recognise a 'red flag' symptom of cancer.

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

Complaint: The Practice unreasonably delayed in diagnosing Child B with Hodgkin's Lymphoma during the period May 2013 to November 2013

Key Events

5. This complaint has been brought by Ms C of the Patient Advice and Support Service (PASS) on behalf of Ms A following the care and treatment that Child B, received from the Practice.

6. Child B was taken to the Practice on 20 May 2013 with a painful swelling on the left side of his neck. He was seen by a doctor (Doctor 1) who noted that the swelling had been there for over a week and that Child B had recently had a cold. Doctor 1 took blood for testing and prescribed an antibiotic (a drug to treat bacterial infection).

7. Child B returned to the Practice on 31 May 2013 and was seen by a different doctor (Doctor 2). It was noted that Child B was coughing yellow

sputum and that he was suffering from tiredness and sweats. A chest x-ray referral form was completed and a note made that blood tests were to be repeated in one month as some of the earlier results were abnormal. Further antibiotics were prescribed.

8. No appointment was made with the Practice for the further blood tests and no chest x-ray appointment was allocated to Child B at the local hospital in the Glasgow and Greater Clyde NHS Board (the Board) area. Consequently, no further investigation of Child B's symptoms was carried out at that time.

9. Child B did not return to the Practice until 11 October 2013 when he was seen again by Doctor 1. Doctor 1 immediately referred Child B for a chest x-ray and for further blood tests. It was also noted that a referral was to be made for a biopsy of the lump.

10. Doctor 1 spoke with Ms A on the telephone on 30 October 2013 about Child B's pain and a consultation took place later that day. Child B was unwilling to have blood taken at that time as he was scared. Doctor 1 noted that there was an appointment in place with the Board's haematology department (specialists concerned with the study of blood and blood-related disorders) for 7 November 2013 and recommended paracetamol for the pain. A further telephone conversation with Ms A took place on 4 November 2013 regarding Child B's continuing pain.

11. Following further investigation of his condition by the Board, Child B was diagnosed with Hodgkin's Lymphoma.

12. Ms A was unhappy with the care provided to Child B by the Practice and contacted PASS to help her complain about the delay in diagnosing his condition.

Concerns raised by Ms C

13. Ms C wrote to the Practice on 5 February 2014 regarding Ms A's concerns. Ms C advised that she wished to submit a formal complaint about the delayed diagnosis of Child B's Hodgkin's Lymphoma.

14. This letter noted that the lump had appeared on the side of Child B's neck in early 2013 and that he had several appointments with Doctor 2 regarding this. Ms C outlined Ms A's concerns that, despite medication being prescribed,

the lump remained and that although Doctor 2 made an x-ray referral after abnormal blood results were reported, no radiology appointment was ever received.

The Practice's response

15. The Practice provided their response to Ms C's complaint on 26 March 2014. In this correspondence, they advised that Doctor 2 had now retired from the Practice but that he had been contacted about the complaint and had advised on his handling of Child B's case.

16. In their response, the Practice noted that Doctor 2 had seen Child B and sent a referral for him to have an x-ray taken, as well as advising that he should return to have blood tests repeated in one month. They stated that Child B did not return to the Practice until October 2013.

17. The Practice advised that the medical notes recorded that Doctor 2 requested an appointment for an x-ray but that due to the way referrals were processed at that time, they were unable to say whether the letter had been lost at the Practice and never posted; lost by Royal Mail; or lost within the records office at the local hospital.

18. They advised that they could only apologise for the delay in Child B receiving his x-ray. The Practice explained that in order to prevent such incidents happening again, the process had been changed so that the referring doctor now gives the referral letter to the patient and instructs them to go directly to the hospital.

19. The Practice also advised that Doctor 2 apologised for the delay caused to Child B and acknowledged that ideally, the referral should have been followed up. However, Doctor 2 also considered that if Child B had attended the following month for repeat blood tests as he had requested, the missing x-ray result would have been identified and followed up.

20. Ms C wrote to the Practice on 21 October 2014. Ms C advised that while it was welcomed that the x-ray referral process had been changed, Ms A still remained concerned about the delay in diagnosing Child B's condition. Ms C explained that Ms A was not made aware that Child B was meant to return for further blood tests following his 31 May 2013 appointment and that they

considered there should have been a system in place to prevent delays from happening.

21. The Practice provided a further response to Ms C on 31 October 2014. In this correspondence, the Practice advised that under Doctor 2, there had not been a robust system for following up referrals or test requests. They advised that a register had been introduced on their computer system for the daily recording of all referrals and test requests. The Practice explained that this is then checked each week and updated with results or other information received, with any entry that has not been actioned for more than two weeks being flagged for immediate attention. They considered that the new system worked well and would prevent a recurrence of the circumstances Child B experienced.

22. The Practice went on to advise that the records office at the local hospital had been contacted and that they had advised that the x-ray referral completed by Doctor 2 on 31 May 2013 had never been received by them. The Practice informed Ms C that it was not possible to comment on whether the referral had been sent or lost in the post but considered that the new system would prevent this happening in future.

23. The Practice advised Ms C that Doctor 1 had met with Ms A and her partner on two occasions and discussed the consultation with Doctor 2 on 31 May 2013. They went on to say it was clearly mentioned in Child B's medical notes that a chest x-ray was to be organised and bloods tests repeated in one month. The Practice acknowledged that neither Ms A nor her partner had any recollection of that and advised that the now retired Doctor 2 should be contacted directly if further clarification was required.

24. In conclusion, the Practice noted that Child B was in complete remission and that they were pleased he was doing well after treatment. They considered that the delay in diagnosis had no adverse effect whatsoever on the outcome.

Relevant guidance

25. Healthcare Improvement Scotland's *Scottish referral guidelines for suspected cancer* provide guidance to doctors on cancer referrals. Of relevance in this case is section 3.12 which deals with child, teenage and young adult cancers:

> 'Urgent suspicion of cancer referral

…

Specific recommendations

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Lymphadenopathy [any disease of the lymph nodes], if:	• non tender, firm/hard and greater than 2cms in maximum diameter • progressively enlarging • associated with other signs of general ill health, fever or weight loss • involves axillary nodes (no local infection or dermatitis) or any supraclavicular lymphadenopathy'

Medical advice

26. The Adviser was asked to comment on Child B's consultation with Doctor 1 on 20 May 2013. They reviewed the clinical consultation record for this date and noted that Child B had presented with symptoms of a throat infection and a swollen lump above his clavicle (collar bone). The Adviser said that this is a description of Virchow's node and explained that this is a lymph node in the area above the left clavicle. They advised that Virchow's node has long been regarded as strongly indicative of the presence of cancer in the abdomen, specifically gastrointestinal cancer that spreads through the lymph vessels or, less commonly, lung cancer.

27. The Adviser explained that this is also known as Troisier's sign and advised that they would have expected further investigation of this to be carried out. They noted that Doctor 1 had arranged blood tests and planned to review Child B once the results were available, however, the Adviser considered that an urgent referral to secondary care at the Board should have been made.

28. In reaching this conclusion, the Adviser referred to the *Scottish referral guidelines for suspected cancer* which state that an urgent referral should occur where there is any evidence of supraclavicular (above the collar bone) nodes.

29. The Adviser was asked whether the blood test results reported after the 20 May 2013 consultation were acted on appropriately by the Practice. The Adviser considered that in view of the presentation of Virchow's node, Child B should have been referred urgently on 20 May 2013. They went on to say that

while blood results could be sent with a referral for information and further management, the outcome of these results should not delay the referral itself.

30. The Adviser was asked to comment on the action taken at the 31 May 2013 consultation. Again, the Adviser reiterated that in view of the presentation of Virchow's node, Child B should already have been referred urgently to the Board by this stage. However, they advised that as the left supraclavicular node was again noted and documented in the medical notes by Doctor 2 on this date, an urgent referral could, and should, have occurred at this stage.

31. In relation to the issue of the x-ray referral, the Adviser explained that in the Board area, a GP practice can arrange an x-ray either by sending an x-ray form to the hospital and waiting for them to contact the patient with an appointment, or they can hand a card to the patient directly and ask them to take it to the hospital to have the x-ray carried out. They noted that Doctor 2 had completed a form but that there was no means to determine where the system had failed in relation to this. The Adviser did consider that as Doctor 2 had recorded in the medical notes that an x-ray had been arranged and there was a plan to repeat blood tests in one month, both the patient and relative at the consultation should have been aware of this.

32. The Adviser was asked whether it was reasonable that, at the time of these events, there was no system in place to follow up referrals. They advised that it is not routine practice to keep a separate record of all tests arranged during consultations. The Adviser explained that referrals are sent and patients are informed during consultations that a referral or test has been arranged for them as well as being given some indication of the time they are likely to wait for this. They went to advise that it was reasonable to expect that a patient would contact the practice if they did not hear back regarding a referral and that this is common practice. The Adviser considered it to be impractical for GP practices to consistently mark all referrals as sent and completed for patients, especially in large practices. The Adviser did, however, commend the new system introduced by the Practice to monitor referral and test requests. They agreed that this would adequately address the issue of the chest x-ray request that arose in this case.

33. The Adviser was also asked to comment on whether it was reasonable that the further blood test appointment had not been followed up by the Practice when no arrangements were made for Child B to attend. The Adviser

commented that a GP practice would have no routine system for chasing up patients who did not make an appointment for blood tests following a consultation for an acute problem. However, despite this, the Adviser said they would have expected a doctor who had arranged blood tests for a patient of Child B's age who presented with a supraclavicular node to have been highly alert to the possibility of an underlying cancer and as such, followed this case more closely.

34. In relation to the 11 October 2013 consultation with Doctor 1, the Adviser considered that it was appropriate to send a referral but noted that this was marked as routine. Again, the Adviser highlighted that an urgent referral should have been arranged.

35. The Adviser explained that it was difficult to quantify the actions taken by Doctor 1 on 30 October 2013 in terms of whether they were appropriate or not, as Child B should already have been urgently referred in May 2013. The Adviser also highlighted that there had been other opportunities by this time for an urgent assessment by the Board to have been arranged but these had not been taken. The Adviser noted that at the 30 October 2013 consultation, Doctor 1 had advised paracetamol for Child B and to wait until the planned appointment on 7 November 2013. In view of the sweats, persistent lump and pain, the Adviser said it was their view that an urgent assessment in hospital that same day should have been proposed and discussed with an on call specialist at the Board, rather than waiting until 7 November 2013.

36. In conclusion, the Adviser commented that they would expect a doctor to be aware of the significance of a left supraclavicular node and its potential as a sign of an underlying cancer. The Adviser said it would have been reasonable practice to refer Child B to the Board at an earlier stage and considered that this delay suggested a lack of clinical knowledge on the part of the doctors at the Practice. Although it was considered beneficial to carry out blood tests and an x-ray, the Adviser said that this should not have delayed the referral being sent when Child B first presented with a Virchow's node.

Decision

37. Ms C only made reference to Doctor 2 in the formal letter of complaint and, as evidenced by the response to Ms C, this doctor (who had since retired) became the focus of the Practice's consideration of the complaint. However, the advice I have received is clear that Child B should have been urgently

referred to the Board following the earlier consultation with Doctor 1 on 20 May 2013. The Adviser made reference to the *Scottish referral guidelines for suspected cancer* which indicate that the lump which Child B presented with should have aroused suspicion of an underlying cancer. On the basis of the independent advice received, I do not consider it reasonable that no referral was made following the 20 May 2013 consultation.

38. The evidence I have seen indicates that there were subsequent opportunities to take appropriate action but these were not taken. Doctor 2 failed to make an urgent referral at the 31 May 2013 appointment where the supraclavicular lump was again recorded. I note the Adviser's comments that the 11 October 2013 referral was inappropriately marked as routine and that an urgent assessment should have been discussed with an on call specialist at the Board on 30 October 2013, given Child B's symptoms, rather than waiting on the forthcoming 7 November 2013 appointment.

39. I am concerned that the events in this case suggest a gap in the clinical knowledge of both doctors who saw Child B at the Practice, as neither identified the significance of the supraclavicular lump. I appreciate that Doctor 2 has now retired but Doctor 1 continues to practice and it is important that this matter is addressed without further delay as a learning priority.

40. I accept the advice received on the issue of the further blood tests following the 31 May 2013 consultation. While Ms C has advised that Child B and his family were unaware of the necessity to return to the Practice, it is noted in the medical notes that these were planned. I note, however, the Adviser's comments that there would be an expectation for doctors to follow a case closely where a patient such as Child B presented with a Virchow's node, given the likelihood of an underlying cancer.

41. It has not been possible within the scope of this investigation to determine why the x-ray form completed by Doctor 2 was not acted upon, however, I accept the advice received that the new process and referral monitoring system introduced at the Practice will prevent such events from recurring in future.

42. In view of the findings outlined in this report, I uphold this complaint.

Recommendations

43.	I recommend that the Practice:	*Completion date*
(i)	issue a written apology for the delays in appropriately referring the child to the Board;	20 April 2016
(ii)	ensure that the practicing doctor identifies the diagnosis and referral criteria for signs of cancer as a learning priority; and	4 May 2016
(iii)	ensure that this case is discussed at the practicing doctor's next appraisal.	18 May 2016

44. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Practice 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

Ms C	the complainant
Ms A	the aggrieved
Child B	Ms A's son
the Practice	a GP practice in the Greater Glasgow and Clyde NHS Board area
the Adviser	a general practitioner
PASS	Patient Advice and Support Service
Doctor 1	a general practitioner
Doctor 2	a general practitioner
the Board	Greater Glasgow and Clyde NHS Board

Annex 2

Glossary of terms

antibiotics	drugs to treat bacterial infection
clavicle	collar bone
Hodgkin's Lymphoma	a cancer that develops in the lymphatic system
lymphadenopathy	any disease of the lymph nodes
red flag	a symptom that is especially likely to indicate a particular serious illness
supraclavicular	above the collar bone
Virchow's node	a lymph node in the area above the left clavicle regarded as strongly indicative of the presence of cancer

Annex 3

List of legislation and policies considered

Healthcare Improvement Scotland: Scottish referral guidelines for suspected cancer