Investigation Report

Investigation of a complaint against the Northern Health and Social Care Trust

NIPSO Reference: 17125

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint about the actions of Northern Health and Social Care Trust (the Trust). The complaint concerned the medical care and treatment given to the complainant's late uncle, who died at Causeway Hospital, Coleraine in 2016. The complainant said that delays in her uncle's chest x-ray and CT scan results meant that he was not given the news that he had terminal lung cancer until 23 December 2015, after he was admitted to hospital. She also complained that as a consequence her uncle was denied the opportunity to spend valuable time with his family.

The investigation identified failings in care and treatment provided to the patient. In particular, there were delays in diagnosis and in the overall timeframe for carrying out and reporting on his condition. There was a failure by the reporting radiologist to flag 'communicate urgently' on the patient's radiology report which resulted in the referring Consultant not being aware of the patient's results and the patient was not advised of his terminal diagnosis until he was admitted to hospital two days before Christmas.

I concluded that the patient should have been advised sooner of his terminal diagnosis and plans could have been put in place for his palliative treatment. The investigation established weaknesses in the system for advising patients about how long it is likely to take for scans to be undertaken and results reported on.

I made a number of recommendations to the Trust including an apology to the complainant and recommendations to improve service and reduce the risk of a delay in the communication of results to patients and patients receiving results in unplanned circumstances.

THE COMPLAINT

1. I received a complaint regarding the actions of Northern Health and Social Care Trust (the Trust). The complaint concerned the medical care and treatment given to the complainant's late uncle, who died on 4 January 2016 at Causeway Hospital, Coleraine aged 87 years old. The complainant stated that her uncle had a routine chest x-ray performed on 30 September 2015. After the results of this x-ray were reported some 19 days later on 18 October 2015, an urgent CT scan was requested and booked the following day, 19 October 2015.

2. The CT scan was performed 38 days later on 26 November 2015 and the result was reported on 29 November 2015. However, due to human error, the report of the scan was not "flagged" on the hospital's computer system, despite the report being designated as "alert". This led to a delay in the patient's medical team being made aware of the radiological findings. Consequently, this led to a delay in the patient being informed of his diagnosis of terminal lung cancer which did not occur until 23 December 2015.

Issues of complaint

3. The issues of the complaint which I accepted for investigation were:
Issue 1: Whether the timeframe in which the tests were carried out and results reported on were reasonable

Issue 2: Whether the communication with the GP was adequate and timely

Issue 3: Whether anything could have been done to have informed the patient of his diagnosis sooner

Issue 4: Whether the procedures which are in place for reporting the results of CT scans to the referring clinicians appear to be adequate

INVESTIGATION METHODOLOGY

4. As part of the investigation the Investigating Officer obtained from the Trust all relevant documentation, together with its comments on the issues raised by the complainant. This documentation included the patient's medical records. The Investigating Officer also made enquires of the patient's GP.

Independent Professional Advice

5. After further consideration of the issues, I obtained independent professional advice (IPA) from the following advisors:

- Consultant Physician in Respiratory and General Internal Medicine (CP IPA)
- Consultant Radiologist (CRad IPA)
- Consultant Radiologist (CRAD IPA)
- Palliative Care Nurse, Bereavement Care Co-ordinator (PCN IPA)

7. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice', however, how I have weighed this advice within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

9. The general standards are the Ombudsman's Principles:[1]

- Principles of Good Administration
- The Principles of Good Complaints Handling

1. These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The Public Services Ombudsman's Principles for Remedy

10. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgement functions of the organisation and individuals whose actions are the subject of this complaint.

11. The specific clinical and operational standards relevant to this complaint are:

- GMC Good Medical Practice - Knowledge, Skills and Performance (2013)
- National Patient Safety Agency Safer Practice Notice (5 February 2007) – "*Early identification of failure to act on radiological imaging reports*".
- Northern Health and Social Care Trust Policy (April 2015) "*Critical, Urgent and Unexpected Significant Radiological Findings (Communication Protocol)"*
- National Institute of Clinical Excellence (NICE) guidance (July 2008) – "*rapid recognition of symptoms and diagnosis"*
- NICE (2011) Lung cancer: diagnosis and management clinical guideline [CG121]
- Royal College of Radiologists (RCR) National Imaging Board for Guidance (2008).

12. Relevant extracts of these documents are reproduced within the body of this report.

13. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

14. In reporting on my investigation I have considered issues 1 and 3 of the complainant's complaint together and I will make a finding on each of issue at the end of my consideration.

15. I have shared this draft report with the Trust and The complainant for comments

on factual accuracy and the reasonableness of the findings and recommendations. The Trust, the complainant and Consultant physician (B) have made comments on the draft report and the report has been amended to reflect this.

INVESTIGATION

Issue 1: Whether the timeframe in which the tests were carried out and results report on were reasonable; and,
Issue 3: Whether anything could have been done to have informed the patient of his diagnosis sooner;

Detail of the complaint

16. The complainant said that her uncle, (the patient) had a routine chest x-ray performed on 30 September 2015. After the results of this x-ray were reported 19 days later, an urgent CT scan was requested. The complainant said that this CT scan was performed 38 days later on 26 November 2015 and the results of the scan had been available from 29 November 2015. However due to human error, the report of the scan was not "flagged" on the hospital's computer system, despite the report being designated as "alert". The complainant stated the patient attended the Emergency Department on 22 December 2015 with a suspected chest infection. He was admitted to hospital and it was only then that he was informed of his diagnosis of terminal lung cancer on the 23 December 2015. The complainant believes that the timeframe in which the x-ray and CT scan were performed and subsequently reported on were unreasonable. The complainant believes that had the patient's tests and subsequent diagnosis been established earlier then her uncle could have received palliative care earlier prolonging his life.

Evidence Considered

17. As part of my investigation of these issues the following evidence was considered;

Policies

- National Patient Safety Agency Safer Practice Notice (5 February 2007) '*Early identification of failure to act on radiological imaging reports*'.
- Northern Health and Social Care Trust Policy (July 2015)

'*Critical, Urgent and Unexpected Significant Radiological Findings (Communication Protocol)'*

Guidance

- NICE Guidance – '*Organisation factors relevant to diagnosis and staging'*
- Twycross & Wilcock, 2001*, 'Symptom Management in Advanced Cancer',* Radcliffe Medical press, pp150-154.

Clinical Records

- Copy of The patient's Causeway Hospital medical records (1 September 2015 to 4 January 2016),
- Copy of The patient's GP records

The Trust's response to investigation enquiries

18. In response to enquiries regarding the chest x-ray, the Trust state *'the chest x-ray was ordered as routine, as part of the routine workup for the patient. At this time, in the first instance, cancer was not considered as a diagnosis. The patient had a chest x-ray one year previously in April 2014 and a CT scan of his chest and a further follow-up x-ray on 12 August 2014, all of which were reported as clear. There was no expectation that the chest x-ray would show anything different, particularly as the complaint that the patient attended the medical outpatients in the Causeway hospital was not chest related.'*

19. The Trust further stated, '*The x-ray was performed on the same day as it was requested, 30 September 2015. The report was completed on 18 October 2015. This period of 19 days is average for routine examinations to be reported, as priority is given to red flag and urgent x-ray requests. The reason for a time difference is*

there is a significant gap between demand for reporting and the number of radiologists available to interpret the x-rays and draft the reports. The Northern Trust are currently addressing this gap with the help of the Health and Social Care Board (HSCB) *and are hopeful that additional recurrent funding will be made available in the new financial year.'*

20. In relation to the waiting time for an urgent CT scan the Trust stated, *[Consultant Physician (B) received the alert report on 18 October 2015 and an urgent CT scan of the patient's chest was booked the following day, 19 October 2015. The waiting time for urgent CT examinations to be performed is approximately 40 days. This is due to the gap between the demand for scans and the number of radiographers and scanners available to perform the scans. As before we are hopeful we will receive confirmation of funding for additional staff for the new financial year. The situation regarding the number of CT scanners available is not likely to change but with extra staff we can create more capacity with longer days, etc.'*

21. My Investigating Officer made additional enquiries in relation to the Trust's 2015 target times for routine, urgent and red flag examinations of radiologist's X-ray and CT scans. The Trust stated, '*The Departmental targets for x-ray and CT in late 2015 and currently are:*

- *0 patients waiting greater than 9 weeks for a diagnostic test;*
- *100% of urgent diagnostic tests reported within 2 days of the test being undertaken.*

As indicated in our submission the Northern Trust had a significant gap between demand and capacity for both these modalities which as recognized by the Health and Social Care Board. This meant the Departmental targets were aspirational as opposed to achievable.'

22. On that note, the Trust confirmed from July 2017 additional funds were provided so as to close the gap in demand and capacity. The Trust stated, *'confirmation of recurrent revenue to appoint additional staff in line with relevant business cases to close the gap was received in July 2017. While some additional in-house activity commenced immediately by using over time and waiting list payments this was not of*

sufficient volume to stabilise waiting times as the funding was for a significant number (30+ additional clinical staff) which are required to increase activity. The Trust had commenced recruitment to the posts however some positions, such as radiographers with specialist skill and radiologists, are difficult to recruit to; therefore demand is continuing to outstrip capacity within the teams.'

23. The Trust also stated, '*This position is starting to show an improvement – our end of year position is projected to be a 9 week wait for routine CT scanning. This is compared to up to 40 weeks in July 2017. This is all dependent on maximum work effort, low DNA rates* [did not attend] *and expected recruitment timelines. However reporting capacity will still be partly curtailed due to the high number of vacant radiologist posts within NHSCT. This is being addressed by the use of non-NHSCT reporters and an ongoing project to increase the number of plain film reporting radiographers.'*

24. Further enquiries were made of the Trust in relation to how long the patient would have waited had the Trust met their targets. The Trust stated, '*We cannot indicate a definitive date when The patient would have been told his diagnosis therefore we need to consider the hypothetical situation. Had the CT scan been red flagged the patient would have got his scan between day 21 and day 28 (9-16 November 2015)'.* The Trust confirmed *'we were approximately 10 days outside of their targets'.* The Trust added *'we had reporting times ranging from 1 to 7 days. Therefore, [the patient] would have had a diagnosis between day 22 and day 35 (18-30 November 2015) from referral. The average time from referral to reporting for a red flag CT scan at that time was 23 days. The patient would have been given his diagnosis as soon as possible thereafter which would have been following discussion at the weekly lung cancer MDM and other clinical / individual circumstance that may have had an impact on the pathway.'* The Trust confirmed, '*lung cancer MDM meetings are held each Monday afternoon (with the exception of bank holidays); therefore it could be presumed that The patient's case would have been discussed at the MDM the week following his diagnosis'.* The Trust confirmed '*the total number of days the Trust were outside of their target times for informing The patient was his diagnosis was 22 days'.*

25. The Trust also stated that *'alert reports are used as a method of highlighting reports to administration staff that they need to bring to the attention of the referring clinician urgently. There are two steps to this process. Firstly the reporting radiologist must dictate 'Alert Report' within the text at the top of the report itself. This allows a paper report to be easily identified as an 'alert report'. This did happen on this occasion. The second step requires the reporting radiologist to select a 'communicate urgently' flag on the request (using a right click on the mouse) so that the report is highlighted to the administration team on their work list, so that they know to urgently contact the referrer. In this case the 'communicate urgently' flag was not selected by the reporting radiologist….this was an unintentional oversight by the reporting radiologist.'*

26. In conclusion, the Trust stated, '*In relation to the patient's case it is Consultant Physician (B)'s opinion that, sadly given the patient's physical condition, and the seriousness of his illness, treatment options would have been extremely limited. It is very much to be regretted that [the patient] was not informed of his diagnosis somewhat earlier when there would have been an opportunity to proactively plan his palliative care needs.'*

Independent Professional Advice

27. The Consultant Radiologist (CRAD) IPA advised, '*The chest radiograph* (chest x-ray) *was performed on 30 September 2015 and reported on 18 October 2015. This is a delay of 19 days. The* [Royal College of Radiologists] *National Imaging Board Guidance 2008* [for radiology reporting times] *'expects that all films should be reported within a day of being performed. The standard however is not a consistent standard achieved throughout the UK radiological environment…..'* The CRAD IPA further stated 't*here is no conclusion in the report* (chest x-ray – my emphasis), *and although there is a recommendation of an up to date chest CT there is no recommendation that this may be associated with a possible diagnosis of cancer that would suggest the need for the CT examination to be undertaken urgently….the report is not clear and although it identifies an abnormality it does not suggest that this abnormality is definitely or potentially malignant in nature.* The CRAD IPA stated '*[Consultant Physician] did not have clear instructions suggesting the lesion was a potential cancer…….but if there was a real concern this abnormality was a potential*

cancer then this study should have been undertaken within two weeks'. The CRAD IPA further advised '*the report does not clearly identify the potential cause of the abnormality and yet an alert has been sent to [Consultant Physician] …this would suggest that the reporting radiologist was concerned that the lesion was cancer and as such the CT should have been performed within two weeks but the result does not make this interpretation clear.*

28. The Investigating Officer made additional enquiries regarding this issue with a CRAD IPA. The CRAD IPA advised '*There is a clear subtle circular line in the right lung which was described. There is no obvious tumour mass associated with it or evidence of fluid around the lung. The soft tissue shadow between the lungs is a little wide, maybe reflecting the lymph node enlargement observed on CT but this could equally be due to the patient being somewhat rotated to the right. The lungs appear a little nodular, but none of the last two observations are convincing and there are no obvious signs of cancer. The report is accurate and appropriate, the need for CT follow up and a level of urgency identified'.*

29. The Consultant Physician (CP) IPA advised '*there are no formal guidelines as to how long it should take for an urgent CT scan to be performed and reported. In cases of suspected concern it is standard practice to apply a '2 week wait rule' to CT scans. That is, the scan is performed within 14 days of the request. I consider that 38 days is excessive and is therefore not reasonable or appropriate'.* The CP IPA advised '*it is very unlikely that the additional 24 days (over and above the accepted 14 days) of delay completing the scan affected the eventual outcome for [the patient]. The scan demonstrated advanced cancer with multiple nodules in both lungs and multiple enlarged lymph glands. These changes usually develop over months, not days/weeks. Treatment for advanced cancer such as this is usually palliative care aimed at symptom control'.*

30. The CP IPA advised, '*The first chest x-ray on the 30 September 2015 demonstrated the cavitating right lung lesion, as reported. In addition there are multiple small nodules in both lungs.* The CP IPA advised '*the chest x-ray was requested as routine work up for [the patient] following his collapse…there were no features in the history that I have seen to suggest it should have been requested*

urgently for suspected cancer'. *The next chest x-ray on the 22 December 2015 demonstrates that the nodules are significantly more prominent. This confirms that the cancer progressed from, in terms of disease volume September to December. However, it was already present in both lungs on the presentation chest x-ray in September which represents advanced stage IV cancer, so the stage (or spread) of the cancer did not change from September to December.'*

31. The CP IPA advised '*local guidance stated that in the case of urgent findings the radiology reported prioritises the report as per protocol by inserting the comment 'urgent report' and flagging the report for urgent communication via the electronic reporting system. The radiology secretary prints the report from the 'communicate report urgently' worklist and communicated the report to the referring clinician in person by fax or by phone. A paper copy is also sent and the method of communication is recorded in a journal'*. The CP IPA refers to page 8 of local radiology "safety net" system states that *'reporting radiologist should attach a "recommend follow up" flag in radiology information service (RIS). This automatically places the report in the electronic follow up folder. An administrator monitors the file on a daily basis to ensure that referrals have been received for all "follow up" reports. If no referral is received then a letter is sent to the responsible clinician'.* The CP IPA states '*national guidance also recommends that it is made clear to patients how and when they should expect to receive the results of a diagnostic test and that tracking systems should be used by the referrer to monitor requests and reports. National guidance also offers other examples of safety net procedures such as copying reports to the GP or cancer service MDT's'.*

32. Furthermore, the CP IPA advised '*in [the patient's case] the abnormal CT report* [26 Nov 2015] *was not flagged as urgent or for follow up so the safety net system within radiology could not be applied. It appears that the scan report was first seen when [the patient] was admitted as an emergency on the 22 December 2015. Presumably the admitting team accessed the report via the electronic radiology reports system. Therefore, it does not appear that the abnormal report was detected by a safety net system'.* The CP IPA advised *'the Trust's response dated 4 January 2017 states that [Consultant Physician] and his secretary have a safety net system whereby all ordered radiology requests and results are chased that are not back*

within 28 days. This is presumably why the original chest x-ray report includes a handwritten note on 5 November 2016 documenting the date of the CT scan. This is evidence of good practice. However, it appears that no further check was made for the report between 26 November 2015 and 22 December 2015. I do not consider this to be appropriate or reasonable. A tracking system for scans performed for suspected cancer should include a report check at 7 days following completion of scan. Furthermore, national guidance was not followed in terms of advising the patient when the scan was likely to be performed and the expected time scale of communicating the result'.

33. The CP IPA advised '*the radiology safety net procedure was not triggered because the reporting radiologist forgot to attach the appropriate flags. The referring clinician safety net procedure was utilised but was not effective at chasing up the scan report in a timely fashion. There is no evidence that a third patient-centred safety net proceed was undertaken in accordance with national guidance, that is a letter to The patient confirming when he will be informed of scan result'.*

34. The CP IPA advised '[*the patient] had very advanced cancer and the treatment options were confined to relieving symptoms only. Confirming the diagnosis 22 days earlier than it was would not have changed this as the cancer would already have been present for months'.* However, the CP IPA further advised *'if the medical team had seen [the patient] in clinic with the result of his CT scan 22 days earlier then an urgent referral to the community palliative care team could have been made on the same day. In my experience the community palliative care team are usually able to review a patient at home within three days to advise on symptom control. In addition, they usually discuss the patients preferred place of death and can arrange hospice admission if appropriate. This may have avoided a hospital admission, although patients with terminal cancer are admitted to hospital relatively commonly during their final illness….'there was no failure by the medical staff to recognise [the patient's] poor health on 24 December 2015. The medical notes during the admission document that [he patient] had metastatic cancer and the patient was seen very promptly by the palliative care team on the same day as admission'.* The CP IPA also highlighted '*when a clinician receives an unexpected radiology result*

recommending CT scan then they should inform the patient by letter which should include expected timescales of the scan and the report'.

35. The Palliative Care Nurse (PCN) IPA '*in my palliative care and end of life care experience I believe this would have a very poor prognosis at the outset. I suspect that if this had been picked up according to the 'usual' alert system then this man would have been referred to a cancer MDT [multidisciplinary team] and a decision re treatment (or not) would have been established. I imagine that he ought to have been planned for palliative care. In the unlikely event that he had been diagnosed as a suspicion of lung cancer following just the chest x-ray; if he had been referred to a cancer MDT at that point there would have been a need for cancer staging etc. in order to ensure the most appropriate treatment (if any)'.*

36. The PCN IPA also advised, '*There does not appear to have been a high index of suspicion at this point, as his GP, despite knowing his past history as a smoker, was not suspicious of lung cancer but was treating a chest infection. However if the confirmed cancer diagnosis had been made sooner and it had been recognised that treatment would be purely palliative, then it is at this point where the patient was compromised in that he did not know he was in his last six weeks of life. The last two weeks of which were spent in hospital against his preferences'.*

37. The PCN IPA further advised, '*I believe there could have been some significant improvements in his palliative care had there been a MDT agreement that he was in the last two weeks of his life. The MacMillan Nurse felt there was a high risk of rapid deterioration on 23 December 2015. Two doctors had a meeting with the family on 24 December 2015.* The PCN IPA stated *'the ward nurse on 2 December 2015 noted that he was seen by a palliative care specialist nurse* (PCSN) *and that this nurse felt patient was "not fit for home at present due to declining physical state"… "patient still keen to discharge back to own home and appears unrealistic about his ability to cope".* The PCN IPA advised *'If he was recognised as being at the end of his life then would his* preferred place of care (PPC) *not be home. These preferences should have been considered and implemented if possible….patient clearly wanted this'.*

The Trust's response to IPA

38. The IPA was shared with the Trust who made the following responses - '*There was a wait of 38 days between referral for CT scan and completion of the CT scan. Unfortunately at the time of [the patient's] referral this period of time was common for urgent CT examinations to be performed with red flag referral seen at four weeks and routine referrals at up to 26 weeks. The reason for this was a significant gap between the demand for scans and activity the Trust was commissioned to deliver. This was recognised by the Health and Social Care Board (HSCB) as there were meetings regularly to discuss closing this gap in CT as well as other diagnostic modalities including plain film reporting. I can confirm we received funding to partially address the gap in July 2017. However, capacity will still be partly curtailed as the Trust also requires capital investment for additional CT scanners.'*

39. The Trust also states, *'The Trust accepts the waiting time for a CT scan at that time is neither acceptable nor reasonable however the Trust was not commissioned/ resourced to provide CT; in line with the demands of the service provision, recurrent funding to partially close this gap was confirmed in July 2017 and work is ongoing to secure substantive staff to provide a more timely CT service which will include, undertaking red flag scans within 2 weeks of referral.'*

Consultant physician (B)'s response to IPA

40. The consultant physician (B) also provided comments in relation to the IPA advice. The consultant physician (B) states '*the adviser states that professional guidance recommends that it is made clear to patients how and when they should expect to receive the results of diagnostic tests and the tracking systems should be used by the referer to monitor requests and reports. There is no reference given for this statement and I would ask that the IPA clarify the particular guidance that he/she is referring to'.* My Investigating Officer sought clarity on this issue for the consultant physician (B) from the CP IPA. The professional guidance referred to relates to the National Patient Safety Agency, Safer Practice Notice 16 dated 5 February 2008 which was forwarded to the Ombudsman by the Trust on 4 January 2017 as part of the assessment process in this case. This guidance has been brought to the consultant physician's (B) attention.

41. The consultant physician (B) also advised, '*Furthermore I was (and am) in no way able to tell when any radiological investigation nor the reporting thereof, might be carried out. The booking for appointments is done after radiological triage and certainly whoever looked at the urgent report coming in to triage, would have had access to the chest x-ray and to its report. Because of the uncertainty of when radiological investigations are to be performed and reported, my secretary will usually check for reports at one months' time. The advisor suggests that it is 'common practice' for Consultants to write to patients when they are requesting an urgent scan to inform them of the need for the scan. I am not sure that this, in fact, is the case. However I am sympathetic to this as a proposal, but I would not be able to tell the patient when the scan was to be done nor when the report would be furnished.*'

42. The consultant physician (B) advised, '*The adviser goes on to say that many consultants will book a patient back onto a clinic within two weeks of an urgent scan to ensure that the scan was reported and actioned. My response would be that there would be little benefit of booking a patient into a clinic within two weeks if I had no idea when the scan was to be reported or carried out. Furthermore, because of the partial booking system, which is universal in Northern Ireland all clinics are fully booked six weeks in advance, so there are no free slots available to book extra patients in. It is possible to overbook patients into pre-booked clinics, but this would tend to be done for patients who have immediate need to be seen as an emergency. This practice has impact on the remainder of the patients who have already been booked into this clinic. So in that case I don't think such a course of action would have been reasonable in this case or could not be made routine.*'

43. The consultant physician (B) states*, 'In my view the reasons for deficiencies for care in this case rests on a double failure in the radiology department and that my secretary's tracking system was yet to be triggered. It would have been triggered within a couple of days of [the patient's] admission to hospital in any event. Having spoken to other physicians at this hospital and at other hospitals I am not aware of any generalised tracking facility that will trigger an investigation when a report does not arrive. An electronic alert system would be most helpful but to imagine that it*

would be possible for me or my secretary…. would be able to manually trawl through the thousands of radiological investigations ordered over the course of a year (both ordered by myself, and by others on my behalf) within the current levels of staffing , I feel is unrealistic'.

44. In a further response and in the context of limited resources, consultant physician (B) stated, '*A failsafe system was in place, this system had a trigger date of one month, this date had not passed by and the failsafe would have been triggered within days. This was the best system that could have been in place given the resources that were available at the time. Some years previously a decision was made in the Department of Health to cut the support given to new clinical consultants by half. The Northern Trust at that time decided to implement a cut of 50% in all frontline consultant's support. Therefore, given workload using a manual system, a one month check is the best that could have possibly been achieved given the resource available to me at that time'.*

45. Consultant physician (B) concluded '*for older medical patients it's not uncommon to request a chest x-ray in anyone who presents with symptoms of any sort especially if they have respiratory symptoms, which [the patient] did, and have a history of tobacco smoking.'*

Examination of Medical Correspondence

46. I examined the patient's referral for a chest x-ray on 30 September 2015 and subsequent report on 18 October 2015.

i. Under section Reasons for Referral states '*wheezy'.*

ii. Under section Priority Level states 1 'R*outine'.*

iii. Under Radiology Report, it states *'30 September 2015, 12.53 EX Chest – Compared to the last plain film there is a new curvilinear ring like shadow in the right mid zone that might represent a cavity. There is extensive background chronic lunch changes persist, but perhaps a little more nodularity is seen in the right upper zone. In this case I would recommend an up to date chest CT. Alert report please.'*

47. I examined the patient's referral for a CT Chest on 19 October 2015 and

subsequent report on 29 November 2015.

i. Under section Reasons for Referral states '*as suggested on CXR report'.*

ii. Under section Priority Level 2 '*Urgent'.*

iii. Under Radiology Report, it states *'26 November 2015 14.51 CT Chest and Abdomen contrast, Alert Report. Indication possible cavitating lesion. Technique spiral acquisition without IV contrast due to poor renal function. Comparison is made to previous examination in June 2014. Findings there are a multitude of the lung nodules throughout both lung fields the largest measuring up to 2.5 cm and some which are less poorly defined than others. There is a further 3 cm cavitating lesion in the right mid zone as described on chest x-ray. There is a background of chronic fibrotic change. There is a right pleural effusion. There are multiple enlarged mediastinal and hilar lymph nodes. These appearances show significant deterioration from previous examination. The adrenal glands are normal. No gross focal liver lesion is seen although this is an unenhanced scan. The kidneys are unremarkable. The bony skeleton shows marked degenerative changes but no focal lesion is seen. Conclusion multiple lung metastases with probably cavitating right mid zone primary and widespread mediastinal adenopathy'.*

48. My Investigating Officer made enquires in relation to this element of the complaint with the Health and Social Care Board, (the Board) (HSCB). The Board advised '*that in 2015/16, they commissioned the NHSCT to provide 180,000 x-rays and 20,512 CT scans.* The Board stated *'the capacity to fund this level of activity was recurrently funded in the Trust'.* The Board further stated '*in 2015/16 they had been made aware that there was an ongoing and increasing demand/capacity gap in a range of radiology services within the Trust. The Board worked with and met regularly with the Trust to review performance (CT and x-ray performance) and address this shortfall first on a non-recurrent basis and then recurrently as recurrent funds, staff and infrastructure became available'….'Additional non recurrent capacity was commissioned from the Trust in 2015/16 to help address a shortfall in recurrently funded capacity. Non recurrent funding was made available to the Trust in June and September of that year and an additional 31,723 x-rays and 6,335 CT scans were commissioned in total'.*

49. The Board stated '*that they had recurrent funding was secured in 2017/18 to bridge the demand/capacity gap and investment is continuing into 2018/19 which aims to close the current/demand/capacity gap. It should be noted that demand for radiology continues to rise year or year. As such, the Board will continue to work with the Trust to understand the nature of the demand and ensure patient pathways are as streamlined as possible'.*

The complainant's response to the draft report

50. On receipt of the draft report and IPA advice, the complainant sought clarity on one issue and made comments in regards to the recommendations. I have considered the complainant's comments in detail. The complainant clarified that no-one from her family '*had made a request to have [the patient] moved to the Robinson'* as indicated by the Nursing IPA. The complainant also highlighted that she did not want money from the Trust and that reminding radiologist is not good enough, procedures need to be reviewed and updated to ensure there is no recurrence of what happened to the patient.

The Trust's response to draft report

51. Upon receipt of the draft report, the Trust acknowledged and accepted the failings identified through the investigation and had no new evidence to present.

52. The Trust made comments on a number of the recommendations and how these might be implemented and the Director of Investigations and Investigating Officer met with the Clinical Lead for Radiology and Clinical Services Manager to identify ways of improving communications with patients.

Consultant physician (B)'s response to draft report

53. Upon receipt of the draft report consultant physician (B) submitted considered comments and reflections. Consultant physician (B) queried the speciality of the CP IPA in comparison to his own role and whether this may have affected the advice offered.

54. Consultant physician (B) queried the advice of the CP IPA that a 28 day time frame for a review system for x-rays was not appropriate. Consultant physician (B) was not aware of any particular standard in this regard and felt there was a balance to be struck between prompting following up reviews and practical workload considerations.

55. In relation to what should have occurred if the patient had been seen in clinic with his CT results 22 days earlier, consultant physician (B) clarified that on receipt of the results he would have referred The patient to a member of the respiratory team to discuss the findings. In these circumstances consultant physician (B) clarified that the respiratory team would have referred the patient to the multi-disciplinary and palliative care teams. Consultant physician (B) indicated that he had reflected on the IPA's comments in relation to when a clinician receives an unexpected radiology result recommending CT scan then they should inform the patient by letter, including expected timescales for the scan and the report. Consultant physician (B) indicated that he has now adopted this practice, albeit that it is not possible to accurately estimate likely timescales for CT scans to be performed.

56. Consultant physician (B) stated that he agreed with the CP IPA that for the patient to wait 38 days to have an urgent CT scan performed was neither appropriate nor reasonable. Consultant physician (B) also accepts that the 'communicate urgently' had not been flagged by the radiologist and neither he nor his secretary received the hard copy of the results on 30 November 2015.

57. Consultant physician (B) highlighted the difficulty in advising patients and their GP of realistic timescales for CT scans and results due to the lack of knowledge of when the scan would be performed and when it would be reported on.

58. Consultant physician (B) commented on the draft report recommendations and sought clarity regarding the intention of the recommendation regarding safety net procedures. Consultant physician (B) again indicated he had reflected '*on the contents of the report and had changed his practice to improve my communication with patients and their GPs about any CT scans requested'.*

Analysis and Findings

Timeframe

59. I established that the patient had a routine chest x-ray performed on 30 September 2015, the same day that the x-ray was requested. I further established that the results of the patient's x-ray were available on 18 October 2015, approximately 19 days after it had been performed. I note the Trust advised patients shall wait no more than nine weeks for a diagnostic test. The patient's chest x-ray was completed within the Trust's estimated targets for x-ray. I would therefore consider the timeframe within which the patient waited on his x-ray being performed to have been reasonable.

60. I note the Trust's explanation for a time difference is that there is a significant gap between demand for reporting and the number of radiologists available to interpret the x-rays and draft the reports. I note that a lack of resources has been referred to in both the responses by consultant physician (B) and the Trust. I made enquiries of the HSCB in regards to this element of the complaint who have supported this view. The Board confirmed they had been made aware in 2015 that the Trust had an ongoing and increasing demand/capacity gap in a range of radiology services and they were working with the Trust to address this shortfall. I understand the Trust were considerably under resourced in Radiology and I accept that they were actively trying to address the shortfall in funding and staffing. I note the patient's x-ray report was not reported on for approximately 19 days after it had been performed on 30 September 2015. I note the CRAD IPA advised the Royal College of Radiologists (RCR) National Imaging Board for Guidance 2008 for radiology reporting times expects that all films should be reported within a day of being performed. Whilst I accept this standard is not a consistent standard achieved throughout the UK radiological environment, I consider 19 days to wait on x-ray results being reported on falls short of RCR standards for reporting times.

61. I note that in response to consultant physician (B)'s comments regarding the CP IPA being a Consultant Physician in Respiratory and General Internal Medicine and consultant physician (B) being a Consultant Physician in General and Geriatric Medicine, the Investigating Officer made further enquiries. The CP IPA advised "*As a*

Consultant in General Internal Medicine, the advice provided was based on standards and guidelines that he would apply as a physician in general medicine and not his second accreditation as a Respiratory Consultant". The CP IPA does not consider the difference in his clinical specialism of respiratory medicine and that of consultant physician (B) in geriatric medicine to have had an impact on his advice.

62. With this in mind, I have considered and I accept the advice of the CRAD IPA that the '*CT scan of 30 September 2015 was accurate and appropriate and the need for CT follow up and a level of urgency identified'*. Furthermore, I accept the advice of the CRAD IPA that the report from the chest x-ray performed on 30 September 2015 was '*unclear and although suggested an abnormality did not suggest the lesion could be cancer'*. That said, the reporting radiologist sent an alert to consultant physician (B). Therefore, if the reporting radiologist had no concerns about a potential cancerous lesion then why was an alert sent to consultant physician (B). By sending an alert to consultant physician (B), I consider the reporting radiologist had concerns regarding the chest x-ray scan. However, I note the CRAD IPA advised '*the chest x-ray shows a subtle new abnormality, suggesting a cavity may have developed in the right lung. There are different possible reasons for this, of which a cavitating cancer is one, although no tumour mass is obvious. The alert status was therefore appropriate'.*

63. I established consultant physician (B) was alerted to the patient's x-ray results on 18 October 2015 and in doing so made a referral for an urgent CT scan the following day, 19 October 2015. I consider the time taken of one day by consultant physician (B) to refer the patient for a CT scan was within the Trust's expected timeframe and therefore reasonable. However, in terms of having the CT scan performed, the Trust stated waiting times for urgent CT scans to be performed can be approximately 40 days. I established the patient had an urgent CT scan performed on 26 November 2015, approximately 38 days after he had been referred. While 38 days is in line with the Trust's expected performance target time of 40 days, I accept the advice of the CP IPA that a wait of 38 days for the patient to have his urgent CT scan performed was neither appropriate nor reasonable.

64. I also established the results of the patient's CT scan were available from 29

November 2015, four days after the CT scan had been performed. I note the Trust advised '*100% of urgent diagnostic tests reported within 2 days of the test being undertaken'.* I do not consider the time taken to report on the patient's CT scan to have been unreasonable. However, upon examination of the clinical records, I note the reporting radiologist did not select the 'communicate urgently' flag that would have brought the results of the patient's CT scan to the attention of Consultant physician (B) and his secretary. I acknowledge the Trust have accepted responsibility in that the 'communicate urgently' flag was not selected by the reporting radiologist on the results of the patient's urgent CT scan. I established that had the 'communicate urgently' flag been selected by the reporting radiologist, consultant physician (B) or his secretary would have known of the patient's results at the earliest on 28 November 2015. I note the Trust advised consultant physician (B) was sent a hard copy of the results on 30 November 2015. However, consultant physician (B) advised he did not receive the hard copy of the results.

65. Therefore, I consider had the patient's CT scan results been known as early as 28 November 2015, he could have potentially been discussed at the next available lung cancer MDT on 30 November 2015 and informed of his diagnosis soon after. I am of the view that by not alerting consultant physician (B) or his secretary to the 'communicate urgently' flag, consultant physician (B) nor his secretary knew to look for the patient's CT scan results earlier. I established the patient was not informed of his diagnosis until 23 December 2015, approximately 26 days after his CT scan results were available. Whilst I accept this was an unintentional mistake by the reporting radiologist, I take the view that this failing by the radiologist led to a delay in the patient being discussed at the lung cancer MDT which led to a delay in him being informed of his diagnosis.

66. I have considered and I accept the CP IPA advice that the delay in diagnosis had no effect on the *'stage (or spread)'* of the patient's cancer from September 2015 to December 2015. In addition, I note the CP IPA advised that as the patient had advanced cancer his treatment options were confined to relieving his symptoms and even if he had been informed of his diagnosis earlier this would not have changed the outcome for the patient. However, I am critical of the reporting radiologist's failure to select the 'communicate urgently' flag. I consider this to be a failure in the patient's

care and treatment. I consider this failure led to the delay in the results being available to the referring clinician, consultant physician (B). I consider this to be a failure in care and treatment. I, therefore uphold issue one of the complaint. I consider the patient to have suffered the injustice of loss of opportunity to have received an earlier diagnosis and a discussion in relation to the setting for palliative care.

67. I have considered the CP IPA advice that national guidance also recommends that patients should be informed of how and when they should expect to receive results of investigations and that a tracking system should be used by referrers for monitoring requests and subsequent reports. However, I have also considered and I accept consultant physician (B) had a failsafe system in place to track his patient's radiology reports and that the guidance does not stipulate what the tracking interval should be. I further consider, as indicated by the Trust, that in order to inform patients as to when a radiology scan has been requested and likely to be performed, this has the potential to generate a significant amount of workload for front-line staff in the Trust. I consider this would also have a significant impact on patient care. That said, I am critical of the Trust for not informing the patient when he was likely to have his scan or receive said results, I consider this to be a failure in the patient's care and treatment and not in accordance with national guidance. I consider this failure to communicate had the effect of removing an additional safety net. I consider had the patient been made aware of the likely date his results would be available it is likely he would have contacted the Trust and the oversight of the radiologist would have been identified.

68. However, I would highlight that in response to this element of the complaint, the Trust stated they are currently developing a radiology scanning and reporting waiting times information system that will enable all primary referrers to its radiology services, to inform patients when they can expect to have their radiological scan performed and when said scan shall be reported on. I welcome the Trust's commitment to ensuring that patients are kept informed of when they can anticipate the likelihood of radiology scans being performed and how soon these will be reported on by the Trust's radiologists.

Earlier diagnosis

69. I note the results of the patient's CT scan indicating lung cancer were available from 29 November 2015. I consider that had the Trusts targets been met the patient's results could have at the earliest, been discussed at a lung cancer MDT meeting at the earliest on 30 November 2015 and the patient subsequently advised of his diagnosis and treatment options thereafter. Having examined the CP IPA advice, I accept that the patient's cancer was very advanced and terminal, an earlier diagnosis would not have changed the outcome for him. However, I accept the CP IPA advice that if an earlier diagnosis had been made then the patient could have been referred to the community palliative care team.

70. I note consultant physician (B) states had the patient's CT scan results from 29 November 2015 been received by either him or his secretary, he would have contacted his colleagues in the respiratory team and requested they inform the patient of the findings and '*consequent diagnosis'*. This is a view supported by the Trust. Specifically, the Trust confirmed that '*upon receipt of [the patient's] CT scan results, the usual pathway would have been for [consultant physician (B)] to make an onward referral to the respiratory physicians and would have written to the patient advising them of the referral. The patient would then have been seen by the respiratory team and a decision made regarding further investigations such as bronchoscopy/discussion at the weekly lung MDM and/or referral to the Community palliative care team'*. I also welcome consultant physician (B)'s comments that when he receives unexpected radiology results recommending CT scans that he now informs patients by letter and includes an estimated timescale for scan and reporting results.

71. I have also considered and I accept the PCN IPA advice that '*if [the patient's] CT scan had been picked up according to the 'usual' alert system, then the patient would have been referred to a cancer MDT and a decision regarding treatment and his plan of care could have been established'*. I also accept the PCN IPA advice that had the patient's diagnosis been made sooner and it had been recognized that treatment would be purely palliative, then '*it is at this point where the patient was compromised in that he did not know he was in the last six weeks of his life'*. I consider it would also have prompted the patient's GP being informed of the

diagnosis (Issue 2 refers).

72. I note that the patient was admitted to hospital on 22 December 2015 where he was subsequently informed of his diagnosis on 23 December 2015. The patient died in hospital on 4 January 2016 which was clearly not in accordance with his expressed view. I note the Macmillan clinical nurse specialist had highlighted on 29 December 2015 to the patient's medical team of her concerns the patient was rapidly deteriorating. However, I accept the CP IPA advice that the patient was seen very promptly by the palliative care team on 23 December 2015.

73. I am of the view that the delay in reporting and the lack of proper alert by the radiologist led to the lack of earlier diagnosis which I consider is a failure in the patient's care and treatment. I also consider this failure in care and treatment led to a missed opportunity by the Trust to have the patient discussed at the lung cancer MDT at the earliest 21 November 2015. I have no doubt if the patient had been discussed at a lung cancer MDT this would have enabled earlier communication of a diagnosis to the patient and for his palliative care to be planned taking into account his wishes. I, therefore uphold issue three of the complaint. I consider the patient to have suffered the injustice of uncertainty, distress and upset at not being diagnosed sooner and having his palliative care planned taking into account his expressed views to be at home. I also consider that the complainant and the wider family to have suffered the injustice of uncertainty, upset and distress and not being informed of the patient's diagnosis sooner and of the lost opportunity to spend quality time with him.

Issue 2: Whether the communication with the GP was adequate and timely.

74. The complainant said that the patient's GP was not kept informed of his condition from the diagnosis of terminal lung cancer.

Evidence Considered

75. As part of my investigation the following evidence was considered:

- Copy of the patient's Causeway Hospital medical records (1 September 2015 to 4 January 2016),

- Copy of the patient's General Practitioner records.

The Trust's response to investigation enquiries

76. The Trust stated, '*Radiology reports are returned to the referrer who initially requested them (in this case, [consultant physician (B))] as the diagnostic is only one part of the clinical portfolio the referrer requires in order to make a diagnosis and decide upon a treatment plan. Reports are immediately available to GPs through the Northern Ireland Electronic Care Record (NIECR) however the GP may not be aware of the diagnostics that the patient has been referred for. Consultant physician (B) has confirmed that [the patient's] GP, was sent a letter informing him that a chest x-ray was being performed. Consultant physician (B) did not communicate with [the patient's] GP on 18 October 2015 as there was no definite diagnosis at that stage.'*

Independent Professional Advice

77. The CP IPA was asked if it is appropriate and reasonable not to advise a patient's GP of a significant life threatening diagnosis (i.e. lung cancer) once detected. The CP IPA advised, '*It is standard practice for consultants to write to patients when requesting an unexpected urgent CT scan and this letter should be copied to the GP for information. NPSA [National Patient Safety Agency] recommendations also state that consideration should be given to sending the GP a copy of any unexpected abnormal CT reports.'* The CP IPA also advised, '*Once the CT report was noted on the emergency admission then the usual course of events for the patient to be reviewed by the lung cancer team and discussed at the lung cancer MDT meeting to agree a diagnosis and management plan. It is standard practice to inform the GP within 24 hours of the MDT meeting. According to the medical notes, the plan was for [the patient's] case to be discussed at the lung cancer MDT meeting during his admission but I cannot see any evidence that this happened. This is possibly because of his rapid deterioration and death. The GP was appropriately informed of the cancer diagnosis on the discharge letter from this* [last] *admission.'*

Analysis and Findings

78. I note that once radiology reports are available they are immediately available to GPs through the NIECR. However, I have not been presented with any evidence that consultant physician (B) informed the patient's GP that the patient had been referred for an urgent CT scan following the results of his x-ray on 19 October 2015.

79. I accept the CP IPA advice that when a consultant writes to patients regarding a referral for an unexpected CT scan '*then this letter should be copied to the GP for information'*. NPSA recommendations state that '*consideration should be given to sending the GP a copy of any unexpected abnormal CT reports'*. I have been presented with no evidence that consultant physician (B) wrote to the patient advising he was being referred for an urgent CT scan. I have also been presented with no evidence that the patient's GP was sent a copy of the CT report.

80. I note that the patient's GP was informed of the cancer diagnosis on the discharge letter from this admission but that the patient had passed away by the time of receipt. I consider the failure to notify the patient's GP that he was being referred for an urgent CT scan and of the results of said scan, to have been a failure in care and treatment as his GP does not have up to date information when meeting a patient when co-ordinating their care.

81. GMC guidelines on continuity and co-ordination of care paragraph 44 states *'you must contribute to the safe transfer of patients between healthcare providers and between health and social care providers'.* I consider the patient's GP had a role in co-ordinating his care and in offering advice and support both to the patient and the wider family. I consider the Trust's communication with the patient's GP was not adequate and I uphold this element of the complaint. I do not consider the patient to have suffered an injustice as a result of this failing.

82. I welcome consultant physician (B)'s comments that he has reviewed his own practice and now writes to both patients and their GP's advising if further tests have been requested.

Issue 4: Whether the procedures which are in place for reporting the results of CT scans to the referring clinicians appear to be adequate

Detail of the complaint

83. The complainant raised concerns about the adequacy of the Trust's procedures if Radiologists had to be reminded to follow the procedures. In particular, the complainant queried why consultant physician (B) did not follow up on his request for an urgent CT scan. The complainant also complained why consultant physician (B) had to depend on someone printing the 'alert report' and presenting him with it rather than and examining the report on the hospital computer system.

Evidence Considered

Policies and Guidance

84. Northern Health and Social Care Trust Policy (July 2015) - *Critical, Urgent and Unexpected Significant Radiological Findings (Communication Protocol).* I have considered the following relevant extracts;

Section 3.4.3 states 'Significant Unexpected Findings - *the Radiology Reporter ensures the report includes the following comment, "Alert Report"*.

Section 3.5 states 'Radiology Safety Net System - *in December 2013 the Radiology Department introduced the following system which provides a manual follow-up with Referrers to ensure that appropriate consideration has been given to the findings in the Radiology Reports*

i. *Radiologists/Reporting Radiographers attach the 'recommended follow up' flag in the Radiology Information System (RIS) when applicable. This will result in the examination being monitored in the 'Safety Net' system.*
ii. *The flagged report is automatically placed in a 'follow up' folder in the RIS.*
iii. *The responsible clinician will contact Radiology to confirm by email the action they have taken in response to the recommendation from Radiology.*
iv. *An Administration Officer monitors the file on a daily basis to ensure that the referrals have been received for all 'follow up' reports within the recommended timeframe of the report verification date.*

v. *If no follow up referral is received within the recommended timeframe, a standard letter is sent to the referrer. A copy of the letter is stored within the patient's request in RIS.*

vi. *If a subsequent referral or confirmation that the examination is no longer required is not received within two weeks of the dispatch of the first letter, a second reminder letter will be sent to the referrer.*

vii. *If a subsequent referral or confirmation that the examination is no longer required is not received following dispatch of the second letter, the Radiology department will escalate the case by informing the Medical Director's office. The Medical Director will then follow this up with the relevant Clinician(s).*

viii. *If the Administration Officer has concerns regarding any referral, the issue will be escalated to the original Reporting Radiologist or Radiologist of the Day for appendicular Radiographer reports'.*

The Trust's response to investigation enquiries

85. The Trust state, '*the procedures are adequately controlled and there is a sound "alert and flag" system in place. In this case, it was an omission as a result of human error and not a system issue. There are almost 14000 alert reports communicated on an annual basis. The number of detected errors in use of the system is extremely low. The process in place is efficient and has a failsafe process. This was a case of human error not system error. This error was taken seriously. From a radiology perspective the incident was discussed on an anonymised basis at the Trust's Radiology Governance meeting to share learning and remind radiologists of the need to be vigilant in the use of the alert system. The event has also been discussed with administration staff to remind them of the importance of their role in this process.'*

86. The Trust state, '*In the majority of cases [consultant physician (B)] relies on the radiology service to provide him with an official report. Together with his secretary they have a system which will look for results that have not come back after 28 days and this would have been followed up at that stage. This represents a further safety net should that be required. In addition [consultant physician (B)] and his secretary have a system in which a list of ordered radiology tests are recorded. A log of phone calls from x-ray for urgent requests are also recorded by [consultant physician (B)'s]*

secretary and this is checked monthly for any outstanding radiology reports.'

87. The Trust further stated, '*When results are on the computer system but a paper copy has not been received [consultant physician (B)'s] secretary will print the result off and leave it for [consultant physician (B)'s] attention. This is a vital safety net which was applied in the case of [the patient]. On occasions paper copies are not received however if an alert is phoned through to [consultant physician (B)'s] secretary, she will print it off immediately.'*

88. The Trust stated, '*The person ordering a test expects to get a paper copy back, this represents the official report. [consultant physician (B)] and his team are responsible for ordering between two and three thousand individual radiological examinations every year. With the volume of results available at any time it is not possible to track all patients in real time. Hence [consultant physician (B)] is dependent on alert reports coming back promptly as the "official results," which he then deals with in a timely manner.'*

Independent Professional Advice

89. The CRad IPA advised, '*There were systems in place for the reporting of the CT scans to be fed back to the referring clinicians, which required the reporting radiologist to set an alert but unfortunately this did not occur and as such the results were not adequately reported back to the referring Doctor. This subsequently meant a further delay. These procedures failed and as such were not adequately controlled.'*

90. The CP IPA advised *'The NHSCT policy reasonably deals with the radiology aspects of communication regarding critical, urgent and unexpected significant radiological findings.'* The CP IPA also advised*, 'With regard to the responsibility and safety net safeguards of the referring clinician, the policy simply states that it is the responsibility of the referrers to actively search for the results of all imaging results. However, the policy does not stipulate how and when this should be done, or how this is monitored across different departments. The safety net policy would be considerably stronger if it specified a process for referrers to monitor the requesting, reporting and action on radiology requests.'*

The Trust's response to IPA

91. In response to the IPA advice, the Trust stated, '*It is the case only one flag is currently required to initiate the "Communicate Urgently" process. All Radiology reporters are familiar with this process. Unfortunately human error meant that it was not followed in this case. The Trust has accepted this error should not have occurred and have apologised to the patient's family.'*

92. The Trust also stated, '*The existing "Critical, Urgent and Unexpected Significant Radiological Findings Communication Protocol" is currently under review. As part of this review it has been identified that the section concerning 'Follow-up' can be confusing to non-Trust Radiology staff. This section is intended to be solely relating to Radiological follow-ups, not clinical follow-ups, but this is not clearly stated within the Policy. This will be clarified in the new version.'*

93. The Trust stated*, 'Due to the large and diverse number of specialities who refer into Radiology it is not feasible to implement one single system for tracking of Radiology requests, dates and reports across areas. However, the Trust will consider adding a 'successful working example' within the new version of the Policy as learning from this complaint.'*

94. The Trust also stated, *'The Trust is currently piloting an electronic 'results acknowledgement' system, which will aid the tracking of requests and results. The initial results are encouraging, however there are a number of concerns regarding 'escalation' and 'safety net' issues which must be resolved with the product supplier prior to full roll-out.'*

Consultant physician (B)'s response to IPA

95. Consultant physician (B) provided comments in relation to this element of the complaint. Most notably, '*having thought at length about this case I think the one thing I would do differently would be, on receipt of the chest x-ray report, and after booking the CT scan that I would write to the patient (and copy to GP) and also immediately refer the patient on to the Respiratory Service. It was obvious that there was something wrong with the patient's lungs, and even if I had not made the diagnosis, onward referral might have been reasonable.'*

Analysis and Findings

96. The Investigating Officer made enquiries of the Trust and established *‘there are almost 14000 alert reports communicated on an annual basis’* [and] *‘the number of detected errors in use of the system is extremely low’…* ‘*the process in place is efficient and has a failsafe process’.* The investigation established the patient’s CT scan results from 26 November 2015 were available on 29 November 2015 and a hard copy of the patient’s results were sent to consultant physician (B) on 30 November 2015. I note the reporting radiologist had the ‘alert’ flagged on the hard copy. However, consultant physician (B) did not receive the hard copy.

97. I note the Trust have sought to provide reassurance that, *‘[consultant physician (B)] together with his secretary have a system which will look for results that have not come back after 28 days and this would have been followed up at that stage’.* I consider that had this system been applied consultant physician (B) and his secretary would have sought to look for the patient’s results no later than 23 December 2015.

98. I have considered the CRAD IPA advice that*, ‘these procedures failed and as such were not adequately controlled.’* I further note the CP IPA’s advice that *‘the policy simply states that it is the responsibility of the referrers to actively search for the results of all imaging results. However, the policy does not stipulate how and when this should be done, or how this is monitored across different departments.’* I concur with the CP IPA’s opinion that*, ‘the safety net policy would be considerably stronger if it specified a process for referrers to monitor the requesting, reporting and action on radiology requests’.* However, I consider consultant physician (B), in accordance with guidance did have in place a failsafe system which would have checked for the patient’s CT scan report no later than one month, 23 December 2015. With that in mind, I consider consultant physician (B)’s failsafe system did not have an opportunity to be triggered as the patient presented to the ED on 22 December 2015 and was subsequently informed of his diagnosis on 23 December 2015. I note the Trust stated that, ‘*due to the large and diverse number of specialities who refer into Radiology it is not feasible to implement one single system for tracking of Radiology requests, dates and reports across all areas.*’

99. I am of the view that a key factor in this case was that the radiologist did not select the ‘communicate urgently’ flag on the patient’s radiology report of 29 November 2015. The failure to appropriately flag the report resulted in consultant physician (B) and his secretary not being able to read the results and have a more informed understanding of the patient’s condition. I consider the impact of this failure led to the patient not being discussed at an earlier lung cancer MDT meeting, not having earlier clinical input from the respiratory team and not having an earlier referral to the palliative care team who would have sought to meet the patient’s wishes. I consider the human error of the radiologist not appropriately flagging the CT scan, the lack of radiologists to read scans in the Trust and consultant physician (B)’s failsafe system not being triggered led to a systemic failure in the patient not being informed of his diagnosis earlier. I am in no doubt that had the patient been aware of his diagnosis sooner he would have been able to discuss his wishes with his family and had access to the palliative care treatment longer, which may have reduced the anxiety and discomfort of his condition.

100. I consider the Trust’s procedures in place for reporting the results of the patient’s radiology report results from the 29 November 2015, where less than adequate. I consider the systemic failures identified led a failure in care and treatment. Therefore, I uphold this element of the complaint. I am satisfied this failure in care and treatment caused the patient and the complainant the injustice of uncertainty, distress, anxiety and discomfort.

101. I note that in response to investigation enquiries consultant physician (B) has expressed his lack of confidence in the present failsafe system. That said, I welcome the Trust’s development and introduction of an electronic sign-off functionality that has been developed in the NIECR which will facilitate staff signing of radiology and laboratory results. I note this is a process which will enhance governance and aid the tracking of radiology requests and results.

CONCLUSION

102. The complainant submitted a complaint to me about the actions of the Northern Health and Social Care Trust.

103. The investigation of the complaint identified failings in care and treatment in respect of the following matters:

(i) Delays in diagnosis and overall timeframe for carrying out and reporting on the patient's condition

(ii) Failure to electronically flag a 'communicate urgently' on the patient's radiology report on 29 November 2015

(iii) Failure to inform the patient when x-rays and scan were going to be performed and expected timescale for results

(iv) Failure to discuss the patient at lung cancer MDT and forward plan his Palliative Care

(v) Failure to write to the patient and advise he was being referred for an urgent CT scan

(vi) Failure to communicate with the patient's GP of the request for an urgent CT scan and the results of the CT scan

(vii) Failure to put in place adequate reporting procedures for reviewing Radiology Reports

104. I am satisfied that the failures in care and treatment I identified caused the patient and the complainant to experience the injustice of loss of opportunity, frustration, uncertainty, distress, anxiety, discomfort and upset.

Recommendations

I recommended that the NHSCT undertake the following action:

(i) In accordance with the Ombudsman's guidance on issuing an apology, provide a written apology to the complainant for the injustice identified in this report. The

NHSCT should provide the apology to the complainant within one month of the date of my final report.

(ii) The Trust remind reporting Radiologists of the importance of ensuring all alerts on reports are appropriately flagged to referring clinicians within one month of the date of my final report.

(iii) The Trust review procedures for referring clinicians ensuring they have acknowledged receipt of report and its flagged status within six months of the date of my final report.

(iv) The Trust review the Consultants safety net system and consider how this can be improved within six months of the date of my final report.

(v) The Trust develop and progress a Radiology Scanning and Reporting Waiting Time Information system within three months of the date of my final report.

I wish to acknowledge the work the Trust are doing through its NIECR system and Radiology services to address the issues raised within this complaint.

PAUL MCFADDEN
Acting Ombudsman **5 March 2020**

Appendices

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.

- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.