Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 201915822

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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 the Belfast Health and Social Care Trust in relation to the care and treatment provided by Belfast City Hospital to the complainant's husband as well as about the Trust's response to the complaint raised about the patient's treatment.

The investigation established there were no failures in the care and treatment in relation to the meeting of targets, the completion of and reporting on scans and biopsies and how the patient's pain was assessed and managed at oncology review appointments. While target times for individual investigations were met the patient had a number of tests and scans which needed to be completed in sequence. This resulted in a significant period of time elapsing before decisions were made on the best plan of care for the patient. The complainant set out clearly the impact this can have on quality of life and the need to take a patient centred approach. A point which I concur with and I note and welcome the Trust's acknowledgement of the need to focus on the overall patient diagnostic journey.

However, I concluded that there were failures in the care and treatment in relation to ensuring an appropriate and effective process for ensuring outcomes of Multi Disciplinary Meetings are completed; the timely access to palliative radiotherapy; and referring the patient to the palliative care team in the community.

I concluded that the failures in care and treatment identified caused the patient to experience the injustice of distress and loss of opportunity to receive timely palliative treatment and to receive assistance with pain management in the community. Although I consider these failures did not affect the patient's overall prognosis I do recognise the significant impact on both the patient and complainant that the increased journey time to receiving palliative radiotherapy caused and the impact of this on the quality of life of the patient.

The investigation also found maladministration in relation to the Trust's handling of the complaint about the patient care and treatment. I concluded that maladministration caused the complainant to experience the injustice of upset, frustration, and time and trouble by bringing a complaint to this office.

I recommended that the Trust provides the complainant with a written apology for the injustice caused as a result of the failures in care and treatment and maladministration I identified.

I also made recommendations for service improvements in relation to the processes of the Bone and Soft Tissue Multidisciplinary Team.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health & Social Care Trust (the Trust) in relation to the care and treatment Belfast City Hospital (BCH) provided to the complainant's husband (the patient). The complainant also raised concerns about the Trust's response to her complaint about the patient's treatment.

Background

2. The patient, who has recurrent oesophageal cancer[1], was under the care of Dr A, Consultant Medical Oncologist[2], following a thoracotomy[3] in December 2016. In April 2019, the complainant contacted Dr A as her husband had lost his voice. Following an inconclusive CT scan[4], a PET scan[5] was requested and carried out on 5 July 2019. The PET scan highlighted an issue with patient's right hip and femur and a MRI[6] was completed on 24 July 2019. Following Upper Gastrointestinal[7] (GI) and Bone and Soft Tissue Sarcoma[8] Multi-Disciplinary Meetings (MDM) on 9 August and 16 August 2019 a bone biopsy[9] was requested and carried out on 27 September 2019. Orthopaedic[10] surgery was recommended following the bone biopsy.

3. While waiting for diagnostic tests, the patient began to lose weight and had increasing difficulty in swallowing. An upper GI endoscopy[11] and further CT scan were requested on 27 September 2019. These were carried out on 17 and 24 October respectively. An Upper GI MDM was held on 25 October 2019 following which the patient was admitted to BCH for a repeat endoscopy and nutritional management prior to receiving Orthopaedic surgery. The patient underwent orthopaedic surgery for Femoral Nail Insertion[12] on 24 November

[1] A type of cancer affecting the food pipe (oesophagus), the long tube that carries food from the throat to the stomach.
[2] A doctor who specialises in diagnosing and treating different forms of cancer.
[3] A Surgical incision of the chest wall.
[4] Uses several X-ray images and computer processing to create cross sectional images.
[5] A scan are used to produce detailed 3-dimensional images of the inside of the body.
[6] A type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
[7] Refers collectively to the stomach and the small and large intestine.
[8] A tumor, often highly malignant, composed of cells derived from connective tissue such as bone, cartilage, muscle, blood vessel, or lymphoid tissue;
[9] An image-guided procedure in which a small sample of a bone is removed from the body and examined under a microscope
[10] Specialist surgery involving the treatment of diseased or damaged bones and joints of the skeleton.
[11] Insertion of a long, thin tube directly into the body to observe an internal organ or tissue in detail.
[12] A surgical technique used to treat a fractured or broken femur, or thighbone.

2019 and commenced radiotherapy on 16 January 2020. The patient sadly passed away on 31 January 2021.

Issues of complaint

4. The issues of complaint accepted for investigation were:

Issue 1: Whether the patient received appropriate care and treatment from the Trust from July 2019 to January 2020. In particular with respect to:-

- The timeliness of scans and bone biopsy
- Pain management, including the access to palliative pain radiotherapy.

Issue 2: Whether the Trust response to the complainant was reasonable and in accordance with good practice.

INVESTIGATION METHODOLOGY

5. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint. The Investigating Officer also requested comments from the South Eastern Health and Social Care Trust (the South Eastern Trust). However, the actions of the South Eastern Trust did not form part of the investigation into the complaint.

Independent Professional Advice Sought

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

- **Consultant Clinical Oncologist**, MBBS, MRCP, FRCReq, MBA, MPH – A consultant who has been trained to treat all adult solid tumours and takes part in the acute oncology rota.

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

Relevant Standards and Guidance

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. I also make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[13]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling
   - The Public Services Ombudsmen Principles for Remedy

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

10. The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
    - The National Institute for Health and Care Excellence's (NICE) Clinical Guideline [NG 12] Suspected cancer recognition and referral, June 2015 (NICE NG12);
    - The Health and Social Care Board (HSC) Diagnostic Imaging Services: *Data Definitions & Information Monitoring,* December 2019 (the HSC Diagnostic Imaging Services guidance);[14]

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

[14] Although this guidance was not in effect until April 2020 the Trust have advised that in relation to red flag referrals the Trust applied the targets, during July 2019 to January 2020, as set out in the guidance.

- The Belfast Health and Social Care Trust Cancer MDT Communication Protocol, August 2018, (the MDT Protocol);
- The Department of Health's (DoH) Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning, April 2009 (the DoH Complaints Procedure); and
- The Belfast Health and Social Care Trust's Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments, March 2017 (the Trust's Complaints Policy);

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied I took into account everything that was relevant and important in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment from the Trust from July 2019 to January 2020? In particular with respect to:-

- **The timeliness of scans and bone biopsy**
- **Pain management, including the access to palliative pain radiotherapy.**

Detail of Complaint

13. The complainant believed that the patient's care was seriously compromised by the delays in access to various diagnostic tests. She believed if the diagnostic work and surgery for the abnormality in her husband's hip had been completed sooner he would have commenced chemotherapy before swallowing difficulties arose. The complainant further believed the patient was left in pain for a

considerable period because of the subsequent delay in receiving palliative radiotherapy.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies and guidance:
    - The GMC Guidance;
    - NICE NG12;
    - HSC Diagnostic Imaging Services guidance; and
    - the MDT Protocol.

The Trust's response to investigation enquiries

The timeliness of scans and bone biopsy

15. In response to investigation enquires about the timeliness of diagnostic examinations the Trust explained it had *'…reviewed the overall timeline for [the patient's] diagnostic journey to palliative orthopaedic surgery and further treatment with palliative radiotherapy and chemotherapy, and acknowledges there was a period of 3 months from initial imaging in July 2019 until [the patient] was referred to the orthopaedic team for palliative surgical treatment.'* The Trust also acknowledged the distress that *'…the cumulative delay would have had upon [the patient's] physical health and mental wellbeing, for which we apologise.'*

16. The Trust went on to explain that the '…*cancer pathway for [the patient] was complex and, to treat the range of symptoms he was experiencing associated with a likely recurrence of his cancer unfortunately required several different radiological investigations (PET scan, CT scan, MRI scan, Renal DMSA scan and Bone biopsy) to confirm the exact nature of his diagnosis prior to any treatment being able to commence. Unfortunately, it was not possible to generate referrals for a number of these investigations concurrently, with the outcome of some investigations indicating the need for further investigations in sequence. In addition, in keeping with national guidelines, MDT discussion is essential to ensure that patients receive optimum care….Whilst the individual*

scanning and reporting turnaround times for the above diagnostic examinations were within our own target times for imaging procedures, we again acknowledge there was a significant time between the initial diagnosis of the bony lesion and treatment being initiated as several of these investigations could not be run in parallel.'

17. The Trust explained its normal procedures for requesting, completing and reporting on diagnostic examinations. *'For the majority of referrals, referrers complete a paper referral form for imaging procedures, which are then sent to the Imaging department. The referral is validated by a Practitioner Radiologist or Radiographer, and the urgency of the request is reviewed. The request is then logged on the electronic Radiology Information Systems. The examination is then appointed based on the priority of the scan and available capacity. The timing of this can range from a number of hours (inpatients) to days, weeks and sometimes months based on the capacity available and the clinical priority. When the scan is performed, it is then added to a reporting list for a Radiologist to report…'*

18. The Trust went on to explain that *'All red flag diagnostic referrals should be completed within 14 days of receipt of referral by Imaging Department. The report should be completed within 48 hours of examination. The diagnostic reporting turnaround target for urgent reports is within 48 hours and for routine reports is 75% of these completed within 14 days and 100% within 28 days. Urgent requests are triaged based on the clinical urgency and the capacity available. The capacity available varies between modalities i.e. CT, PETCT, MRI… A bone biopsy is an interventional procedure as opposed to a diagnostic imaging procedure - although it is completed under image guidance. Interventional procedures are scheduled based on the capacity available. [The patient's] procedure was booked into the first available interventional CT slot available…once the referral was received…. The results of the bone biopsy are returned directly from the laboratory to the referrer. The time taken for the results to be acquired varies depending on the type of test. It is the responsibility of the referring clinician to advise patients of their scan results.*

The referrer is best placed to correlate clinically the results of the scan with the patient's condition.'

19. The Trust explained how referrals to the South Eastern Trust are normally made. *'Patients can be referred to the South Eastern Trust or Belfast Trust for bone biopsies to be carried out. Referrals to the South Eastern Trust are made via MDM letter after discussion at the MDM and it is specified on the letter who is responsible for the action. Normally after the procedure is performed the clinician would refer the patient back to the relevant MDM for further discussion.*

20. It went on to explain *'In this case the patient was discussed at the MDM on the 16 of August and a referral was accepted by South Eastern Trust's [Dr B, Consultant Radiologist] who was present at the MDM and therefore accepted responsibility for the bone biopsy. The referral to confirm this was forwarded from the Belfast Trust Sarcoma MDM, however 4 days later [Dr B]… unfortunately required a period of…absence. On the 6 September 2019 [Dr A] noted that this biopsy had not yet been performed therefore the Belfast Trust Oncology team contacted the South Eastern Trust and were advised that [Dr B] was absent from work. [Dr A's] team therefore discussed the request with Consultant Radiologist [Dr C] of BHSCT and organised for an urgent CT guided biopsy to be undertaken in place of the bone biopsy in the Belfast City Hospital on the next available date.' '…On Friday 06 September, [Dr D], Oncology Specialist Registrar] discussed the case and reviewed the images in person with…[Dr C]… from BHSCT…[Dr D] explained and [Dr C] agreed that the request was urgent as [the patient] had a previous cancer diagnosis and was displaying symptoms and had imaging suspicious for recurrence…' '…[Dr D] reports that unfortunately she entered an incorrect date on the CT bone biopsy request form dated 19th August. [Dr D] reports that she completed and hand delivered the form on the 09 September. [Dr C] also approved the request on the same date.'*

21. The Trust provided clarification on the phrase '*The referral to confirm this was forwarded from the Belfast Trust Sarcoma MDM…'* It explained that '*The referral for biopsy was accepted by the person responsible at the MDM. The*

MDM do not refer to radiology, it is the clinicians responsibility to follow-up on the MDM action.' The Trust also explained who had responsibility for follow up to ensure a bone biopsy was completed on this occasion. It stated *'This is normally recorded in the MDT action. In this case, it is clearly documented that Dr B had accepted responsibility for completing that recommendation from the MDT.'*

22. The Trust went on to explain *'…It is really difficult to advise whether or not [the patient's] survival time has been impacted by the diagnostic delays. It undoubtedly led to poorer quality of life during this time. His life expectancy will depend on whether his cancer responds to his current treatment with chemotherapy.'*

23. It also explained that '…*Cancer Services staff work closely in partnership with diagnostic and treatment teams to ensure clinical management guidelines and patient pathways are streamlined with a focus on reducing diagnostic/imaging waiting times. Several quality improvements projects have demonstrated improvements in such waiting times and…this work can be shared…' '…The Imaging service are also working towards electronic requesting which will further streamline the referral process in the future.'*

Pain management

24. In relation to pain management the Trust advised that *'The Trust, the clinical teams and individuals involved in [the patient's] care are deeply apologetic that the time it took to complete and evaluate the series of investigations to form a diagnosis and treatment plan meant that [the patient] was in pain and distress.*'

25. The Trust explained that *'[The patient]'s pain was assessed at each of his Oncology review appointments on 15 July, 19 August, 10 October, 19 December 2019, and 13 January 2020. On 19 August 2019 [Dr D]…advised [the patient] to take regular pain relief rather than the co-codamol taken intermittently as required which he had been taking. She also provided [the patient] with a GP prescription for Oromorph. When [the patient] was reviewed, and advised of the result of his bone biopsy on 10 October 2019, [Dr A]*

documented [the patient's] pain levels in his clinic letter noting his reduction in mobility, and referred [the patient] to [Mr E] and the orthopaedic team for consideration of palliative surgical treatment to his hip to help alleviate his pain…'

26. It went on to explain that the patient's *'…orthopaedic surgery to provide palliative pain relief and reduce the risk of fracture was completed on 24 November 2019…[The patient] required admission in early November for an upper GI endoscopy, to have biopsies taken and to have a feeding tube inserted, as he needed additional nutritional support in preparation for his planned hip surgery…[Dr F, Oncology Specialist Registrar] saw [the patient] on 19 December 2019. [Dr F] noted his pain had improved following surgery however, she felt he was not fit for palliative chemotherapy at that time. Pending further review in 4 weeks, [Dr F] referred [the patient] for palliative radiotherapy for pain relief, which he received on 16 January 2020. [The patient] was reviewed again by [Dr A] on 13 January 2020 and has now commenced on chemotherapy treatment,…which it is hoped will further help to manage his symptoms…'*

27. The Trust also explained that the patient *'…had access to the Oesophageal gastric (OG) Clinical Nurse Specialists (OG CNSs) throughout his care who offered additional support. This was mostly in the form of telephone contact with [the complainant]. The OG CNSs reviewed [the patient] when he was an inpatient in Ward 6 North, BCH for the placement of an oesophageal stent. The CNSs were able to provide support and symptom management during his time in hospital. On discharge, the CNSs supplied their contact details to allow for continued support. [The complainant] contacted the CNS team on a few occasions however; from the records, this was to discuss delays in [the patient]'s treatment, not with regard to his symptom management. His pain control was being managed by his GP with some input from the Oncology team. While the CNS recalls that a discussion occurred, [the patient] does not appear to have been referred to his community palliative care team, which he may have found helpful in managing his symptoms.'*

Overall

28. The Trust went on to state it would provide *'…a fulsome, reflective apology, details of improvements made to the service as a result of this complaint, and active oversight of [the patient's] further treatment to avoid delays wherever possible.'*

The South Eastern Trust's response to investigation enquiries

29. In relation to investigation enquiries about the referral of the patient's bone biopsy the South Eastern Trust explained *'…The case was discussed at the Bone Tumour meeting (MPH) on 16/08/19 and [Dr B] agreed to perform the biopsy. To organise and perform the biopsy, the radiology department normally receive a request from the referring clinician. The radiologists are unable to generate clinical requests. In this case the CT guided biopsy request was not generated by the referring clinician or MDT. [Dr B] was on…leave from 20th August 2019. Had there been a request for CT guided biopsy generated by the referring clinician on the RIS system, [radiology information system] the procedure would have been appointed by another radiologist. The Bone Tumour MDM is actively looking into ensuring future mechanisms are in place to avoid repetition of this incident.'*

Clinical Records

30. The patient's clinical records were considered.

Relevant Independent Professional Advice

The timeliness of scans and bone biopsy

31. The IPA advised a PET CT *'…was requested because the patient presented with symptoms of hoarse/lost voice in April 2019 and the CT scan which was performed did not show any obvious cause for the symptoms. Given the previous history of cancer for this patient, it was good practice to investigate further with a more detailed exam such as the PET- CT. This represented good practice based on clinical suspicion of recurrent cancer.' 'The results of the PET-CT scan showed a probable sinister (cancer looking) lesion in the right hip/femur…The scan did not show any evidence of esophageal [sic] cancer recurrence.'* The IPA also advised why a MRI scan was completed following the

PET scan. *'…The lesion in the hip was an unexpected finding and an MRI would give more details regarding the amount of bone destruction in the area and potential infiltration of cancer to surrounding tissues. The MRI hip would give valuable information for the orthopaedic [sic] surgeons to operate safely. This represents good practice.'*

32. In relation to the scheduling of the MDT meetings the IPA advised *'..It is good practice that the MDTs are conducted when all necessary investigations are completed…Without the necessary clinical information, there is risk that MDT makes the wrong decision. In this case, the PET-CT and MRI scan guided the decision to perform a bone biopsy to confirm diagnosis, given that the PET-CT did not show any evidence of local esophageal [sic] cancer recurrence. The hip lesion could have been a completely new cancer (such as sarcoma) which may have required different treatment.'* She further advised if the bone biopsy could have been completed without an MRI. *'…In my experience as an Oncologist looking at PET-CT scans and in this occasion too, it is very difficult to distinguish the tissue anatomy around the hip joint on a PET-CT and requires more detailed investigation in the form of an MRI scan which could guide the insertion of the needle biopsy and also inform the orthopaedic surgeons of their surgery.'*

33. The IPA went on to advise '*The timelines for scans and reporting…were appropriate...the scans/biopsies were given the appropriate urgency…, however, there was a 5-week delay between the request for bone biopsy and the biopsy taking place* which is outside the 4 weeks window[15]…*This was due to the person responsible for arranging this to go on urgent leave, not handover request and the fact that there was only one radiologist to perform the test in another site on the 27th of September 2019.*

34. The IPA commented on the procedures in relation to making a referral from a MDT. She advised *'…The person requesting the investigation referral in the same or different Trust should be documented in the MDT outcome and… In*

[15] This 4 weeks relates to the Trust's reporting turnaround target ie from when the biopsy is taken to the results reported on and the time to complete the biopsy.

line with good practice, it should be the responsibility of the oncology clinician in charge of the patient care…(or an allocated deputy clinician) to ensure that the bone biopsy is requested in the system.' She further advised *'It seems that [Dr B] (consultant radiologist) was tasked with requesting the bone biopsy in this occasion (allocated deputy clinician for [Dr A]). When [Dr B] left for urgent leave and was found that the biopsy was not booked, then Dr A (oncologist responsible for care of patient) arranged the referral request.'*

35. The IPA went onto advise '*There are no standards stating exactly who should be arranging investigations after MDTs. Good Medical Practice Domain 3 guidelines should be followed which involves clear communication between team members of who is requesting which test. This should be documented in the MDT outcome. In this scenario, the radiologist took the responsibility to request the test but did not complete the request before he left for urgent leave and did not handover the request to another colleague. This was picked up by the patient's oncologist [Dr A] on the 6th of September who then arranged the test.'* The IPA further advised that the oncology could have followed up the referral *'…a week earlier but this would not have resulted in any change in the management plan as the only date for the next bone biopsy was the 27th of September.'*

36. The IPA commented on the impact to the patient as a result of the time taken to undertake and report on the bone biopsy. She advised that '*The cancer was progressing fast in this patient and there is evidence of clinical deterioration whilst awaiting for the hip surgery. The delay in getting the bone biopsy contributed to the delay getting the hip surgery…and in the meantime, the patient came into hospital on the 5th of November to have stent inserted to enable him to swallow (as cancer was getting worse). As a result, chemotherapy was inevitably delayed for another month after surgery. Patient was not fit for chemotherapy when assessed prior to stent insertion in November and ultimately, his chemotherapy was delayed until he was nutritionally optimised…which resulted in the cancer growing in the meantime. However, this is unlikely to have affected overall prognosis of the patient as he*

eventually started on chemotherapy with good response. It may have led to the prolongation of symptoms from cancer such as pain.'

37. The IPA identified the following learning and improvements;

i. *'The cancer MDT Chair with the support of the MDT Coordinator should ensure that there is clear documentation in the MDT outcome of who is responsible for requesting tests.*

ii. *Clinicians responsible for patient care are responsible for requesting tests from the MDT or allocating a deputy to do this. Responsible Clinicians that have been tasked to do this should handover to other colleagues (deputy) if unable to request tests.*

iii. *Responsible clinicians for patient care are ultimately responsible for ensuring that patient tests are requested and performed, acknowledging the results of such tests.'*

Pain management, including the access to palliative pain radiotherapy

38. The IPA advised that the *'…Patient's pain management was done by the Oncology team and with the support of the patient's GP. The patient was initially given Cocodamol and non-steroidal anti-infammatory [sic] medications (NSAIDs) in July 2019 (WHO ladder of pain control [16]step 2) and then moved to level 3 (morphine patches, pregabalin and NSAIDs around November time when his cancer started progressing). This was done appropriately. The stent and subsequent hip radiotherapy also helped his pain.'* She went on to advise that *'…Radiotherapy was given to treat the cancer in the right hip and improve pain, after pinning the hip to prevent break. Chemotherapy was given to push back the cancer of the oesophagus which had recurred, improve patient's dysphagia symptoms and prolong his life.'*

39. The IPA was asked to comment on the timescale from when the bone biopsy was taken to when palliative radiotherapy commenced. She advised *'The*

[16] created by the World Health Organisation (WHO) as a guideline for the use of drugs in the management of pain. Originally published for the management of cancer pain

radiotherapy could not have commenced before the hip surgery. The latter was delayed because the bone biopsy was delayed but the radiotherapy happened at the appropriate time after surgery to let the surgical wound to heal.'

40. The IPA went on to advise *'The delay in requesting and performing the bone biopsy has resulted in delayed hip surgery, which may have prolonged patient's pain. However, pain management was appropriate. I agree that a referral to the palliative care team in the community would have also helped with pain management. The chemotherapy could not have been given before the hip surgery which led to the cancer progressing and patient needing a stent insertion and nutritional maximisation in November. The patient was not deemed fit for chemotherapy in November and therefore the timing of chemotherapy was appropriate as was the timing of radiotherapy (some weeks after surgery to allow the wound to heal).'*

Overall care

41. The IPA advised *'The patient's condition was complex and required a lot of multidisciplinary input to establish the right diagnosis and have the right treatment. Overall, the care was appropriate and in line with standards.'*

Complainant's response to draft report

42. In response to the draft report the complainant raised concerns in relation to the following issues:

Bone biopsy

43. The complainant welcomed the Ombudman's provisional findings in relation to the delay to the bone biopsy and believed it *was '…such a stumbling block to the [patient's] progression through the system that it has to be highlighted for the benefit of other patients…'* The complainant also stated that she contacted the Oncology Department of the Trust, at the end of August 2019, to advise of Dr B's absence, and it was this phone call, that she considered prompted the Trust's follow-up with the SE Trust.

Pain Management, including access to palliative radiotherapy

44. The complainant welcome the provisional finding to provide timely access to palliative radiotherapy. In relation to the Trust's comments that the complainant did not refer to the patients pain in various phone calls, she highlighted that the patient *'..had been seen at clinics…'* where his pain was highlighted. She also commented on the content of the phone calls concerned explaining, given her professional background, she understood the effect of delays in progressing the patient to radiotherapy which, once commenced would help reduce the negative impact on his quality of life as a result of the pain medication side effects.

Trust response to initial investigations

45. The complainant noted the Trust comments that they would 'provide active oversight' of the patient's future treatment. However she felt this was not the case as she was required to follow-up with the Trust, on various occasions, due to a lack of communication. As a result the complainant welcomed the proposed monitoring of the recommendations made.

Overall

46. The complainant expressed her thanks to the Trust for their responses to our investigation given their work pressures even prior to Covid 19 pandemic.

Trust response to draft report

47. In response to the draft report the Trust made the following comments:-

Bone biopsy

48. The Trust explained *'…The MDM communication protocol states that during the MDM, the Chair dictates a management plan to the MDT coordinator and where appropriate will outline and include the person responsible for the outcome. This patient's MDM outcome stated Dr B as the person responsible for the action, who in this case is a core member of the Sarcoma MDM'.* They went on to explain that they had relooked at the MDT Protocol and on reflection believed the *'…issue is that the language in the…protocol could be read two ways. The protocol states – 'Belfast MDT coordinator/chair to copy MDT outcome to local*

referrer or person presenting case if not a core member of the MDT.' In this case the person presenting the case was a core member of the MDT, so we would not have also copied the MDM outcome to referrer unless the core member asked the MDT coordinator to do so, which would have been the usual practice….' '….the wording could be read that if either the local referrer or person presenting the case is not a core member, the MDT outcome should be copied to both of them. Following this case we will amend the protocol to make it clearer and change our practice so that if a core member is asked to present a case on behalf of a local referrer, we will also copy the referral to the local referrer.' The Trust further explained that if Dr B had been unable to complete the action they would have expected him to have advised the local referrer to arrange the biopsy. The Trust also explained that they understood the response provided by the SE Trust radiology team as they had not *received a referral from either Dr B or the local SE Trust referring clinician '…We now know that unfortunately due to absence from work this referral did not happen and the issue when discovered was fortunately picked up by our Oncology team and arrangements made.'*

49. They also advised they had checked the checked *the* MDM sign off sheet that is competed by the MDM co-ordinator after the MDM and that this confirmed that a MDM update report would have been forwarded to the MDM distribution list including Dr B as the SE Trust Core member detailing the patient's outcome. The Trust explained Dr B had presented the patient's case rather than the local referrer and had accepted the action. The Trust also explained that as Dr B was a core member the action would have only been sent to him as he had not requested at the meeting that it should be forwarded to the local referrer.

50. The Trust went onto advise that further investigation into the patient's referral found that he *'…was initially discussed at the Upper GI MDM on 9 August 2019 at the request of the BCH Oncology team. The MDM action stated "suspicious of metastases, requires bone biopsy". A referral was then made to the Sarcoma MDM via referral form from [SE Trust] on 13 August 2019 from [Dr I, SE Trust GI speciality Doctor] & Dr J, SE Trust Consultant Gastroenterologist] it was*

noted on this form that the referral had been discussed with Sarcoma core team member, Dr B, to present the case at MDM…'

Referral to the community palliative care team

51. The Trust concurred with the IPA's advice about the patient's referral to the palliative care team in the community and acknowledged that he *'…should have also referred [the patient] with challenging pain to the community palliative care team, or liaised with his GP team to complete the referral.'*

SE Trust response to further enquires

52. The SE Trust advised *'The normal practice is for requests to be made to Radiology for imaging or image-guided procedures. These requests typically come from the referring clinician or a member of the clinical team. It is not normal practice for the Radiologist to make such a referral…It would be normal practice for the responsible clinician to formally submit a request for any imaging or image-guided procedure after discussion of any individual case at the MDM…Upon receipt of a request for a procedure, this would be scheduled in a timely manner on a list being run by an appropriate Radiologist…no such request was submitted after the MDM discussion…[Dr B] was on sick leave shortly after the MDM. If the request had been made, the procedure would have been scheduled on the list of another Radiologist who performed bone biopsies in [Dr B's] absence…..'*

53. They went onto advise that they could not *'…comment on systems used by the regional bone tumour MDM to ensure communication of the outcome of any case discussion to all relevant parties and clinical teams…'*

Analysis and Findings

The timeliness of scans and bone biopsy from July 19 to Jan 20

54. The complainant raised concerns that the patient's care was seriously compromised by the delays in access to various diagnostic tests. She believed if the diagnostic work and surgery for the abnormality in her husband's hip had been completed sooner he would have commenced chemotherapy before

swallowing difficulties arose. I note from clinical records the dates when a PET CT scan and MRI were requested and completed and that the MRI was red flagged. I also note that following the MRI the patient was discussed at both the Upper GI and Bone and Soft Tissue MDM, on 9 and 16 August 2019 respectively, with the plan from both to carry out a bone biopsy. I also note that the SE Trust clinicians made the referral to the Bone and Soft Tissue MDM and Dr B accepted the case for presentation at the MDM on behalf of Dr I and Dr J. I further note that Dr B, from the Ulster Hospital (UH), was documented as person responsible for making the necessary arrangements for the bone biopsy following the MDM on 16 August 2019 and the Trust's comments that *'..that a MDM update report would have been forwarded to the MDM distribution list..*' and unless specified at the meeting would not have gone to the referring clinician. I further note the Trust comments that the MDM protocol could be read in two ways.

55. I also note the staff from BCH contacted the UH on 6 September 2019 and found that Dr B was on leave and *'…no date arranged as yet…'* for the patient's bone biopsy. As a result, the bone biopsy was urgently arranged for the first available date, in BCH, on Dr C's list which was 27 September 2019. I further note the MDM report from the Upper GI MDM on 25 October 2019 documents the MDM action as *'Admit to Gastro team for repeat endoscopy and nutritional management…'* and that that was *'…required to ensure adequate nutrition for ..impending hip surgery…'*

56. I note the Trust's comments that it '*…acknowledges there was a period of 3 months from initial imaging in July 2019 until [the patient] was referred to the orthopaedic team for palliative surgical treatment.'* The Trust also acknowledged the distress *'…the cumulative delay would have had upon [the patient's] physical health and mental wellbeing…'* I also note the Trust's comments that *'…it was not possible to generate referrals for a number of these investigations concurrently, with the outcome of some investigations indicating the need for further investigations in sequence...'* and that MDT discussion was essential to ensure the patient received optimum care.' I further note the Trust's comments in relation to timescales for completing and reporting on referrals

including that *'…A bone biopsy is an interventional procedure as opposed to a diagnostic imaging procedure... Interventional procedures are scheduled based on the capacity available. [The patient's] procedure was booked into the first available interventional CT slot available…once the referral was received…'*

57. I also note the Trust's comments that following contact with the South Eastern Trust on 6 September 2019 *'…[Dr A's] team…discussed the request with Consultant Radiologist [Dr C] of BHSCT and organised for an urgent CT guided biopsy to be undertaken in place of the bone biopsy in the Belfast City Hospital on the next available date…'* and Dr C approved the request on 9 September 2019.

58. I note the Trust's comments in relation to clarifying how the referral for the bone biopsy was made in this case. *'…The referral for biopsy was accepted by the person responsible at the MDM. The MDM do not refer to radiology, it is the clinician's responsibility to follow-up on the MDM action…In this case, it is clearly documented that Dr B had accepted responsibility for completing that recommendation from the MDT.'* However I also note the Trust stated the normal process for '…*Referrals to the South Eastern Trust are made via MDM letter after discussion at the MDM and it is specified on the letter who is responsible for the action…'* I also note the South Eastern Trust's comments in relation to the bone biopsy referral that *'…[Dr B] agreed to perform the biopsy…' and that '…the radiology department normally receive a request from the referring clinician. The radiologists are unable to generate clinical requests. In this case the...request was not generated by the referring clinician or MDT. [Dr B] was on…leave from 20th August 2019. Had there been a request for CT guided biopsy generated by the referring clinician on the RIS system, the procedure would have been appointed by another radiologist. The Bone Tumour MDM is actively looking into ensuring future mechanisms are in place to avoid repetition of this incident.'*

59. I further note the Trust's comment that *'…It is really difficult to advise whether or not [the patient's] survival time has been impacted by the diagnostic delays. It undoubtedly led to poorer quality of life during this time. His life expectancy will*

depend on whether his cancer responds to his current treatment with chemotherapy.'

60. I note the IPA's advice that '…*The timelines for scans and reporting…were appropriate..'* and in relation to MDT meetings that is good practice that *'…MDTs are conducted when all necessary investigations are completed..'* and *'…In this case, the PET-CT and MRI scan guided the decision to perform a bone biopsy to confirm diagnosis.'* I also note the IPA's advice that, *'…Responsible clinicians for patient care are ultimately responsible for ensuring that patient tests are requested and performed...'* I further note her advice that oncology could have followed up the referral *'…a week earlier but this would not have resulted in any change in the management plan as the only date for the next bone biopsy was the 27th of September.'*

61. Based on the available evidence I accept that the PET–CT scan and MRI were completed in line with NICE NG12 and the HSC Diagnostic Imaging Services guidance as well as the need for, and scheduling of, the MDT meetings on 9 and 16 August 2019. I accept the Trust comments that the bone biopsy is an *'…an interventional procedure as opposed to a diagnostic imaging procedure…'* and *'…Interventional procedures are scheduled based on the capacity available…'* and that once a referral was received by Dr C it was completed in an acceptable timeframe. I also accept that the sample taken, as a result of the bone biopsy was reported on within the Trust's four week timescale.

62. I am concerned that it took five weeks to complete the bone biopsy. It is my opinion that this delay arose from a weakness in the MDM process relating to the following up of MDM actions. I accept Drs I and J were the referring clinicians on behalf of the SE Trust and that Dr B took on the responsibility to present the case to the MDM and subsequently to make arrangements for the bone biopsy to be carried out. Information provided by the SE Trust would indicate that Dr B would have been required to inform Drs I or J of the MDM outcome to enable a radiology referral to be made. However, given Dr B's absence this was not possible. I note the Trust explained that the MDM update report would have been circulated to the MDM distribution list including Dr B as

a MDM core member but not Drs I or Dr J as this had not been requested and that Dr B accepted responsibility for making the necessary arrangements for the bone biopsy in the SE Trust. While I acknowledge the Trust's view that the MDT protocol could be read in two ways on balance, it is my view the MDT Protocol requires that communication should be issued after a MDM and under '*Communication required,'* '*Communication to referrer if not a core member'* is clearly listed. Having considered all the information it may not have been apparent to Dr I or Dr J that they would not be advised of the outcome unless they requested this and that the MDM update would come via Dr B. On the basis of the information that I have reviewed I have not identified any evidence that either Dr I or Dr J sought to follow up on the referral they had made.

63. I consider the patient's case has exposed a weakness in the MDM process relating to how actions are communicated. In this case, Dr B presented the case and accepted the action however went on leave unexpectedly before the action could be arranged. The MDM, due to it's interpretation of the MDT Protocol, does not communicate the outcome to the local referring clinician unless requested. Having reviewed what occurred in this case I consider there should be clarity about the communication provided following MDMs and safety mechanisms put in place either at local level or by the MDM which can capture uncompleted actions, due to unforeseen circumstances. This may go some way to prevent unnecessary delay in a patient's treatment journey. I note that the Trust did follow up on bone biopsy on 6 September 2019 and this was appropriate action by Trust clinicians. However, I also note the complainant considers that it was a follow up telephone call by her, when the patient had not been contacted about the bone biopsy, which may have prompted this action.

64. I consider there was a breakdown in the operation of the MDM as a result of the unexpected absence of the SE Trust MDM core member which impacted on the care received by the patient. I consider the Trust as the MDM host need to ensure appropriate and effective process are in place with the SE Trust and, for that matter other referring Trusts, to ensure that there are clear responsibilities and processes for following up on outcomes. I consider the breakdown in the

operation of the MDM in this case a failure in the patient's care and treatment which caused delay. As previously stated, the actions of the South Eastern Trust were considered to establish the sequence of events but I have not made a determination on the SE Trusts actions as part of the investigation into this complaint. However I consider Trusts must work in partnership with each other when actioning clinical referrals as outlined in domain three of the GMC guidance. As regional services continue to be developed it is critical that the arrangements for the operation of such services are clear to all those involved and have appropriate safety mechanisms in place. I note and welcome the Trust's comments that following this case it will *'…amend the protocol to make it clearer and change our practice so that if a core member is asked to present a case on behalf of a local referrer, we will also copy the referral to the local referrer.'*

65. I note the IPA's advice that '*The delay in getting the bone biopsy contributed to the delay getting the hip surgery…and in the meantime, the patient came into hospital on the 5th of November to have stent inserted to enable him to swallow (as cancer was getting worse). As a result, chemotherapy was inevitably delayed for another month after surgery….'* I accept the IPA's advice that the patient's overall prognosis was unlikely to have been affected and agree that '*It may have led to the prolongation of symptoms from cancer such as pain.'* It is my opinion the failure in care and treatment identified resulted in a loss of opportunity for the patient to receive palliative treatment in a timely manner.

66. *I note that the Trust comments that 'Several quality improvements projects have demonstrated improvements in such waiting times…*' and '…*The Imaging service are also working towards electronic requesting which will further streamline the referral process in the future.*' I further note the Trust's willingness to *provide '…a fulsome, reflective apology, details of improvements made to the service as a result of this complaint..'* I also welcome the SE Trust's comments that '…*The Bone Tumour MDM is actively looking into ensuring future mechanisms are in place to avoid repetition of this incident.'*

Pain management, including the access to palliative pain radiotherapy

67. The complainant raised concerns that the patient was left in pain for large proportion of time with delays in receiving palliative radiotherapy. I further note the complainant's comments reading the detrimental impact on the patients quality of life due to side effects of pain medication and commencing palliative radiotherapy sooner. I note from clinical records that during Oncology review appointments on 15 July 2019, 19 August 2019, 10 October 2019, 19 December 2019 and 13 January 2020 that pain in the patient's right hip is discussed. I further note that on 19 August 2019 the patient was encouraged '*…to consider some regular analgesia either PARACETAMOL or CO-CODAMOL…'* and provided *'…with a GP script of ORAMORPH to use for severe flares in pain…'* I further note that on 10 October 2019 *'…orthopaedic surgical intervention..'* may be required *'…prior to considering any other treatment for… cancer…'* and on 19 December 2019 a referral was made for palliative radiotherapy.

68. On 13 January 2020 I note that medication was reviewed to consider '…a*dding in IBUBROFEN SUSPENSION with a dose of 400mg 3 times daily and also PREGABALIN initially at a dose of 20mg twice daily, increasing to 40mg twice daily after 4 or 5 days to try and improve his pain control . In addition….it would be worth increasing ORAMORPH dose to 6mg (3mls) as required for breakthrough pain.'* I also note radiotherapy treatment commenced on 16 January 2020.

69. I note the Trust comments that the patient's *'…pain was assessed at each of his Oncology review appointments…'* and following the consultation on 19 August 2019 adjustments were made to the patient's medication. Following a review on 10 October 2019, I note the Trust explained the patient was *'…for consideration of palliative surgical treatment to his hip to help alleviate his pain…'* I also note that *'…orthopaedic surgery to provide palliative pain relief and reduce the risk of fracture was completed on 24 November 2019…'* and that following a review on 19 December 2019 the patient was '…*not fit for palliative chemotherapy at that time..'* but was referred for *'…palliative radiotherapy for pain relief, which he received on 16 January 2020.'*

70. I also note the Trust's comments that the patient '…had access to the Oesophageal gastric (OG) Clinical Nurse Specialists…throughout his care who offered additional support. *'…His pain control was being managed by his GP with some input from the Oncology team… [the patient] does not appear to have been referred to his community palliative care team, which he may have found helpful in managing his symptoms.'*

71. I note the IPA's advice that the *'…Patient's pain management was done by the Oncology team and with the support of the patient's GP and ' …This was done appropriately.'* I further note the IPA's advice that *'The radiotherapy could not have commenced before the hip surgery. The latter was delayed because the bone biopsy was delayed but the radiotherapy happened at the appropriate time after surgery…'* and *'… The chemotherapy could not have been given before the hip surgery which led to the cancer progressing and patient needing a stent insertion and nutritional maximisation in November…the timing of chemotherapy was appropriate…'* I also note the IPA's advice that *'…a referral to the palliative care team in the community would have also helped with pain management.'*

72. Having considered the issues it is clear that the delay in bone biopsy being conducted affected the overall journey of the patient. Palliative radiotherapy is an effective means of controlling pain and I am satisfied that while this was provided at the appropriate time after surgery it is likely that the surgery was delayed as a result of the delay in the bone biopsy being conducted. I accept that overall the patient's pain was appropriately assessed and managed at each of the oncology review appointments. However, I am satisfied there was an overall delay in the patient's journey caused by the delay due to in the biopsy being conducted. I therefore consider the failure to have timely access to palliative radiotherapy a failure in care and treatment. I am satisfied this failure in care and treatment resulted in distress to the patient as well as a loss of opportunity to receive the benefit of palliative radiotherapy at the earliest opportunity. I therefore uphold this element of complaint.

73. Furthermore, I consider the lack of a referral, to the palliative care team in the community, as a failure in care and treatment. I consider this failure in care and treatment resulted in a loss of opportunity for the patient to receive further assistance with pain management in the community which may have provided a chance to provide a more holistic approach to pain management. I note the Trust's acknowledgement that this referral should have been completed by them or by liaising with the patient's GP to complete the referral.

74. I note that the *'…Trust, the clinical teams and individuals involved in [the patient's] care are deeply apologetic that the time it took to complete and evaluate the series of investigations to form a diagnosis and treatment plan meant that [the patient] was in pain and distress.'* It is evident that the Trust conducted tests in line with guidelines and targets. However, given the number of tests, procedures and MDM discussions required the overall time to treatment meant that the patient was in pain and his condition progressed during this period. I also acknowledge the IPA's advice that '*The patient's condition was complex and required a lot of multidisciplinary input to establish the right diagnosis and have the right treatment…'* Nevertheless, it is important that the patient and their best interests remains at the centre of decisions and that a holistic perspective of the patient journey is adopted. I note and welcome the Trust's acceptance of this and the steps being taken to improve the time taken to complete diagnostic tests so that patient journey times can be improved. It is clear that waiting time for tests and results and a plan for treatment has a significant impact on patients. I consider it is imperative that all involved in health and social care use their best effort to improve outcomes for patients by reducing the amount of time that patients wait for diagnostic tests and treatment. I welcome the Trust's offer to share details of the work being undertaken as part of its Cancer Improvement Plan and I will avail of this offer.

Issue 2: Whether the Trust response to the complainant was reasonable and in accordance with good practice?

Detail of Complaint

75. The complainant also raised concerns about the Trust's response to her complaint about the patient's treatment. In particular, she believed the Trust's response failed to address the overall delay to palliative treatment and the subsequent increase in distress and pain that the patient suffered. She also believed the Trust did not regard the patients holistically merely looking at target times for individual procedures within its response.

Evidence Considered

Legislation/Policies/Guidance

76. I considered the following policies/guidance:
    - DoH Complaints Procedure; and
    - Trust's Complaints Policy.

Trust's response to investigation enquiries

77. The Trust explained *'We sincerely apologise that the Trust complaint response of 12 December 2019 failed to acknowledge the pain and distress [the patient] was experiencing and did not address the issues regarding [the patient's] treatment in a holistic way. The cancer pathway for [the patient] was complex and, to treat the range of symptoms he was experiencing… unfortunately required several different radiological investigations…to confirm the exact nature of his diagnosis prior to any treatment being able to commence. Unfortunately, it was not possible to generate referrals for a number of these investigations concurrently, with the outcome of some investigations indicating the need for further investigation in sequence…'*

78. The Trust provided a timeline into the patient's care including the decision-making undertook by the various clinical teams. It went on to explain that '*…Again the Trust wishes to apologise to [the patient and complainant] that this*

level of detail was not provided in the response of 12 December 2019, nor did we acknowledge the context in which the requests for imaging were made.'

79. The Trust went on to explain learning identified that being, *'…the reinforcement of the need in our complaints investigations and responses to acknowledge the impact on the patient and their relatives of the matters raised therein. The Trust has an ongoing Cancer Improvement Plan which focuses on improving cancer pathways and the experience for patients across all tumour sites and would be happy to share details of this work…'*

The Trust complaints records

80. I considered the records relating to the Trust provided complaint.

81. I considered the complainant's letter to the Trust emailed on 29 October 2019. The letter documented that the patient's *'…care has been seriously compromised by the delays in access to various diagnostic service. Individually a wait of several weeks for most test is not too detrimental; however cancer patient may require a sequence of three or four scans and test, leading to delays in treatment of several months….and as a result the [Trust] is failing to meet the required standards of palliative care…to minimise pain…"* The letter also set out a timeline of the diagnostic tests planned and received.

82. I also considered the Trust's written response to the complainant date 12 December 2019. Three sections, *'Endoscopy*', '*Imaging'*, and *'Nuclear Medicine'*, are set out in the letter. Under Endoscopy the Trust stated it was *'...sorry there was a delay between endoscopies. [Dr F]..in the interest of patient safety and establishing all the clinical facts, required that time…'* Information in relation to the each of the steps from patient referral to gastroscopy to, the completion of relevant treatment, was also provided. The Imaging section documents the request and reported on dates for the patient's MRI, bone biopsy and CT scan. Reference was also made to the referral and reporting targets for red flag referrals for MRI scans. In relation to the bone biopsy the response states that the Trust *'…apologise that [the patient] had to wait over 5 weeks form his referral for this procedure…'* The Nuclear Medicine

section documents the reasoning for the delay to the renal DMSA scan[17]. That being *'…there was no stock of DMSA across the UK for a 6 week period from the end of July 2019 into September 2019. This directly impacted on the waiting time for [the patient's] scan to be scheduled…apologise for this delay which was out of our control.'*

Complainant's response to the draft report

83. The complainant welcomed the Trust's acceptance that there was a need to look holistically at the patient's progression throughout the diagnostic process. She commented that the *'…aim of palliative care is to improve the quality of the patient's life. That aim is missed completely if medical investigation are so slow that one problem is only dealt with in time for another to arise…*' She further hoped that this complaint leads to the Trust *'…shortening the overall diagnostic work up time for future patients…'*

Analysis and Findings

84. The complainant believed the Trust's response to her failed to address the overall delay to palliative treatment and the subsequent increase in distress and pain that the patient suffered. She also believed the Trust did not regard the patients holistically merely looking at target times for individual procedures within its response.

85. I accept that the complainant's letter to the Trust, raised the issue of overall treatment time or holistic care rather than individual target times of specific test/treatments and given the Trust's complaint policy a discussion with the complaint would have useful to clarify with the complaint her issues of concern. I also note the that Trust response to the complainant, dated 12 December 2019 does not acknowledge any pain or distress suffered by the patient during the time period but does reference whether or not it has met target times for specific test/examinations.

[17] Radioactive chemicals (dimercaptosuccinic acid) used to assess the function and location of the kidneys

86. The first Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The second Principle of Good Complaint Handling, 'being customer focused', requires, '*Listening to complainants to understand the complaint and the outcome they are seeking.'* Given the failure to acknowledge the patient's pain or distress and that the overall delay to treatment was not addressed I consider that, the Trust failed to act in accordance with these Principles in the response provided to the complainant. I am satisfied that this constitutes maladministration. Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of upset and frustration. Furthermore, I am satisfied that it also caused the complainant the time and trouble of bringing her complaint to this office. I acknowledge and welcome the Trust's acceptance of these failures however I consider reflection is required to avoid the repetition of these failures.

CONCLUSION

87. I received a complaint about the actions of The Trust in relation to the care and treatment provided by BCH to the patient between July 2019 to January 2020 as well as about The Trust's response to the complaint raised about the patient's treatment.

Issue 1

88. The investigation of this complaint did not find a failure in the relation to the following matters:
    i. The meeting of targets in relation to the completion of and reporting on scans and biopsies; and
    ii. The patient's pain being assessed and managed at oncology review appointments.

89. However, the investigation established failures in the care and treatment in relation to the following matters:

i. The failure to have an appropriate and effective process for ensuring outcomes, arising from MDMs, are completed, with the South Eastern Trust as well as other MDM members;
ii. The failure to have timely access to palliative radiotherapy; and
iii. The lack of a referral, to the palliative care team in the community.

I am satisfied that the failures in care and treatment identified caused the complainant to experience the injustice of distress and the loss of opportunity to receive the benefit of palliative radiotherapy at the earliest opportunity and to receive assistance with pain management in the community.

Issue 2

90. The investigation established maladministration in relation to the Trust's response to the complainant in relation to the following matters:
    i. The failure to acknowledge the patient's pain or distress; and
    ii. That the overall delay to treatment was not addressed within the Trust's response.

I am satisfied that the maladministration identified caused the complainant to experience the injustice of upset, frustration, and time and trouble by bringing a complaint to this office.

Recommendations

91. The Trust identified the reinforcement of the need, in complaints investigations and responses, to acknowledge the impact on the patient and their relatives in relation to the matters raised therein was required. It also highlighted an ongoing Cancer Improvement Plan which focuses on improving cancer pathways and the experience for patients across all tumour sites and several quality improvements projects which have demonstrated improvements in such waiting times for relevant scans.

92. I recommend within one month of the date of this report:
    i. the Trust provides the patient and complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016),

for loss of opportunity experienced by the patient, as a result in the failures of care and treatment and, the upset, frustration and time and trouble caused to the complainant as a result of the maladministration identified;

ii. the Trust discusses the findings of this report with the clinicians involved in the patient's care; and

iii. the Trust shares and discusses relevant findings with Bone and Soft Tissues Sarcoma MDT colleagues from the South Eastern Trust

93. I further recommend, for service improvement and to prevent future recurrence, the Trust:

i. Provide evidence of the ongoing Cancer Improvement Plan which focuses on improving cancer pathways and the experience for patients across all tumour sites;

ii. Provide evidence of the quality improvements projects which have demonstrated improvements in such waiting times for relevant scans;

iii. In conjunction with other regional group members, review the arrangements for ensuring outcomes are completed following Bone and Soft Tissue Sarcoma MDMs. This should also include the revision of the Cancer MDT Communication Protocol to ensure local referrers who are not core MDM members are advised of patient outcomes. Provide an update of any recommendations from this review to this office; and

iv. Provide evidence that staff involved in complaint investigations have been reminded of the need to acknowledge the impact on the patient and their relatives in relation to the matters raised within complaints.

94. I recommend that the Trust implements an action plan to incorporate recommendations and should provide me with an update within three months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY
Ombudsman **August 2021**

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.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.