# Investigation Report

## Investigation of a complaint against the Belfast Health & Social Care Trust

**NIPSO Reference: 16740**

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

## 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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# EXECUTIVE SUMMARY

I received a complaint from a councillor on behalf a constituent who claimed to have sustained injustice because the care and treatment he received from the Belfast Health and Social Care Trust (the Trust) for his spinal condition fell below a reasonable standard.

**Issues of Complaint**

I accepted the following issues of complaint for investigation:

Issue 1: Whether the patient's referral for an out-patient spinal consultation was correctly assessed as 'routine' in July 2014 and again in January 2015.
Issue 2: Whether it was reasonable to place the patient as an 'urgent' patient at the bottom of the in-patient waiting list for Spinal Surgery (de-compression fusion) in July 2015.
Issue 3: Whether there was maladministration in the Trust's handling of the complaint.

**Findings and Conclusion**

The investigation of the complaint identified maladministration in respect of the following matters:

- The decision to classify the patient as 'urgent' on the in-patient waiting list for specialist spinal surgery was not in accordance with his clinical needs and amounted to a failing in clinical judgment. However, this did not cause him an injustice.
- The Trust's complaint handling was attended by maladministration. This caused an injustice to the patient because he did not have his complaint investigated promptly and thoroughly.

I did not find maladministration in respect of the following issues of complaint.

- I found that the patient was correctly graded as 'routine' when his referral was

assessed by the ROS triage team

- I also found, in view of his clinical presentation, the Trust acted reasonably in placing the patient at the bottom of the surgical in-patient waiting list.

**Recommendations:**

I recommended that:

- The Trust discuss my findings with the consultant spinal surgeon and highlight the requirement to record the reasons for clinical decisions to grade patients as urgent.
- I raise this issue as a learning point for the Trust and I suggest that the Trust reviews and consults on the additional 'factors'/criteria used by the consultant spinal surgeons in order to ensure compliance with the 'factors'/criteria defined set by IEAP and the Trust's 2003 Guidelines.
- The Trust provide an apology and make a payment of £500 to the patient as a solatium for the injustice of frustration, uncertainty and distress in consequence of the maladministration identified. This amount also reflects the injustice of inconvenience caused to him for the time and trouble in pursuing his complaint to my office.

# THE COMPLAINT

1. The patient began experiencing severe lower back pain in 2012 which progressively worsened. He attended the Integrated Clinical Care Assessment and Treatment Service (ICATS)[1] in March 2014. In June 2014 he was referred by ICATS to Regional Orthopaedic Service (ROS) which is based at Musgrave Park Hospital (MPH). In July 2014, his referral was assessed by the ROS triage team and graded as 'routine'. Subsequently, his functioning deteriorated significantly and in January 2015 his GP requested a reassessment of his grading. Later that month his grading was reassessed but it was again classified as 'routine'.

2. In April 2015 a councillor[2] acting on his behalf contacted the Trust. She stated there was a severe deterioration in his condition. She requested a review of his case and an explanation as to why a consultant appointment had not been offered within the 12 week time-frame initially indicated to him. The councillor also enquired whether an updated MRI would now be necessary. An MRI was arranged in June 2015 and following a review of the results by a consultant spinal surgeon the patient was offered an out-patient consultation in July 2015. He was placed at the bottom of the surgical in-patient waiting list as an 'urgent' patient on this date.

3. The patient complained to the Trust and my Office that his clinical symptoms were such that he should have been assessed as 'urgent' from the start of July 2014. He also complained that he should not have been added to the bottom of the in-patient waiting list, given that he had already been waiting a year on the out-patient list. Finally he complained that he found the Trust's complaint handling procedure to be '*cumbersome, protracted and failed to address the matters complained of.*'

[1] ICATS is based in the Western Health and Social Care Trust
[2] Councillor Karina Carlin

**Issues of complaint**

4. I accepted the following issues of complaint for investigation:

Issue 1: Whether the patient's referral for an out-patient spinal consultation was correctly assessed as 'routine' in July 2014 and again in January 2015.
Issue 2: Whether the decision to place him as an 'urgent' patient at the bottom of the in-patient waiting list for Spinal Surgery (de-compression fusion) in July 2015 was reasonable.
Issue 3: Whether there was maladministration in the Trust's handling of the patient's complaint

# INVESTIGATION METHODOLOGY

5. The Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues of complaint. The responses included information relating to the Trust's handling of the patient's complaint.

**Independent Professional Advice Sought**

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

- Consultant Spinal Surgeon[3]

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

[3] He also provided advice on the ROS Triage process

**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. The general standards are the Ombudsman's Principles[4]:

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

   These are set out in full in the Appendices to this report.

   The specific standards are those which applied at the time the events occurred and which governed the administrative and professional judgment of the Trust and the professional judgment of the relevant clinicians whose actions are the subject of this complaint. The specific standards relevant to this complaint are:

   - Green Park Health Care Trust Orthopaedic Guidelines (the 2003 Guidelines)
   - Integrated Elective Access Protocol (IEAP)
   - BHSCT Complaints Procedure
   - The HSC Complaints Standards and Guidelines (updated 20013)
   - The BHSCT Trust Protocols Public Liaison (June 2007 updated July 2017)[5]
   - The General Medical Council's 'Good Medical Practice' (2014)

9. 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. The complainant and the Trust were both given the opportunity to see and comment on a draft of this report before the final version was issued.

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

[5] I have considered the protocol which applied at the time of his complaint

# MY INVESTIGATION

***Issue 1: Whether the patient's referral for an out-patient spinal consultation was correctly assessed as 'routine' in July 2014 and again in January 2015.***

**Detail of Complaint**

10. The patient complained that the assessment of his spinal condition by the ROS Triage team at MPH in July 2014 and again January 2015 was inadequate because his clinical presentation was such that he ought to have been classified as 'urgent'.

**Evidence Considered**

11. I have considered the patient's clinical records which included his assessment referral form, letters from his GP, Extended Scope Physiotherapist and the reports of his MRIs and x-rays.

12. The patient first complained of debilitating pain in December 2012. He was referred by his GP on 18 December 2013 to the ICATS[6] for assessment. His initial ICATS appointment took place in March 2014. He had an MRI of his lower back at MPH in May 2014. The relevant extract from that MRI is set out below:
'*Routine MRI lumbar spine examination performed. The lowermost mobile disc space is referred to as L5 – S1. The disc is degenerate with disk space height loss and Modic type 2 end–plate change. There is a diffuse relatively mild disc bulge which becomes larger in the right paracentral location. This partially effaces the right lateral recess, touching and displacing the exiting the right S1 nerve roots-probably irritating. Mild stenosis of the right L5 neural exit foramen and is of doubtful significance'.*

13. The initial assessment of July 2014 and reassessment July 2015 were both

[6] The ICATS service is part of the Western Health and Social Care Trust

undertaken by clinical nurse specialists[7] within the ROS triage team. The same form was used on both occasions and on both occasions the patient was graded as 'routine'.

14. His GP wrote to the Spinal Surgery Department at MPH in January 2014. The relevant extract from his letter states:
*'I am writing on behalf of this 47-year-old patient of mine who is suffering from severe lower back pain with pain radiating down his right leg…. Unfortunately his symptoms have deteriorated since the original referral and his pain has increased and his mobility has reduced. He is continuing to work but this is becoming almost impossible due to pain. Current analgesia is with MST 30mg and Gabapentin 300mg tds but this only gives limited relief.*
*I am writing to ask if his case can be upgraded in the hope that he might have his surgical assessment in the near future. He is at the end of his tether after waiting eight months and has rung the Department several times with no success. It was advised that I send an update letter in the hope that he may be offered assessment as a priority. Thank you for your help'.*

*The Trust's Polices and Guidance*

15. I have considered the 2003 Green Park Health Care Trust Guidelines for Orthopaedic Referral (the 2003 Guidelines), which were the applicable guidelines for the Trust's referral to orthopaedics. I also considered the Integrated Elective Access Protocol (IEAP) which was the Trust's protocol for the referral and assessment of spinal surgery.

<u>General Medical Council's 'Good Medical Practice Guidelines' (GMC Guidelines)</u>

16. The GMC Guidelines require doctors to record their work clearly, accurately and legibly and in particular state that
'*Clinical Records should include:*
*a. relevant clinical findings*

[7] Both were Registered General Nurses, Orthopaedic Nursing Certificate, (Band 7 Sister)

*b. the decision was made and actions agreed, and who is making the provisions and agreeing the actions*

*c. the information given to patient*

*d. any drugs prescribed or other investigation or treatment*

e. *who is making the record and when*'.

17. I have considered the response provided by the Trust and the relevant extracts are set out below. As part of my investigation, the Trust were asked to provide an overview of their ROS Triage service and the Trust's response is as follows:

*'Unfortunately, the Regional Spinal Service is under extreme and growing pressure within Spinal Outpatient waiting times growing at 4 week increments on a monthly basis. As a result, the Triage criteria for urgent referrals is extremely strict, given that the service receives up to 100 GP referrals marked urgent on a weekly basis. The criteria for urgent grading is based on clinical symptoms and radiological findings which had been agreed by the orthopaedic clinical director and lead spinal consultant. Examples of urgent referral criteria include:*

- *Tumour*
- *Neurological compromise*
- *Infection*
- *Respiratory compromise*
- *Ulceration*

*All other clinical information provided in the referrals which includes pain is not solely considered to make a referral clinically urgent. …The process for managing spinal referrals is that they are assessed and triaged by the Specialist Spinal Team consisting of Specialist Nurses, Consultant Spinal Surgeons and Spinal Registrars. Once the referrals are received at MPH and assessed, they are graded by the Orthopaedic Specialist Team, based on the clinical information detailed on the referral and any available imaging results. Regrettably, we are seeing an increasing number of Spinal referrals which are marked urgent but with all the referrals assessed by the Orthopaedic Specialist*

*Team, the grading of some of them may be changed to routine based on the application of the criteria above'.*

18. The Investigating Officer further enquired of the Trust in relation to the triage assessment process and the Trust's response of 6 February 2017 expanded on the triage assessment process and explained as follows:
*'The Belfast Trust follows orthopaedic guidelines which were devised in 2003[8] by Green Park Trust, now part of the Belfast Trust, for the triage and grading of orthopaedic conditions. In addition to this guidance practice has evolved and our orthopaedic specialist triage team also base the grading of outpatient referrals on:*
    - *specialist orthopaedic experience*
    - *imaging*
    - *current waiting times*
    - *following discussion with consultant Orthopaedic surgeons[9]*

*Prior to this time, the patient did not meet the criteria for urgent grading and if patients were all graded as urgent the waiting time for urgent patients would continue to rise which would present a patient safety risk. Nonetheless any patients who are re- referred to us by their GP or extended scope practitioners with additional symptoms are always reviewed again to ensure the grading is correct and if required are upgraded to urgent based on the additional information provided….*
*... Patients are not added to an inpatient waiting list before they are seen by a Specialist Orthopaedic Consultant as surgery is only one of the treatment options available and until the patient is assessed at outpatients by the specialist, surgery has not yet been decided on and may not be a treatment option. In addition patients are seen based on chronological order. If a primary care practitioner or the patient makes further contact with the Trust and provides additional information regarding a patient and possible deterioration, this information is brought to the attention of the spinal consultant to review the grading of the patient. A patient's clinical grading can be upgraded based on the new information if clinically appropriate…'*

[8] Page 22 of the 'Guidelines for Orthopaedic Referral'
[9] In complex cases

19. The Trust also explained in response to investigation enquiries that when a referral for an out-patient consultation comes in the referral is assessed and the assessment recorded on a 'Referral Assessment Form'. The Trust confirmed: '*… that it is common practice that the same triage documentation is used when repeat referrals come in for the same patient. Under the 'Specific Consultant Instruction' section of the form - this is commonly used as the comments field rather than Specific Consultant comments only. It was on this section that the second referral was graded. It states 2nd referral routine and the date the assessment completed 23 January 2015*. *Therefore this document is the triage for both of the referrals and both are graded as routine*'

20. My investigation has established that a single form was used for the patient's initial grading and the review of that grading. The form indicates that he was graded as routine on both occasions. The Trust[10] confirmed '*we have no record that a Spinal Consultant Surgeon was consulted with at this time based on the records that we have. A second referral highlighting clinical changes and worsening clinical symptoms will usually require an opinion from consultant spinal surgeon, however if there are no new urgent symptoms or information as part of the referral, the triage is carried out by the orthopaedic triage team which is made up of experienced orthopaedic clinical nurse specialists'.*

**Consultant Spinal Surgeon**

21. As part of my investigation I obtained advice from a consultant spinal surgeon. In relation to the ROS triage system, the IPA advised that '*the purpose of the triage system is to try to ensure the following:*
    a. *Patients with clinically urgent problems are seen urgently. This would include cancers, spinal infections and possible then neurological catastrophe (e.g. paralysis).*
    b. *Patients who have not received all appropriate and non-surgical treatment do so before seeing a surgeon.*
    c. *Specialist (expensive or risky) investigation are only ordered where*

[10] Correspondence from the Trust of 22 June 2017

*appropriate; and are in place before seeing a specialist.*

d. *Patients for whom surgery is not an option directed to other, more suitable services than a (spinal) surgeon'*.

22. In considering the issue of the patient's triage assessment and re-assessment the IPA advised that -

*'July 2014 – referral date stamped … and prioritised 1 July 2014 within timescale set out in the Integrated Elective Access Protocol 3.4.5. Referral gave all the relevant clinical information to allow prioritisation. Relevant procedures followed. January 2015 – reassessed as result of GP letter date stamped on Wednesday 21 January 2015 and prioritised on 23 January 2015. This falls inside the target for referral letters but there is actually no target for follow- up letters like this. The clinical information in the GP letter indicated increased pain but not a change to clinical priority. Relevant procedures followed…'.*

23. The Investigating Officer enquired of the IPA whether the patient was correctly graded as 'routine' rather than 'urgent' when he was included in the out-patient waiting list on 1 July 2014. The IPA responded-

*'I have been supplied with Green Park Health Care Trust: Guidelines for Orthopaedic Referral 2003. Criteria for urgent referrals to Orthopaedics are set out generally on page 4 and specifically with regard to the spine on pages 19 to 24.*

*Generally: at no stage has there been a suggestion that the patient had a tumour or infection (sepsis).*

*<u>Spine:</u>*

- *Emergency – he did not have a suspected cauda equina syndrome.*
- *Urgent -*
  - *Suspected serious underlying pathology (red flag): criterion not met.*
  - *Suspected early spinal cord compression: criterion not met.*
  - *Sciatica (nerve root pain): although the patient had an element of nerve root pain, he did not fit the clinical picture described (of acute disc prolapse).*
- *Routine –*

- *Suspected spinal stenosis: this was the cause of the patient's leg pain. The caveat under 'mode of referral' is 'Spinal stenosis referral urgent if new urinary symptoms develop: this was not the case'*
- *Disabling back pain: this was the patient's primary complaint.*

*On this basis the patient's referral was correctly assessed as 'routine'.*

24. The Investigating Officer also enquired whether the triage nurse ought to have referred the matter to a spinal consultant for advice on the grading on both occasions. The IPA advised that *'there was nothing in the clinical information that would require clarification. This was not a case sitting close to a borderline decision re urgent/routine. There was therefore no reason to seek consultant input.'*

25. The Investigating Officer queried whether the referral letter from the patient's GP which was received in January 2015 was appropriately assessed by the ROS triage team. The IPA advised *'Yes, because there was no suspicion of serious underlying disease'.*

26. The Investigating Officer queried whether there were any clinical indications of an underlying neurological problem at this point which should have triggered further investigations. The IPA advised '*None*'.

27. The IPA was asked if there was any evidence from the MRI scans that the patient's condition significantly deteriorated in the period May 2014 to June 2015. He advised -
'A*t most there has been a very slight further reduction in height of the L5/S1 disc. This is not a significant change. There is no reason to class this as clinically 'urgent' although it may have been considered urgent on social grounds'.*

28. The Investigating Officer asked the IPA to review the process the ROS Triage Team followed when conducting the assessment and re-assessments of the patient's referrals. In particular, the IPA was asked to comment on the use of the same form for both the referral assessment and re-assessment. He

advised:

*'Use of the same form ensures the previous decision was explicitly reviewed and that all of the information is kept together. I see no reason why this would be a failing.'*

29. The Investigating Officer asked the IPA whether there was anything in this patient's clinical presentation and medical notes which meant that this referral should have been graded as urgent at the point of assessment and re-assessment (July 2014 and Jan 2015). The IPA stated: '*it is impossible to compare one patient's pain with another's prioritising on the basis of reported pain risks penalising stoic patients with 'worse' action marks pain in favour of vocal patients with 'less' pain. IEAP specifically forbids any such sub-classification of patients: 3.3.5 patients of equal clinical priority would be selected for booking in strict chronological order*'.

30. The IPA concluded that -

'*Triage seeks to ensure fairness of access to services. It also maximises the use of scarce resources (especially in this case MR scan slots and spinal clinic appointments). Once that has been achieved, it will not solve problems of under capacity in the system. The patient waited an unacceptably long time, but that was not due to failings in the triage system*'.

and;

'*He has certainly experienced significant delays in his progress from 1st assessment to surgery. Patients like this will generally have the lowest clinical priority and when a service has severe capacity issues, these patients will wait the longest. As the complaint response pointed out- there are many waiting even longer than him'.*

31. The advice obtained from my Independent Professional Adviser was shared with the Trust. The Trust responded as follows-

*'The Lead Consultant in Spinal Services in the Belfast Trust has reviewed the assessment from the Independent Clinical Advisor and has indicated that he feels this is an appropriate assessment. He has concluded that the change in*

*the patient's symptoms would fall with the remit of the patient's GP to manage and would have required the GP to refer the patient for a neurological opinion'.*

## ANALYSIS AND FINDINGS

32. The patient complained his referral was incorrectly graded as 'routine' when it was assessed by the ROS triage team in July 2014 and assessed again in January 2015. My investigation of this issue found that all out-patient referrals for spinal surgical consultations are independently assessed when they are received by the ROS triage team. The referrals are then graded as 'routine' or 'urgent' using the criteria.

33. The IPA has advised that the referral from the ICATS Service in June 2014 '*gave all the clinical information necessary to allow prioritisation*'. My investigation has established that the patient's referral was assessed by a Senior Nursing Specialist in July 2014 who reviewed his clinical history, examination and imaging report. I am satisfied from the advice that she correctly graded the patient's referral as 'routine' in accordance with the clinical information available and the criteria set by the Trust at that time.

34. The Trust's procedure for the assessment of out-patients spinal surgical referrals indicates that if the patient or his GP provides further evidence of possible deterioration, that evidence should be referred to the spinal consultant to re-assess the patient's grading. I also note that they state the patient's clinical grading can be upgraded based on new information if clinically appropriate.

35. The Investigation Officer asked the IPA whether the patient's case should have been referred to the spinal consultant for advice on receipt of his GP's letter in January 2015. The IPA advised-

*'The clinical information in the GP letter indicated increased pain but not a change to clinical priority……There was nothing in any of the clinical*

*information that would require clarification. This was not a case sitting close to a borderline decision re urgent/routine. There was therefore no reason to seek consultant input'*

36. The Investigation Officer asked the IPA if there was any significant deterioration in the patient's condition in the period from May 2014 to July 2015. He stated that having reviewed the MRI of 2014 and the one of June 2015 he noted that at '*most there had been very slight further reduction in height of the L5/S1 disc this was not a significant change. There was no reason his referral should have been assessed clinically 'urgent' although it may have been considered urgent on 'social grounds*'.

37. **Finding: Having considered the IPA advice on this point I am satisfied that both the patient's initial referral assessment and his request for reassessment were correctly graded as 'routine' by the ROS triage team. I conclude that this aspect of his care and treatment was of a reasonable standard. I do not, therefore, uphold this issue of complaint.**

***Issue 2: Whether the decision to add the patient to the bottom of the in-patient waiting list for Spinal Surgery (de-compression fusion) in July 2015 was reasonable.***

**Detail of Complaint**

38. The patient was added to the in-patient waiting list for spinal surgery following an outpatient consultation in July 2015. He was graded by the consultant spinal surgeon as an 'urgent' patient and added to the bottom of the list. He complained that he had already been waiting a year for surgery and no account had been taken of this previous waiting time.

**Evidence Considered**

39. I considered the patient's clinical records in respect of his updated MRI scan

and the notes of his out-patient consultation appointment as follows:

8 June 2015 - Updated MRI

The updated MRI records:

'*degenerate disc at L5-S1 with sub endplate reactive fatty and oedematous changes. There is some high signal within the disc which is thought to be to be degenerate in origin. There is generalised disc protrusion at L5-S1 with potential irritation of both descending S1 nerve roots in the lateral recesses. No significant interval change with comparison to the previous study performed in May 2014'.*

40. His second MRI results were reviewed by a consultant spinal surgeon in June 2015. Following this review an out-patient appointment was arranged by him for July 2015. The Trust have confirmed that spinal consultants do not use a triage form to record the reasons for this decision. There is therefore no clinical record of the reasons why the reviewing surgeon considered the patient should be given an urgent out-patient consultation appointment.

41. In response to my investigation enquiries the Trust have explained the reasons for the grading as an 'urgent' in-patient are recorded by the spinal consultant in the consultation notes of the patient's out-patient appointment. The relevant extracts from the patient's notes of the out-patient consultation in July 2015 are set out below:

'*On examination today he has no neurological deficit. He has a slight weakness on dorsiflexion but not significant. His MRI scan carried out at previously shows severe degeneration and collapse at the level of L5-S1 with impingement on the right S1 nerve root. I discussed with him the options of management surgical versus conservative along with the pros and cons; he is happy to go for the surgical option, as you suggested. I discussed the option of surgical fusion and decompression and the possible risk in the form of infection, clots, damage to the nerve roots and dural tear. He is happy to go ahead with this plan of management. I have put his name on the urgent list for L5/S1 decompression and fusion'.*

42. The Trust stated in their response to my investigation enquiries that all patients who are placed on the in-patients waiting list for spinal surgery are: 'a*ssessed based on clinical need. This assessment is carried out by the Consultant Orthopaedic Surgeon at the patient's outpatient appointment. The consultant grades the patient based on the referral, available radiological findings and clinical presentation of symptoms at the time of the out-patient appointment'.*

43. In response to an investigation enquiry relating to the trigger for the decision to commission an additional MRI in June 2015, the Trust advised that the councillor acting on behalf of the patient:
*'…made contact with the Belfast Trust in May 2015. The councillor outlined severe deterioration of the patient's condition and based on this change in condition a repeat urgent MRI was arranged and carried out in June 2015'.*

44. In response to further queries relating about the criteria the Consultant Orthopaedic Surgeons use to grade surgical in-patients, the Trust explained that the surgeon decides the grading following the patient's out-patient consultation and record their decision in the consultation notes for the out-patient appointment. The Trust stated in its response of 26 June 2017:
*'Once the patient is seen and assessed at that clinic, treatment options are considered and discussed with the surgeon and the plan is put in place, this may or may not include a surgical procedure depending on the patient's condition. The patient is then added to the in-patient waiting list either as a routine or an urgent case as of the date of this Consultant assessment. A triage form is not used as it [the grading] is based on the Consultant's clinical assessment of the patients using their experience and clinical judgment of the patient that day…..*
*When the surgeon grades the patient as clinically urgent, they take into consideration how the patient feels, the symptoms they outline and the length of the current waiting times to ensure the patient has their surgery as timely as possible for their clinical condition'.*

45. The Trust also explained the process for re-evaluating the categorisation of the patients on the in-patient waiting list if information regarding a deterioration in the patient's condition is received.
'*As with patients waiting on an outpatient appointments, we rely on further referrals and contact from the patient or their GP with additional symptoms or concerns. These further requests are always reviewed again to ensure the grading is correct and if required are upgraded to urgent based on the additional information provided*'.

46. In response to a query about how patients on the in-patient waiting list are prioritised, the Trust stated that the IEAP protocol and 2003 Guidelines are followed. The Trust also explained that at the time there were 25,000 people on the Trust's Orthopaedic Services Outpatients waiting list and 10,000 on their in-patients list[11]. I note that there were 251 urgent patients on the spinal in-patients surgical list when the patient was included on the 8 July 2015. I note that the Trust's spinal surgeons have their individual lists and there were 62 urgent patients on the list which Mr Devine was included on.

47. The Trust stated in its response to this Office of 6 February 2017 that individual spinal consultants adhere to the IEAP protocol and the 2003 Guidelines when managing their own in-patient waiting lists. The Trust also explained that -
'*The patient was seen in outpatients by the consultant in July 2015. He was added to the in-patient waiting list on that day as an urgent patient. Patients are not added to an in-patient waiting list before they are seen by specialist consultant surgeon as surgery is only one of the treatment options available and until the patient is assessed at outpatients by the specialist, surgery has not yet been decided on. Therefore, before this date the patient had not been waiting on surgery for 1 year but rather on an out-patient assessment.*
*The patient's position on the in-patient waiting list could not be backdated at that time of the decision to operate had not yet been made before this date and therefore he was not yet on the in-patient waiting list but rather on the out-patient list. If the patient had been brought forward at this stage in his urgent in-*

[11] As of 6 February 2017

*patient wait, this would penalise other patients who had been waiting longer with urgent symptoms and again this would pose a risk to patient safety……. In addition patients are seen based on chronological order. If a primary care practitioner or the patient makes further contact with the Trust and provides additional information regarding a patient and possible deterioration, this information was brought to the attention of the Spinal Consultant to review the grading of the patient. The patient's clinical grading can be upgraded based on new information if clinically appropriate.'* [12]

It also stated:[13]

*'…..The orthopaedic surgeons do not follow a set criteria from which they grade the patient for surgery. This is based on their clinical assessment of the patient at their clinic. They use their experience, knowledge, the patient's clinical presentation on the day, any updated radiological findings. All patients are assessed and graded as per the surgeon's clinical judgement'.*

48. The Trust stated that the in-patient grading by the consultant spinal surgeon on 8 July 2015 is based on the experience and clinical judgment of the consultant at the time of the out-patient appointment. It stated:
'*A triage form is not used as it [the grading] is based on the consultant clinical assessment of the patients using their experience and clinical judgment of the patient that day. It is not unusual for the status of the patient on the inpatient waiting list to be different from the status of the patient on the outpatient waiting list. For example, the patient's history when the GP refers the patient could be triaged as urgent based on the information provided, however when the consultant spinal surgeon sees the patient at the outpatient clinic and assesses them, the status on the in-patient waiting list may be made routine based on the clinical evidence. It is also possible that the status was changed from routine to urgent for the same reasons. When the surgeon grades the patient as clinically urgent, they take into consideration-*
    *i. how the patient feels,*
    *ii. the symptoms they outline and*

[12] Page 2 and 5 Trust response of 6 February 2017
[13] E-mail of 26 June 2017 BHSCT to NIPSO

*iii. the length of the current waiting times to ensure the patient has their surgery as timely as possible for their clinical condition.'*[14]

49. The Investigating Officer enquired as to the nature of the patient's clinical presentation which led to the Trust's grading as an 'urgent' in-patient. The Trust responded that these were set out in the consultant's out-patient appointment consultation notes as:
*'His MRI carried out previously shows severe degeneration and collapse at the level of L5/S1 with impingement on the right S1 nerve root'*

50. The Investigation Officer also asked the Trust to comment on the handwritten notes which were on the report of the MRI of June 2015. The Trust stated that the handwriting (in red) reads: '*Routine, 4-6 months*'. The Trust explained that a Specialist Trainee Registrar reviewed and, based on the MRI alone, graded the appointment as routine in August 2015. The Trust also explained that: '*Given that the patient had been on the waiting list since June 2014 and the councillor had outlined significant concerns and issues that the patient was having, an urgent appointment at out-patients was organised to see the consultant based on this additional information'*

51. My investigation established that the Trust did not use psychosocial criteria when grading patients. The Investigating Officer enquired repeatedly of the Trust as to the reason that psychosocial assessments did not form part of the Regional Orthopaedic Services urgent referral criteria. The Trust did not provide an explanation but stated:
*'Psychosocial assessments are part of the Trust's new spinal pathway assessments which have been in place since approximately February 2016, but were not in use at the time of the patient's referrals'.*

52. I issued my draft report to the Trust on 1 August 2017. The Trust asked me to consider their comments regarding the accuracy of the evidence upon which I based my decision and relevant information which they believe may not have

[14] E-mail from the BHSCT of 26 June 2017

been fully considered.

It stated that all requests to the ROS are re-assessed by specialist teams and reviewed on an individual basis to ensure all patients are treated equitably. It indicated the updated MRI scan which contained relevant clinical information was shown to the spinal team with the consequence that the patient was re-graded as 'urgent' and provided with an out-patient appointment in July 2015. When he was assessed by the consultant spinal surgeon, surgery was agreed as the best option and he was added to the in-patient waiting list as an urgent patient. The surgeon graded him based on his referral information, available radiology findings and clinical presentation of symptoms at the time of the outpatient appointment. It stated *'It is important to note that the clinical presentation of patients is always individual as no two patients cope with the same condition in the same way and therefore how they present at outpatients to the Surgeon is relevant to their ultimate grading. This ability to use experience, knowledge and professional judgement is important to ensure an experienced clinician can adopt appropriate discretion, where required ….in this case, the surgeon contends he adopted a patient centred approach in his handling of the patient's case and as a result treated the patient as an individual'.*

53. I have fully considered the points raised by the Trust but my findings in relation to these issues (set out below) are unchanged.

54. The Investigating Officer asked the IPA (Spinal Surgeon) for evidence in the MRI scans that the patient's condition significantly deteriorated in the period May 2014 to June 2015. The IPA stated that having reviewed the two MRI scans:

'… *at most, there has been very slight further reduction in height of the L5/S1 disc. This is not a significant change. There is no reason to class this as clinically urgent – although it may have been considered urgent on social grounds'*.

55. The IPA was also asked to advise on whether any aspect of the decision to grade the patient as an 'urgent' in-patient which fell below a reasonable

standard or anything in the criteria which may generate unfairness to other patients. He advised:

'*Conservative management is a perfectly reasonable option. The risks and benefits of surgery do not significantly change over a period of many months or even years. There is therefore no clinical basis for listing as urgent – (iii) above I am unclear on the basis by which criteria (i) and (ii) could be reasonably applied on an equitable basis so that other patients (who may be less vociferous but in no less pain) were not disadvantaged'.*

**Analysis and Findings**

I have considered this aspect of the complaint under the following two sub-headings:

**a. *Was the decision to add the patient to the bottom of the in-patient wait list reasonable?***

56. The Trust confirmed that patients are not added to an in-patient waiting list until they are seen by a Specialist Orthopaedic Consultant as surgery is only one of the treatment options available and '*until the patient is assessed at outpatients, surgery has not yet been decided on'.*

57. In the patient's case, his spinal consultant discussed the options with him in July 2015. The consultation notes of that meeting record: *'I discussed the option of surgical fusion and decompression and the possible risk in the form of infection, clots, damage to the nerve roots and dural tear. He is happy to go ahead with this plan of management. I have put his name on the urgent list for L5/S1 decompression and fusion'.*

58. In response to investigation queries, the Trust have explained that spinal surgeons apply the 2003 Guidelines together with the IAEP protocol in order to manage their waiting lists together with the additional factors outlined at para 48 above. The Trust also confirmed that patients are seen in chronological order. In the patient's case, the Trust explained that his position on the in-patient waiting list could not be backdated prior to July 2015 because this would

penalise other patients who had been waiting longer with urgent symptoms and this would pose a risk to patient safety.

59. The IPA also advised that: '*Conservative management is perfectly reasonable option. The risks and benefits of surgery do not significantly change over a period of many months or even years.'*

**60. Finding: In light of the IPA's advice I am satisfied that the decision to place the patient on the bottom of the in-patient list, given that he had already been waiting for a year for his outpatient consultation, was reasonable. This is because the relevant protocol requires '*patients of equal clinical priority to be seen in strict chronological order'*. I acknowledge that the patient was experiencing increased pain. However, based on the Trust's protocol, this was not a sufficient clinical reason for him to be seen in advance of other patients with a similar diagnosis. Therefore I do not uphold this issue of the complaint.**

**b. *Was the decision to include the patient on the in-patient waitlist as an 'urgent patient' reasonable?***

61. In the patient's case, the justification for his grading as an 'urgent' patient was recorded by the his spinal consultant in the notes of consultation in July 2015: '*His MRI carried out previously shows severe degeneration and collapse at the level of L5/S1 with impingement on the right S1 nerve root'*

62. The Investigating Officer asked the IPA to review the relevant criteria and clinical records. He advised that the patient's MRIs indicated that there was only '*only a very slight reduction in height*' which did not meet the criteria for a grading of 'urgent' which the Trust used at that time.

63. My IPA was also asked to comment on the additional factors[15] which the Trust

[15] As stated by the Trust in its e-mail to this Office of 26 June 2017
i. how the patient feels
ii. the symptoms they outline and
iii. the length of the current waiting times to ensure the patient has to surgery as timely as possible for their clinical condition

advised that the individual spinal consultant applied to grade the patient as an urgent in-patient. He advised that:

'*The risks and benefits of surgery do not significantly change over a period of many months or even years. There is therefore no clinical basis for listing as urgent- point (iii) above'. I am unclear on the basis by which criteria (i) and (ii) could be reasonably applied on an equitable basis so that other patients (who may be less vociferous but in no less pain) were not disadvantaged.'*

64. The Trust explained that since February 2016 it includes psycho-social assessment as part of the new spinal pathway assessments. These were not in place at the time of the patient's referral in 2015. Therefore, the Trust was unable to prioritise his spinal referral on 'social grounds' at that time.

65. I note that the decision of the consultant spinal surgeon does not clearly explain the reasons why he felt that the patient's clinical presentation in July 2015 met the urgent criteria which is defined in the IAEP and the 2003 Guidelines and the further criteria which he considers when making this decision.

66. The GMC Guidelines (paragraph 12 refers) require doctors to record all decisions made and actions agreed. In addition, the Third Principle of Good Administration 'Being open and accountable' requires public bodies to act consistently, so that those in similar circumstances are dealt with in a similar way. Any difference in treatment should be justified by the individual circumstances of the case.

**67. Finding: I accept the IPA's advice that the patient's clinical presentation did not meet the Trust's criteria for grading as an 'urgent' in-patient in July 2015. I consider that this amounts to a failing in clinical judgement. However, the patient did not sustain an injustice in consequence of this failing.**

68. As a result of representations made on behalf of the patient and considered by the Trust, a fresh MRI was commissioned in June 2015 and he received an 'out-patient' appointment for July 2015. However, in light of the IPA advice, his clinical presentation was not such as to warrant this.

***Issue 3: Whether the Trust's handling of the patient's complaint was reasonable***

69. The patient's councillor[16] complained to my Office on his behalf that the Trust did not deal with his complaint adequately because:
    - It failed to address his complaint that he was incorrectly triaged as 'routine' when his referral was assessed in July 2014 and then reassessed in Jan 2015
    - It provided him with incorrect information about the waiting times for the assessment of his suitability for spinal surgery.
    - It failed to respond to this complaint within a reasonable time.

70. I have considered the following policies as relevant to the issue of the Trust's handling of the complaint:
    - DHSSPS, Complaints in Health and Social care, Standards and Guidelines for Resolution and Learning (2009 and updated October 2013)
    - BHSCT Complaints Procedure (referred to as 'the Trust's complaints procedure')
    - HSC Belfast Health and Social Care Trust Protocols Public Liaison (July 2007, updated July 2017)

71. The Trust's complaints procedure[17] is based on the HSC Complaints procedure and defines a complaint as:
    '*any expression of dissatisfaction about care or services provided by the Trust which requires a response. Complainants may not always use the word 'complaint…*'

72. The complaint procedure also defines an enquiry as '*a request for information, explanation or clarification'.*

73. At section 3 of the procedure entitled – 'Handling Complaints' the target

[16] Councilor Carlin
[17] At page 11

timescales for the acknowledgement and provision of a full response to a complaint are outlined as follows:

- *Acknowledgement - 2 working days*
- *Full response - 20 working days*

The complaints procedure states if it is not possible to provide a response within this time-frame: '*Whatever the reason, as soon as it becomes clear that that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HCS organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements.'*

74. The complaints procedure also states:

*'The acknowledgement should:*

- *seek to confirm the issues raised in the complaint*
- *offer opportunities to discuss issues either with a member of the complaint staff or, if appropriate a senior member of staff; and provide information about the availability of Independent support and advice.'*

75. I also reviewed the Trust's procedure for dealing with enquires from elected representatives, set out in its 'Protocols for Public Liaison'.

76. I note that at section 3 of this protocol, entitled 'Constituency Enquiries' it states:
'*Constituency enquiries are received by public liaison directly from an elected representatives by telephone, e-mail or letter. They are also received by the Chief Executive's office who then redirects to public liaison for action. ….*
*3.5 Aim to respond within 10 working days and give service area the deadline for response.*

*3.6 When response is received from appropriate co-director/service manager] ensure information is kept to a minimum. It is not always appropriate to provide specific information about nature of business or treatment plan – only answer what has been asked*.'

77. I note that the councillor contacted the Trust on the patient's behalf in April 2015. Relevant extracts from the correspondence are included below.

78. In her first letter to the MPH dated 28 April 2015, the councillor states:
*'My constituent was advised [in May 2014] that he would require further assessment and a surgical opinion and that the waiting time to see the consultant was approximately 12 weeks. At the end of the 12 week period my constituent enquired as to his appointment status only to be told that the waiting time had now been extended to 21 weeks. When no appointment was offered within the 21 week period, my constituent again made enquiries and was duly advised that the waiting time had been extended to 44 weeks which has just expired. My constituent's frustration at this unexplained delay was compounded by the following factors:*

- *His GP had written on two occasions in December 2014 and January 2015 asking Musgrave Park hospital to prioritise his appointment to no avail.*
- *That a physiotherapist has written, as his condition has deteriorated, asking for his referral be dealt with as a priority.*
- *My constituent's level of pain and debility has greatly increased in the interim. This has had an extremely adverse impact on his ability to work, as well as loss of social amenity, and chronic pain, which is managed by morphine and other drug treatment. In totality, this has had a very significant detrimental effect on quality of life.*
- *My constituent is concerned that by the time he is offered a consultant appointment (he has been advised that the new waiting time is 52 weeks), the original MRI would be a year old and the MRI results may be outdated. The MRI may have to be redone setting up a further cycle of delay.*
  *….. It does appear, from what he has advised me, that scant regard has been given to his medical needs or his ever deteriorating condition; and on*

*his behalf I have been asked to request an urgent and sympathetic review of his particular case to see why a consultant appointment was not offered within the original timescale of 52 weeks. He has also asked me to seek clarification as to whether an updated MRI will now be necessary.*

79. I note that this letter did not explicitly state that the patient was making a complaint but it outlined the outcome she wanted to secure was *'an appointment with an appropriate consultant for the patient*'. The councillor advised that if this was not forthcoming '*she had been asked to make representations to the Patient Advocate at Musgrave Hospital, the Patient and Client Council and the Minister for Health'.*

80. On 29 May 2015, the Trust's Public Liaison Officer responded to the councillor explaining that the patient's referrals were triaged as 'routine' in the first instance and when a reassessment was requested. It stated that '*the Belfast Trust was continuing to prioritise patients based on a number of factors including clinical need and urgency, elective patient management and chronological order. This is in line with guidance from the Department of Health*'.

81. I note that the councillor responded also on 29 May 2015 enclosing a letter of authority from the patient. She states:

'*Please note [my constituent] has noticed a severe deterioration in his condition since his last MRI scan was conducted and has greatly reduced mobility and functionality. My constituent's concern is that the MRI scan of 2014 will not show that the degenerative changes that are causing this further deterioration. As such, my constituent feels that his medical needs cannot accurately be assessed and are not being met. We would urge you to reconsider the conclusion reached in this case as my constituent's health and well-being is severely compromised by the delay in addressing these issues'.*

82. On 1 June 2015 the Trust responded to this letter explaining that an MRI had been arranged for the patient for the following week. The Trust explained the

results of this MRI would then be shown to a consultant and '*outpatients will then be made aware of the timescale of out-patient appointment'*.

83. On Monday 15 June 2015 the Trust notified the councillor that the results of the patient's recent MRI would be shown to a consultant 'on Monday'. On Friday 19 June 2015 the Trust wrote to advise that an Outpatient appointment had been made for 8 July 2015.

84. On 15 September 2015 the councillor wrote again to the Trust stating that:

'*We acknowledge that following correspondence and discussions, an up to date MRI was carried out…..at that point my constituent instructed that he would be offered surgery and the worst case scenario time scale would be a minimum of 9 months ….my constituent now requests an update on where he stands on the waiting list and when he can expect to undergo surgery as his condition continues to deteriorate with his right foot now completely limp and paralysis. We appreciate there is a significant waiting list, however given the severe impact of my constituent's condition on his quality of life, functionality and ability to financially support himself, we would urge his case to be raised on an urgent and sympathetic basis.* '

85. On 17 September 2015 the Trust acknowledged receipt of the complaint and agreed to investigate the matter pursuant to the Trust's complaint procedure. A consent form was enclosed and the complaints manager asked her to complete and return it as soon as possible. The Trust advised her once the consent form was received it hoped to respond within 20 working days.

**The Trust's response to Investigation enquiries**

86. The Trust explained in its response to enquiries made by the Investigating Officer that:
'W*e apologise if the patient felt that the Trust did not adequately engage with him regarding his complaint. The Belfast Trust Complaints Department received a letter of complaint from the councillor acting on behalf of her constituent on 17*

*September 2015. An acknowledgement letter and consent form was sent to the councillor on the same day advising that consent was required to allow the Trust to provide confidential information in relation to the patient.*

*Orthopaedic services provided and approved a written response on 24 September 2015 which could not be issued to the councillor because the complaints department had not received consent. A further letter requesting consent was sent to the councillor on 2 October, 16 of October and 26 October 2015. The councillor returned the consent form on 10 November 2015 with additional information which was forwarded to orthopaedic services.'*

87. The Investigating Officer asked the Trust to explain why the councillor's initial letter of 28 April 2015 was dealt with using the public liaison route and not treated as a complaint. The Trust responded as follows;
'*The ….letter of 28 April 2015 was about the patient's position on the waiting list and would have been sent directly to Public Liaison to deal with. The subsequent letter of 15 September 2015 was sent to Complaints Department and not Public Liaison as it needed to address treatment and care and required a more detailed response*.'

**Analysis and Findings**

88. I have carefully considered all the correspondence between the Trust and the councillor regarding the issues the patient raised together with the complaint's procedure and its Protocols for Public Liaison. I have also assessed the actions of the Trust against the Principles of Good Administration and Good Complaint Handling which are attached at Appendix One and Two.

89. I note that the first contact by the councillor on behalf of the patient took place on 28 April 2015 and this letter set out the following concerns:
    - The patient was provided with wrong information because he was told initially that his waiting time a surgical assessment was 12 weeks; this was then extended to 21 weeks and then extended again 44 weeks.

- The patient was not given an explanation for the extension to his waiting period.
- The patient's GP and Extended Scope Practitioner both wrote requesting an urgent referral for a surgical consultation and these requests were not acted upon.

I note that the councillor did not expressly state that she was raising a complaint but her letter did state the outcome she wanted to secure for the patient and that she would make further representations using the Patient Advocate and the relevant Minister if this was not forthcoming.

90. The Trust's complaint procedure defines a complaint as '*any expression of dissatisfaction about care or services provided by the Trust, which requires a response*'. It also highlights that a complainant may not necessarily state they are making a complaint. The Trust has a dedicated complaints handling department to investigate complaints from the public and a well-established complaint procedure which is based on the HSC statutory complaint procedure.

90. I note that the Trust's Public Liaison department has a protocol for dealing with 'enquiries' from an elected representative. This protocol states when an enquiry of this nature is received the public liaison team should proceed to obtain consent from the patient and then the enquiry should be referred to the appropriate service. The timeframe for a response to an enquiry is one week and the liaison team is expressly directed '*when a response is received, ensure information is kept to a minimum (i.e. it is not appropriate to provide specific information about nature of illness or treatment plan*'.

91. I consider that the response time-frame of one week and the direction '*it is not appropriate to provide specific information about nature of illness or treatment plan*' distinguishes and limits the role of the Trust's Public Liaison team to addressing enquiries as opposed to investigating and responding to complaints.

92. My Investigating Officer made further enquires of the Trust regarding its

complaint process in this case. In particular the Investigating Officer questioned why the correspondence of 28 April 2015 was not treated as a complaint. The Trust responded by stating that:

*'The ….letter of 28 April 2015 was about the patient's position on the waiting list and would have been sent directly to Public Liaison to deal with. The subsequent letter of 15 September 2015 was sent to Complaints Department and not Public Liaison as it needed to address treatment and care and required a more detailed response*.'

93. I have reviewed this correspondence and I consider that the letter of 28 April 2015 should have been interpreted as a complaint as 'an expression of dissatisfaction requiring a response'. I consider that this letter was sufficient to engage the Trust's complaint procedure and the issues of complaint should have been clarified and investigated at this stage.

94. I consider that the failure to activate the complaint procedure in April 2015 and to adequately investigate the matters set out in that correspondence constitutes maladministration. In consequence, there was an avoidable delay of four months in dealing with the complaint.

95. The Trust failed therefore to meet the standard required by the First Principle of Good Administration 'Getting it Right' (Appendix Two) which requires public bodies to follow their own policy and procedural practice. I also consider that the Trust failed to meet the standard set out in the First Principle of the Principles of Good Complaint Handling.

**Finding: I consider that these failings amount to maladministration and as a consequence the patient has suffered the injustice of frustration, uncertainty, time and trouble because his complaint was not dealt with promptly and adequately.**

96. I have reviewed the initial response issued from the Trust's Public Liaison Department on 29 May 2015 in response to the councillor's letter of 28 April 2015. It apologised for the extended waiting time experienced by the patient

and for the incorrect information he had received. It also stated that his referrals had been assessed on both occasions as 'routine' rather than 'urgent'. However, the Trust did not provide a reasoned explanation as why these referrals were classified as 'routine' rather than 'urgent' and it did not address the other matters set out in the councillor's letter of 28 April 2015.

97. The Trust stated that '*the Belfast Trust was continuing to prioritise patients based on a number of factors including clinical need* ***and urgency****, elective patient management and chronological order. This is in line with guidance from the Department of Health*'.

98. The Trust's criteria are included at paragraph 14 and 15 of this report. I note that the presence of one or more of these criteria determines whether the Orthopaedic Triage team grades the referral as 'urgent' or 'routine'. This grading determines whether the patient is added to the urgent or routine waiting list and consequently the waiting time for surgery.

99. I consider that the Public Liaison department's response failed to provide a clear, evidenced based and transparent explanation for the decision to grade the patient's referral as 'routine' and to explain the effect this grading would have on his waiting times. It also failed to provide a clear explanation of the Trust's policy of management of its waiting lists.

**100. Finding: I therefore consider that this response falls short of the requirements of the Third Principle of Good Administration which requires public bodies to be open when accounting for their decisions and to provide clear evidenced based explanations and reasons for decisions. I am satisfied that this failing amounts to maladministration which caused the patient the injustices of frustration, upset and uncertainty, and also the injustice of further time and trouble in pursuing his complaint to my office.**

# CONCLUSION

On investigation of this complaint I found maladministration in relation to the following matters:

- The decision to include the patient as an urgent patient to the 'in patient' waiting list for specialist spinal surgery was not in accordance with his clinical needs and amounted to a failing in clinical judgement. However, this did not cause him an injustice.
- The Trust's complaint handling was attended by maladministration in that there was an avoidable delay and the handling of the complaint was not in accordance with the DHSSPS complaints procedure. This caused an injustice to the patient because he did not have his complaint investigated promptly and thoroughly.

I did not find maladministration in respect of the following issues:

- The patient was correctly graded as 'routine' when his referral was assessed by the ROS triage team.
- In view of his clinical presentation it was reasonable of the Trust to place him at the bottom of the surgical in-patient waiting list notwithstanding the fact he had already been waiting for a year.

I am concerned to note that additional 'factors' other than those outlined in the 2003 guidelines and IEAP were applied in this case. My investigation has established that these additional 'factors' were not codified at that time by the Trust, therefore there is a risk that these criteria could not be reasonably applied in an equitable way so that other patients whose prognosis was similar to this patient were not disadvantaged. The Third Principle of Good Administration 'Being open and accountable' requires public bodies to state their criteria for decision making and to give reasons for their decisions. I consider that the failure on the part of the Trust to codify these additional 'factors' does not meet the standards of the Third Principle. It is important that 'factors' used in decision making are codified, so as to ensure consistency in

decision making in the application of that criteria. Further, the codification of the criteria ensures fairness, as it permits those affected to understand the reasons for the decision and, where appropriate, challenge the decision making.

**Recommendations:**

I recommend that:

- The Trust discuss my findings with the consultant spinal surgeon and highlight the requirement to record the reasons for clinical decisions to grade patients as urgent.
- I raise this issue as a learning point for the Trust and I suggest that the Trust reviews and consults on the additional 'factors'/criteria used by the consultant spinal surgeons in order to ensure compliance with the 'factors/criteria defined set by IEAP and the Trust's 2003 Guidelines.
- The Trust provide an apology and make a payment of £500 as a solatium for the injustice of frustration, uncertainty and distress in consequence of the maladministration identified. This amount also reflects the injustice of inconvenience caused to the patient for the time and trouble in pursuing his complaint to my office.

**MARIE ANDERSON**

**Ombudsman**
**April 2018**

## 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.