Investigation Report

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

NIPSO Reference: 17043

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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 regarding the actions of the Belfast Health & Social Care Trust (the Trust) about the care and treatment received by the complainant's late father who was a patient in Belfast City Hospital from September to November 2013. I also received a complaint about the way the Trust subsequently handled this complaint.

Issues of Complaint

I accepted the following issues for investigation:

- Was the care and treatment provided to the patient appropriate?
- Was there appropriate communication between medical staff and the complainant during her father's time in hospital?
- Was the Trust's handling of the complaint attended by maladministration?

Findings and Conclusion

The investigation of the complaint identified the following failure in the care and treatment provided to the patient:

- The Trust failed to provide the 'no treatment' option to the patient at his consultation with a Consultant Clinical Oncologist in August 2013.

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

- The Trust's failures to provide alternative contact details for support services to the patient.
- The Trust failures in record keeping identified in this report.
- The Trust's failure to provide clear information to the patient and his wife on transport provision to and from the Belfast City Hospital Cancer Centre.
- The delays in the Trust providing a response to the complaint.

The investigation did not uphold elements of the complaint related to:

- The decision to treat the patient as an outpatient

- The provision of support to the patient and his wife in Glenview House
- The Trust's treatment of the patient's mucositis
- The care provided to the patient on his final day of radiotherapy treatment
- The provision of the patient's records to Altnagelvin Hospital
- The communication between medical staff and the complainant during her father's time in hospital.

I am satisfied that the maladministration I identified caused the patient to experience the injustice of loss of opportunity, upset and uncertainty and caused his daughter to experience the injustice of upset, uncertainty and frustration.

Recommendations for Remedy

As the patient has passed away, it is not appropriate to make recommendations directed at remedying the injustice he personally suffered. However, having considered all relevant facts and evidence in this case and the nature and extent of the injustice sustained by his daughter in consequence of the maladministration I have identified, I recommended the following:

- The Trust should apologise to the complainant for the failures identified in this report.
- The complainant should receive a payment of £750 by way of solatium for the injustice I have identified.

I recommended that the Trust should provide the apology and a payment within one month of the date of my final report.
In order to improve the service delivery of the Trust I also recommended the following:

- The Consultant Clinical Oncologist should be reminded of the importance of record keeping in line with GMC guidelines.

I recommended that the Trust should provide me with evidence that this recommendation has been actioned within three months of the date of my final report.

THE COMPLAINT

1. The complainant's father was diagnosed with nasopharyngeal cancer[1] in August 2013. He received radiotherapy treatment as an outpatient at the Belfast City Hospital Cancer Centre between September and November 2013. During this time he and his wife stayed at Glenview House[2] on weekdays, before returning home each weekend to Strabane.

2. In November 2013 the patient was taken by ambulance from his home address to Altnagelvin hospital. He was diagnosed with sepsis and admitted to a respiratory ward. He remained in hospital where he passed away on 27 November 2013. The recorded cause of death was pneumonia, aspiration and nasopharyngeal cancer.

3. The patient's daughter made a complaint to my Office in relation to the care and treatment her father received at Altnagelvin Hospital. She also complained about the actions of the Trust in relation to the care and treatment provided to her father at the Belfast City Hospital and Glenview House. She also complained about the level of communication between her family and medical staff, and the Trust's handling of her complaint.

Issues of complaint

4. The issues of complaint which I accepted for investigation were:

Issue 1: Was the care and treatment provided to the patient appropriate?

Issue 2: Was there appropriate communication between medical staff and the complainant during her father's time in hospital?

Issue 3: Was the Trust's handling of the complaint attended by maladministration?

[1] Nasopharyngeal cancer is a rare type of cancer that affects the part of the throat connecting the back of the nose to the back of the mouth.

[2] Glenview House is approximately a hundred yards from the BCH Cancer Centre. It is a bed and breakfast accommodation for people who would otherwise have to travel long distances during treatment at the Cancer Centre.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included the patient's medical records and information relating to the Trust's handling of the complaint.

6. The complainant outlined in writing her issues of complaint. She also submitted copies of all correspondence with the Trust in relation to the complaint.

7. As part of my process I shared a draft report with both the complainant and the Trust. I considered the responses from both parties carefully before arriving at my conclusions in this report. I am grateful to both parties for their detailed responses to my draft report.

Independent Professional Advice

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

   - Consultant Oncologist (Oncologist IPA)
   - Social Worker (Social Work IPA)

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

Relevant Standards

10. 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.

11. The general standards are the Ombudsman's Principles[3]:

[3] Principles established through the experience of public services ombudsmen affiliated to the Ombudsman Association.

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

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

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

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

- Belfast Health & Social Care Trust Guidance for the Management of Patients Who Become Ill Whilst Receiving Radiotherapy or Within 6 Weeks of Radiotherapy (February 2013)
- Belfast Health & Social Care Trust Clinical Protocol for the Treatment of Head and Neck Cancer (March 2012)
- Belfast Health & Social Care Trust Belfast City Hospital Radiotherapy Department Work Instructions Manual 7.1 Use of Patient Monitoring Form (October 2013)
- Belfast Health & Social Care Trust Belfast City Hospital Radiotherapy Department Procedures Manual 7.2 On Treatment Review Clinics (October 2013)
- Belfast Health & Social Care Trust Belfast City Hospital Radiotherapy Department Radiographer Review Protocol – Protocol for Head and Neck Cancer Clinical Specialist Radiographer Review for Patients with Head and Neck Cancer (September 2011)
- Belfast Health & Social Care Trust Employers Procedures for External Beam Radiotherapy and Sealed Source Brachytherapy (June 2011)
- General Medical Council (GMC) Good Medical Practice 2013
- General Medical Council (GMC) Guidance on Consent: patients and doctors making decisions together (2008)

- Health and Social Care Standards and Guidelines for Resolution and Learning October 2013.

14. 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.

MY INVESTIGATION

Issue 1: Was the care and treatment provided to the patient appropriate?

Detail of the Complaint

15. The complainant raised the following issues relating to the care and treatment provided to her father from September to November 2013:

i. That her parents were not offered counselling to come to terms with the patient's cancer diagnosis. She also stated that her parents were not given a patient information pack prior to commencement of her father's treatment.

ii. That her father was not provided with the option of 'no treatment' for his condition and he was not informed of the potential risks or benefits associated with this option.

iii. That her father was initially informed by the Consultant Clinical Oncologist that he would receive his radiotherapy as an inpatient at the Belfast City Hospital. She complained that he then decided instead to treat him as an outpatient; he and his wife would reside at Glenview House on weekdays, and would travel home to Strabane at the weekends. The complainant believes that given the age of her parents at that time (84 and 78) that her father should have been treated as an inpatient and Glenview House was not an appropriate place for her parents.

iv. That her father should have been admitted as an inpatient to the Oncology Department during his treatment due to the pain, loss of weight and mucositis[4] he was experiencing. The complainant stated that at no time did her father

[4] Mucositis is the painful inflammation and ulceration of the mucous membranes lining the digestive tract, usually as an adverse effect of chemotherapy and radiotherapy treatment for cancer.

decline admission to the Oncology Department. She also stated that her parents were told that her father was to be admitted as an inpatient on 2 October 2015 but this never occurred.

v. That her parents did not receive appropriate support at Glenview House and during the weekends in Strabane. In particular, that:

- Her parents should have been offered counselling during her father's radiotherapy treatment.
- The Trust failed to provide her parents with transport to and from the Cancer Centre despite initially being told that this support was available. She stated that staff at Glenview House knew nothing about the availability of transport when her parents enquired about this service.
- The Trust would not allow her brother to take over caring responsibilities from her mother during her father's stay in Glenview House.

vi. That her father did not receive appropriate care and treatment for his mucositis as his pain was not controlled.

vii. That her father developed sepsis during his radiotherapy treatment. She complained that he should not have been discharged from the Cancer Centre given his condition. She has questioned why he was not medically examined upon completion of his treatment and why sepsis was not identified prior to discharge.

viii. That there was a delay in the Belfast Trust providing medical records to the Western Health & Social Care Trust (the Western Trust) following her father's admission to Altnagelvin hospital in November 2013.

(i) The provision of counselling and information to the complainant's parents.

16. In response to enquiries regarding the provision of support to the patient and his wife following the cancer diagnosis, the Trust responded as follows: '*The Trust can confirm that counselling services would have been available for the patient and his family [following his cancer diagnosis]. At the beginning of a patient's cancer journey through the oncology service they are given a patient information pack which includes information on the services, such as*

counselling, that are available via the MacMillan Information and Support Centre on the Belfast City Hospital site.'

17. The Trust stated further that before the commencement of treatment *'all patients receive an information pack…confirmation that this information was given to [the patient] is recorded on his consent form. Prior to his first treatment he was given information about his treatment and possible side effects by an experienced radiographer.'*

18. The Investigating Officer requested advice from the Oncologist IPA regarding the provision of support pre-treatment. In response the Oncologist IPA advised that:

(i) 'I cannot see any evidence of counselling being offered prior, at the time of diagnosis or during radiotherapy treatment.'…
(ii) 'It is indicated that there was access to MacMillan Services and Friends of the Cancer Centre.'…
(iii) 'There are no areas highlighted that would have indicated a specific need for urgent patient-directed counselling.'

19. I have reviewed the consent form signed by the patient during his consultation with the Consultant Clinical Oncologist on 27 August 2013. I note that it records that he received an information booklet during this consultation. I have reviewed the content of this booklet. I note that it provides detailed information about radiotherapy treatment to the patient. It also contains details of three websites for patients to access to avail of support services.

Analysis and Findings

20. I note the concerns raised by the complainant in relation to the provision of information and support to her parents before the commencement of her father's radiotherapy. I also note the comments of the Trust in this regard. I have also considered the advice of the Oncologist IPA on this issue. In particular I note her opinion that in this case there was no indication of '*a specific need for urgent patient-directed counselling*'. I also note her advice

that in this case *'it is indicated that there was access'* to support services.

21. I note the content of the consent form signed by the patient on 27 August 2013, and am satisfied, on the balance of probabilities, that this form evidences that he was provided with an information booklet during his consultation on 27 August 2013. In her response to the draft report the complainant reiterated her view that her parents were not provided with an information booklet during this consultation. I considered these comments, however I am satisfied on the balance of probabilities that a booklet was provided by the Trust.

22. Although I am satisfied that the information booklet provided to the patient signposted him to support services including counselling I consider that more detailed contact information ought to have been provided by the Trust. In particular, there ought to have been a Freephone number for patients and their families.

23. I consider that the failure to provide alternative contact details does not meet the second Principle of Good Administration 'Being customer focused' which requires a public body to ensure that people can access services easily, and this constitutes maladministration. I welcome that the Trust has updated its Glenview House information leaflet with detailed information on support services available and has listed the various ways patients can access these services.

24. As a consequence of the maladministration, I am satisfied that the complainant's parents suffered the injustice of loss of opportunity to access support services. **I therefore uphold this element of the complaint.**

(ii) The provision of a 'no treatment' option to the patient

25. I have reviewed the GMC Guidance on Consent: patients and doctors making decisions together (2008). This guidance sets out principles for good practice in making decisions. I note that paragraph 5 of the guidance states that:

'If patients have capacity to make decisions for themselves…the doctor [should

explain] the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for their patient, but they must not put pressure on the patient to accept their advice.'

'The patient decides whether to accept any of the options and, if so, which one.'

26. In response to enquiries regarding the provision of a 'no treatment' option to the patient, the Trust responded as follows:

(i) '*The Trust has acknowledged that the patient should have been offered the no treatment option, however the consequences of offering no treatment to this type of cancer would have most certainly led to local progression, metastases and death. This was explained to the patient and his wife.'*

(ii) *'The Trust acknowledges that the option of not having treatment was not fully discussed with him as part of the consent process. The Trust acknowledges this as learning and has referred to this learning in previous responses to the complainant.'*

(iii) The Trust provided comments from the Consultant Clinical Oncologist regarding this issue. He stated that: *'The patient had an early curable cancer which would have proved fatal if left untreated and this was explained to him alongside the risks of treatment. The risk of the treatment was a lot smaller than the risk of no treatment.'*

27. The Investigating Officer requested advice from the Oncologist IPA regarding the provision of a 'no treatment' option to the patient. In response the Oncologist IPA advised that:

'This was a small potentially curable nasopharyngeal cancer presenting in an 84 year old man who was otherwise of good performance status. Even taking into account this gentleman's age a no treatment option would not be the usual preferred recommendation for potentially curative head and neck cancer.' The IPA also advised that: *'However, given that he was 84 at the time of his presentation it would have been appropriate to discuss the likely benefit of treatment with curative intent accepting that the short-term toxicity of head and*

neck cancer can be very significant versus the alternative of no treatment so that he could have considered the latter as a potential option.'

Analysis and Findings

28. I note the concerns raised by the complainant in relation to the Trust's not providing a 'no treatment' option to her father. I also note the comments of the Trust in this regard. I have considered the relevant GMC guidance on consent which sets out clearly that the option of no treatment should be discussed with and offered to the patient.

29. I have considered and I accept the advice of the Oncologist IPA on this issue. In particular I note her opinion that although the '*no treatment option would not be the usual preferred recommendation for potentially curative head and neck cancer'* it would have been *'appropriate to discuss the alternative of no treatment so that the patient could have considered the latter as a potential option.'*

30. I note that there is no record that the 'no treatment' option was discussed at the consultation with the Consultant Clinical Oncologist. I also note that the Trust has accepted that the patient was not offered this option and there was a lack of discussion about this option during the consultation. I consider that the patient ought to have been provided with detailed information on all the options open to him regarding his treatment and the non-treatment option for cancer. This would have enabled him to have made an informed choice in this regard. I find that the consent in this case was inadequate and this amounts to a failure in the care and treatment provided to him.

31. I refer also to the Patient and Client Experience Standards which reflect human rights principles of fairness, respect, equality, dignity and autonomy (FREDA). The human rights values and principles outlined in the Patient and Client Experience standards and in the FREDA principles are relevant in this case. I am satisfied that the Trust did not have regard for the patient's dignity and autonomy by failing to properly obtain his consent as a result of the failure to

communicate to him the option of 'no treatment'. **I therefore uphold this element of the complaint.**

32. I am satisfied that this failure caused the patient to suffer the injustice of loss of opportunity to make an informed choice about the 'no treatment' option. I am also satisfied that that this failure caused the complainant to experience the injustice of upset and uncertainty with regards to her father's options for treatment.

33. In relation to the Trust learning from this complaint, I note and welcome that the Trust has informed the complainant that in future the Consultant Clinical Oncologist will provide patients with a clear explanation of the 'no treatment' option. I will deal with the issue of remedy for this injustice at the conclusion of this report.

(iii) The decision to treat the patient as an outpatient

34. In response to investigation enquiries regarding the decision to treat the patient as an outpatient, the Trust responded as follows:
The Trust stated that *'during the consultation [on 27 August 2013] the Consultant advised that the patient would benefit from staying in hospital rather than travelling daily from Strabane for treatment. The patient voiced concern at the length of time he would be away from home. The radiographer in attendance at the clinic suggested that Glenview House may be an option, as this would allow the patient's wife to stay with him, which they were both keen for. The Consultant supported this, pending a full nursing assessment to ensure the patient was fit enough to reside in Glenview.'*

35. Further, the Trust stated that *'The decision to treat the patient as an outpatient was made following consultation with him and his wife when he was deemed fit on assessment. The Consultant was happy for the patient to have his treatment as an outpatient in Glenview House, as admission was not necessary for medical reasons but rather to ease the burden of travelling from so far away. Patients who live closer to hospital are not generally admitted for this type of*

treatment.'

36. The Trust also stated that the patient's nursing assessment *'documented that he was able to walk independently, he was independent with his personal hygiene needs and had no communication or breathing difficulties.'* The Trust confirmed that Glenview House is a '*facility for self-caring or patients who require the support only of a relative or carer.'*

37. The Investigating Officer requested advice from the Oncologist IPA regarding the decision to treat the patient as an outpatient. In response the Oncologist IPA advised that:

(i) *'The letter dated 27.8.2013 [from the Consultant] indicated admission as an in-patient with the possibility of weekend leave. This recommendation of in-patient care will be due to the distance that it was required for radiotherapy treatment over seven weeks not due to a medical health need as the notes indicate that he was in good health.'*

(ii) The decision to stay in Glenview House was made by the Consultant *'in conjunction with the patient so it was a joint decision.'*

(iii) *'An assessment was made by [a nurse] which confirmed the patient met the criteria to reside in Glenview and his wife was able to stay with him as his carer. This assessment also confirmed that his wife was self-caring and there is a question on the form that highlights the need to consider in more detail if the carer is not able to self-care.'*

(iv) The decision to treat the patient as an outpatient was *'a reasonable decision as the Consultant had assessed him and felt that he was of a suitable fitness for a curative course of radiotherapy. This would indicate that his performance status (level of fitness) would not require medical admission to hospital as this would have inferred his performance status was poor and he would not have been suitable for curative treatment. The use of establishments such as Glenview House are a very useful resource to reduce the daily travelling commitment for patients receiving radiotherapy and prevent exposing otherwise fit patients to the potential of hospital acquired infections. It is unusual to admit patients to hospital for radiotherapy unless there is a medical need that requires active in-*

patient treatment that cannot be delivered in the community.'

38. I have examined the patient assessment form completed by a nurse which was used to determine the patient's and his wife's suitability to reside at Glenview House. I note that the assessment, completed on 27 August 2013, recorded that he would be able to '*walk independently'* from Glenview House to the Cancer Centre. I also note that the form records that the patient's wife would act as his carer and she was 'self-caring'. The nurse also recorded her opinion that it was suitable for the patient to reside at Glenview House with a carer.

Analysis and Findings

39. I note the concerns raised by the complainant in relation to the decision to treat her father as an outpatient. I also note the comments of the Trust in this regard. I have carefully considered and I accept the advice of the Oncologist IPA that the decision to treat the patient as an outpatient was '*reasonable*'. The decision was based on a nursing assessment which deemed him as being suitable to reside at Glenview House with a carer. I also note the contents of this nursing assessment. I am satisfied that the decision to treat the patient as an outpatient was reasonable. **I therefore do not uphold this element of the complaint.**

40. I note that the Trust has not provided me with contemporaneous records to evidence the discussion between the patient and his wife, the Consultant and the radiographer about the Glenview House option. I consider that contemporaneous record keeping allows for through independent assessment of the care and treatment provided to patients and helps ensure transparency. Additionally it provides protection to clinicians and nursing staff involved in patient care by providing a clear picture of their actions and reasons for decisions. I note that in its response to the draft report the Trust provided me with additional records to evidence the discussion between the couple, the Consultant and the radiographer on 27 August 2013. I have considered the content of these records. However, I remain of the view that the standard of the third principle of Good Administration has not been met as the records are

either not contemporaneous or are not sufficiently comprehensive in content.

41. I consider that this failure in record keeping is contrary to the third principle of Good Administration 'Being open and accountable' which requires a public body to keep proper and appropriate records. I consider that the Trust's failure to record this discussion did not meet the standards required and this failing constitutes maladministration. However, I have not identified any injustice suffered as a result of this failure in record keeping.

(iv) The patient's status as an outpatient during treatment

42. I have considered the relevant guidance from the GMC Good Medical Practice (2013). I note that paragraph 19 of the guidance states that:

'Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'

43. I note that paragraph 21 of the guidance states that:
'Clinical records should include:
a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.'

44. In response to investigation enquiries regarding the patient's status as an outpatient during his treatment, the Trust responded as follows:

The patient *'was offered an inpatient bed on a number of occasions and it was documented on a number of occasions that he did not wish to be admitted'… 'The number of [Patient Monitoring Forms] recorded in relation to his treatment would indicate he was closely reviewed and monitored. The team recall this*

was to ensure they did not miss any need to enforce his admission to hospital'…

'Patients who are receiving radiotherapy are assessed daily by a radiographer and at least weekly by medical staff.'

45. The Trust also stated that the patient and his wife were *'closely reviewed by multiple professionals who are all trained to use verbal and non-verbal skills to detect when a patient or relative is not coping… all staff felt they had supported them both to meet all their needs.'…*

The patient was reviewed on in October 2013 by [a Specialist Clinical Oncology Registrar] who recorded that he *'had suggested hospital admission but the patient was keen that this did not happen. He was reviewed again two days later by the Consultant and was offered admission but this was declined.'…*

'*The Trust has no record of any intention or request to admit the patient on 2 October 2013.'*

46. The Investigating Officer requested advice from the Oncologist IPA regarding the patient's status as an outpatient during treatment. In response the Oncologist IPA advised that:

(i) *'It is appropriate that a patient who was fit enough to be considered for radiotherapy should be able to participate in decision making for where he resides during treatment.'*

(ii) *'The Consultant and his registrar undertook regular assessments each week. These were all appropriate. On 21.10.2013 the patient was reviewed by [a Specialist Clinical Oncology Registrar] who offered hospital admission but the patient declined. Regular assessments were undertaken of blood tests during his treatment as would be part of standard practice.'*

(iii) *'The radiotherapy treatment team were seeing him on a daily basis and his medical team (the Consultant and his specialist registrar) reviewed him on a weekly basis. The allied health professionals (dieticians and speech and language therapist) were seeing him one to two times a week.'*

(iv) *'From my review I cannot see a medical indication for admission during [the patient's] radiotherapy treatment.'*

47. I have reviewed the content of the patient's patient monitoring forms that were completed during his radiotherapy treatment. I note an entry dated 21 October 2013 from the Specialist Clinical Oncology Registrar which states: *'Suggested admission for optimizing analgesia [and] feeding. [Very] keen to avoid.'*

48. I have also reviewed the content of his oncology nutritional care plan. I note that on 23 October 2013 a Dietician recorded that '*if admitted it will be unlikely he will manage above oral intake as [his] wife is the person who insists he takes fluid and [oral nutritional supplements]'.* It also records that the dietician explained this to the Consultant and it was *'agreed to remain as an [outpatient] and reviewed regular (sic) as keen to remain [an] outpatient. To be monitored daily.'*

49. I note that a radiographer met with the patient's wife on 24 October 2013 to discuss the complainant's concerns that her parents were 'not managing' in Glenview House. I have reviewed the radiographer's notes of this meeting. In particular, I note that the radiographer recorded that the patient's wife felt that *'he is managing OK and not keen to come into the ward. I reminded her that they need to let us know if that changes.'*

Analysis and Findings

50. I have considered the concerns raised by the complainant in relation to her father's continuing status as an outpatient during his radiotherapy treatment. I note that she reiterated these concerns in her response to the draft report. I have also considered the comments of the Trust on this issue. I have reviewed and carefully considered the Oncologist IPA's advice on this issue and I note her opinion that she could not *'see a medical indication for admission during radiotherapy treatment*.' I also note her advice that '*a patient who was fit enough to be considered for radiotherapy should be able to participate in decision making for where he resides during treatment.'*

51. I have carefully considered and accept the advice of the Oncologist IPA. I am

satisfied that the decision to continue treating the patient as an outpatient throughout his treatment was reasonable. **I therefore do not uphold this element of the complaint.**

52. I have considered the relevant GMC guidance on record keeping. I note that the Trust clearly recorded several discussions with the couple about the possibility of admitting the patient to hospital. However, I consider that the Consultant Clinical Oncologist failed to make a contemporaneous note of his conversation with the patient on 23 October 2013 when this issue was discussed. It appears that details of this conversation were recorded 'second-hand' by a dietician in the patient's oncology nutritional care plan.

53. I consider that keeping accurate and contemporaneous records allows for thorough independent assessment of the care and treatment provided to patients and helps ensure transparency. This provides protection to clinicians and nursing staff involved in patient care by providing a clear record of their actions and reasons for decisions.

54. I consider that this failure in record keeping is contrary to the third principle of Good Administration 'Being open and accountable' which requires a public body to keep proper and appropriate records. I consider that the failure to make a contemporaneous record of the Consultant's conversation with the patient on 23 October 2013 did not meet the standards required and this failing constitutes maladministration. However, I have not identified any injustice suffered as a result of this failure in record keeping.

(v) The provision of support to the patient and his wife in Glenview House

55. In response to investigation enquiries regarding the provision of support to the patient and his wife in Glenview House, the Trust stated:

(i) That the couple were assessed by a social worker on 25 October 2013 following a telephone call from their daughter expressing concern about how

her parents were 'managing' in Glenview House. *'The social worker carried out an initial assessment which looked at home circumstances and available support networks to determine whether a referral for additional support was required. Both individuals were clear that they felt they were managing in Glenview House.'*

(ii) The complainant's mother *'told the social worker that she had good support from her son and that neither she nor her husband wished for any community social work referral or involvement at that stage. The social worker provided information to them as to how to contact the social work department if the situation changed.'*

(iii) *In discussion with the patient, consideration is given regarding counselling…the Trust can confirm there was no referral made from our Social Work team for formal counselling for the patient.'*

(iv) *'The [social work] assessment indicated that there were no specific needs at the time and therefore a comprehensive assessment of need was not deemed necessary. No further referrals or identification of need were made to the social work staff.'*

(v) On 24 October 2013 the patient's wife met with an Information and Support Radiographer who '*described what general support was available if required*.' The Radiographer stated that she *'reinforced to her that she could be contacted at any time for help or support as needed during or after treatment.'*

(vi) The Trust stated that it has no record of a request for the complainant's brother to take over caring responsibilities for his father in Glenview House and that *'Staff at the Radiotherapy Reception are aware and able to book transport for patients who need transported to and from Glenview House.'*

(vii) The Trust also stated that *'internal transport was available and could have been utilised in 2013, however such requests at that time were rare. The Trust sincerely regret that the patient was not provided with this service at the time when his wife had enquired about it.'*

56. The Investigating Officer requested advice from the Oncologist IPA regarding the support provided to the couple during their stay in Glenview House. In response the Oncologist IPA advised that:

(i) *'I would not expect patients to need additional support [at the weekend] if this had not been identified as a need during the week.'*

(ii) *'General clinical support was provided by the medical team and allied health professionals during radiotherapy.'*

(iii) *'It is indicated that there was access to Macmillan Services and Friends of the Cancer Centre but no specific patient focused services for head and neck cancer patients on active treatment. I cannot see any evidence that the patient accessed these services. My opinion is that the support offered during radiotherapy was in line with what I would expect for patients undergoing a radical course of radiotherapy. There are no areas highlighted that would have indicated a specific need for urgent patient-directed counselling.'*

57. The Investigating Officer requested advice from the Social Work IPA in relation to the social worker's meeting with the couple on 25 October 2013. In response the Social Work IPA advised that *'In my opinion the social worker acted appropriately. The couple presented no problems or issues they could not address. In addition they identified positive support from their son to help them cope. Finally there had been no referral from within the hospital to indicate that support was needed.'*

58. I have reviewed the social worker's record of her meeting with the couple on 25 October 2013. I note the following comments made by the social worker:
'[The patient's wife] has found it hard being in Glenview some of the time.'…
'Although both in their 80s they are very mobile and able to manage together. They have good support from their son'…
'Neither thought there was any need for community social referral as [they] anticipate being able to manage as they have done so far.'…
The Social Worker advised them to ring her if she could help them in any way.

59. I have also reviewed the entry made by the social worker in the Radiotherapy Department Patient Monitoring Forms. I note that she recorded that the patient is *'managing independently and [there is] very good support from his wife and son. No role for community social worker at this time.'*

Analysis and Findings

60. I note the concerns raised by the complainant in relation to the provision of support to her parents during their stay in Glenview House and at weekends in Strabane. I have considered the response of the Trust about this issue. I also considered Trust records of the social work assessment of the patient and his wife on 25 October 2013.

61. I have reviewed and carefully considered the Oncologist IPA's advice on this issue. In particular I note her opinion that *'the support offered during radiotherapy was in line with what I would expect for patients undergoing a radical course of radiotherapy.'* I accept the advice of the Oncologist IPA. I have also carefully considered the advice of the Social Work IPA and I note his opinion that the social worker *'acted appropriately.'* In light of this advice and the available evidence, I am satisfied that the support provided to the patient and his wife during radiotherapy treatment was reasonable. **I therefore do not uphold this element of the complaint.**

62. I note that the Trust has no record of a request from the family for the complainant's brother to take over caring responsibilities at Glenview House. I am therefore unable to conclude on this element of the complaint. I note and welcome the fact that the updated Glenview House information leaflet clearly explains that a different carer can stay with a patient during radiotherapy treatment.

63. I have considered the issue relating to the provision of transport to and from the Cancer Centre during the patient's radiotherapy treatment. I note that he and his wife were advised that transport was available prior to their stay at Glenview House. However, I note that neither the Glenview House information leaflet at the time or the radiotherapy booklet provided to the patient provided them with details of who to contact to avail of this service. **I therefore uphold this element of the complaint.**

64. I consider that the failure to provide clear information on transport provision to

the patient and his wife is contrary to the second principle of Good Administration 'Being customer focused' which requires a public body to deal with people helpfully, bearing in mind their individual circumstances. I also find that this failure is contrary to the third principle of Good Administration 'Being open and accountable' which requires a public body to ensure that any information provided is clear, accurate and complete.

65. I consider that the Trust's failure to provide clear information on transport provision did not meet the standards required by these Principles and this failings constitutes maladministration. As a consequence of the maladministration, I am satisfied that the couple suffered the injustice of upset and uncertainty due to the pressure to arrive at the Cancer Centre in a timely manner. I am also satisfied that this maladministration caused the complainant to suffer the injustice of upset and uncertainty. I will deal with the issue of remedy in the conclusion of this report.

66. I note and welcome that the Trust has updated the Glenview House information leaflet with clear guidance on who to contact if patients require transport to the Cancer Centre, and has made all Glenview House Reception staff aware of the availability of transport to the Cancer Centre. I am therefore satisfied that the Trust has taken the necessary steps to address this issue generally.

67. I note that radiotherapy nursing staff now complete an additional assessment midway through a patient's treatment to ensure the patients remains fit to reside in Glenview House. I also note that every patient who now receives radiotherapy for head and neck cancer is given contact details for a key worker. I welcome these initiatives and I am satisfied that the Trust has taken the necessary steps to improve the provision of support to cancer patients.

(vi) The Trust's treatment of the patient's mucositis

68. I have considered the content of the Trust's Guidance for the Management of Patients Who Become Ill Whilst Receiving Radiotherapy or Within 6 Weeks of Radiotherapy (February 2013). I note the following guidance detailing the

required action for patients who are suffering from mucositis as a result of radiotherapy on the head and neck area:

'Avoid alcohol containing mouthwashes.'

'Oral care - Increase frequency of mouthcare. Prescribe protective mouthcare eg Gelclair sachets four times daily. If lips sore prescribe white soft paraffin when required.'

'Pain relief - Step up pain relief as per WHO analgesic calendar.'

69. In response to enquiries regarding the treatment of the patient's mucositis, the Trust responded as follows:

(i) The patient *'did develop a mild posterior mucositis'* during his first week of treatment '*which was treated appropriately and which did not prevent him continuing with his treatment.'*

(ii) *'The degree of mucositis had improved during the final 2 weeks of treatment. This was as a result of the change in his radiotherapy treatment field during the latter part of his treatment to the primary tumour only, with discontinuation of treatment to the lower pharynx and neck. Severe mucositis is expected at this stage but was still not confluent (flowing) or haemorrhagic (oozing).'*

(iii) He *'was treated appropriately for mucositis by an experienced team with supportive therapies including nutritional support, analgesics-opioids, steroids, topical anaesthetic gel, mouthwashes with hygiene advice and antifungals'.*

70. The Investigating Officer requested advice from the Oncologist IPA regarding the treatment of the patient's mucositis. In response the Oncologist IPA advised that:

'The treatment prescribed [for mucositis] was appropriate consisting of dietary advice which is essential for optimum recovery, local protectants in the form of gelclair and analgesia...mucositis is a very painful condition and often it is not possible to achieve complete control of pain for patients. The input provided by the dieticians was extremely comprehensive and [the patient] had in the region of sixteen reviews during his treatment.'

Analysis and Findings

71. I note the Trust's comments on its treatment of the patient's mucositis. I have reviewed the Trust's guidance for the treatment of mucositis. I have also carefully considered the Oncologist IPA's advice on this issue. I note her opinion that the treatment provided was '*appropriate*'. I accept the advice of the Oncologist IPA and I am satisfied that the care and treatment provided to the patient for his mucositis was reasonable. **I have not upheld this element of the complaint, however I can fully understand her concerns for her father in the circumstances.**

72. In her response to the draft report the complainant questioned the Trust's comment that '*The degree of mucositis had improved during the final 2 weeks of treatment.'* The Trust has provided me with additional information on this issue as stated above. I hope this additional information provides clarity to the complainant on this issue. I note that the Trust has accepted that the patient's mucositis was *'severe'* at this time. I also note the comments of the IPA that having *'moderate to severe'* mucositis during this period was *'in keeping with the fact that [the patient was] near completion of his treatment'.*

(vii) The completion of treatment

73. I have reviewed the Trust's Protocol for the Treatment of Head and Neck Cancer (March 2012). I note that paragraph 18 of the protocol states that *'at the conclusion of treatment an end of treatment summary is documented on the patients treatment chart…on the final day of treatment the radiographer undertaking post treatment information and follow-up instructions will make a final note on the Patient Monitoring Form in respect of the acute toxicities[5].'*

74. I have considered the content of the BCH's Radiotherapy Department Radiographer Review Protocol. I note that the protocol states that *'Named*

[5] Acute toxicity describes the adverse effects of a substance that result either from a single exposure from multiple exposures in a short period of time

consultant clinical oncologists will delegate the responsibility for on-treatment review & post radiotherapy treatment follow-up to the [Clinical Specialist Radiographer] within this agreed protocol'.

75. In response to enquiries regarding the completion of the patient's treatment, the Trust responded as follows:

(i) *'On the final day of treatment there were no concerns expressed by the team treating him and therefore there was no indication for him to be medically assessed. Had there been concerns regarding his clinical condition these would have been acted upon by the treating team and contact made with the medical staff. He was given a routine follow up appointment to reassess his condition after treatment for the following Monday. Unfortunately he developed pneumonia, possibly an acute aspiration pneumonia following discharge'.*

(ii) *'The experienced team of radiographers who deal with head and neck cancer patients assessed the patient daily.'*

(iii) '*There was no indication from the blood tests [taken on 28 and 31 October 2013] that he required a medical review'.*

(iv) *'Patients who are attending for radiotherapy are not usually assessed on the final day of radiotherapy unless there is a clinical concern.'*

(v) *'Regular clinical reviews are conducted while a patient is undergoing radiotherapy treatment. At the conclusion of treatment, an end of treatment summary provides a clinical evaluation of the radiotherapy course.'*

(vi) The radiographer who '*completed the clinical evaluation for the patient on the last fraction of treatment…noted that the immediate clinical effects were as expected for the site treated and the dose that was delivered.'*

(vii) *Dr A and his registrar undertook regular assessments each week. These were all appropriate.'*

76. The Investigating Officer requested advice from the Oncologist IPA regarding the completion of the patient's treatment. In response the Oncologist IPA advised that:

(i) *'An annotation [on the Patient Monitoring Form] that is marked as 26.10.2013*

notes that [the patient] has had no nose bleeds or evidence of infective complications. His mucositis is described as moderate to severe… he was reviewed by a dietician on the 30th of October where it was noted that he was meeting his nutritional requirements. These findings are in keeping with a patient who is shortly due to complete a course of radiotherapy of this nature.'

(ii) *'There was no medical assessment on his last day of treatment. He had been seen by the Consultant Clinical Oncologist on the 26th of October 2013 in his radiotherapy review clinic. It is not standard to see patients on the last day of treatment. Patients are generally scheduled to be reviewed on one day of the week in a radiotherapy review clinic. If the treating radiographers feel that the patient is unwell or the patient asked to be seen then patients can be seen on the other days of treatment.'*

(iii) *'The radiotherapy team would have seen him on the last day of treatment…the team would have known him very well at this stage so would have indicated if something had occurred that needed referral for medical intervention… from the documentation that I have read I do not see any indication for him to have had a medical review on the last day of treatment.'*

(iv) *'The patient had an episode of oral candida which was treated appropriately. Oral candida (thrush) is extremely common during head and neck radiotherapy as the normal bacterial protection in the mouth is lost. There is no evidence of any other infective episode during radiotherapy.'*

(v) *'He was experiencing the expected side-effects of treatment but there was no indication of any acute changes prior to the completion of treatment.'*

Analysis and Findings

77. I note the concerns raised by the complainant in relation to the completion of her father's radiotherapy treatment. I note that she reiterated these concerns in her response to the draft report. I also note the Trust's comments on this issue. I have reviewed the Trust's guidance on end of treatment care for radiotherapy patients.

78. I have carefully considered and accept the Oncologist IPA's advice on this issue. I note her opinion that she did *'not see any indication for the patient to*

have had a medical review on the last day of treatment.' I note her advice that apart from oral candida there was *'no evidence of any other infective episode during radiotherapy.'* I also note her opinion that the Consultant '*undertook regular assessments each week. These were all appropriate.'* I am satisfied that the care and treatment provided to the patient on his final day of radiotherapy treatment was reasonable. **I therefore do not uphold this element of the complaint.**

(viii) The provision of the patient's records to Altnagelvin hospital

79. In response to investigation enquiries regarding the provision of the patient's records from the Belfast City Hospital to Altnagelvin hospital, the Trust responded as follows:

(i) In November 2013, *'when patients completed their radiotherapy treatment, the radiotherapy treatment chart summary would have been annotated onto the Clinical Oncology Information System[6] (COIS). In the case of this patient a summary of his treatment was annotated on 21 November 2013 but was not typed until 26 November 2013.'*

(ii) The Trust acknowledges there *'was a delay in our communications system regarding the end of treatment summary, however at the time of admission to Altnagelvin hospital, colleagues would have had access to his history, examination and treatment plan. We can also reassure the complainant that although there was no formal discharge summary, our staff did email and telephone colleagues in the [Western Trust] to update them regarding all aspects of the patient's treatment'.*

80. The Investigating Officer requested advice from the Oncologist IPA regarding the provision of the patient's records from the Belfast City Hospital to Altnagelvin hospital. In response, the Oncologist IPA advised that:

[6] COIS an electronic patient record which records patients' attendance at the Cancer Centre and the radiotherapy and chemotherapy that they receive.

(i) The Speech and Language Therapy Team from the BCH were *'contacted [by] the patient's wife on the 7th of November 2013 and were informed that the patient had been admitted to Altnagelvin Hospital and an email was sent that day to [Altnagelvin Hospital] outlining treatment and how his condition had been on the 21.10.2013.'*

(ii) *'A summary of treatment is available on a Palliative Care Team [Multi-disciplinary team] report dated 12.11.2013 which has the relevant information relating to his radiotherapy treatment…the information [in this report] appears correct with regard to his diagnosis and treatment.'*

(iii) *'It is good practice for patient's to have copies of their treatment plan so that this can be given to health professionals in the community or other hospitals.'*

81. The complainant also made a complaint to the Western Trust in relation to the care and treatment received by her father at Altnagelvin hospital during November 2013. As part of my investigation of this complaint I requested and obtained independent professional advice from a Consultant in Emergency Medicine and a Consultant Respiratory Physician in relation to the Western Trust's receipt of information from the BCH.

82. In response to my enquiries the Consultant in Emergency Medicine advised that:
'I do not feel additional information from the Cancer Centre would have altered treatment in the first instance during admission to Altnagelvin hospital. However, it would have been appropriate for the Cancer Centre to have provided him with a summary of the important information about his care and treatment in the event he was taken ill and admitted to a different hospital.'

83. In response to my enquiries the Consultant Respiratory Physician advised that the patient's medical notes of 4 November 2013 contain *'detailed information on his nasopharyngeal tumour stage, treatment and likely prognosis.'* The consultant IPA also advised that *'I do not consider that any additional information, beyond that documented by the palliative care team on 4 November…was required from the Belfast Trust.'*

84. I have reviewed the content of the patient's oncology nutritional care plan. I note that on 6 November 2013 a dietician recorded that she was aware he had been admitted to Altnagelvin and she had *'transferred [his] care'.*

Analysis and Findings

85. I note the Trust's comments in relation to the provision of information to Altnagelvin hospital. I have carefully considered and I accept the advice of the IPAs on this issue. In particular I note the opinion of the Consultant in Emergency Medicine that *'additional information from the Cancer Centre would [not] have altered treatment in the first instance during his admission to Altnagelvin hospital.'*

86. I also note the advice of the Consultant Respiratory Physician that *'additional information, beyond that documented by the palliative care team on 4 November [2013]…was [not] required from the Belfast Trust.'* Although it is unclear how this information was obtained I am satisfied that the Western Trust received the necessary information in relation to the patient's cancer treatment in a timely manner. **I therefore do not uphold this element of the complaint.**

87. I note and welcome that the Trust has recently established information systems which ensures that health professionals in other Trusts have access to patient's oncology records.

Issue 2: Was there appropriate communication between medical staff and the complainant during the patient's time in hospital?

88. The complainant alleged that her parents were not provided with contact details for the Consultant Clinical Oncologist during her father's radiotherapy treatment. She stated that this meant she had difficulty trying to contact him and on her third attempted call she finally spoke with his secretary on 16 October 2013. His secretary told her that the Consultant would return her call. The complainant alleged that he did not return her call.

89. During the Trust's investigation into the complaint it referred to telephone calls between her and an information & support radiographer on 22 and 23 October 2013. The complainant complained that these phone calls did not take place.

90. I have considered the relevant guidance from the GMC Good Medical Practice (2013). It stipulates that:
'You must listen to patients, take account of their views, and respond honestly to their questions.
You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.
You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.
When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.'

91. In response to enquiries regarding the level of communication between the complainant and medical staff, the Trust responded as follows:

During a meeting between the Trust and the family on the Trust stated that *'[in 2013] patients were not given a card with consultant contact details or other contact details for Belfast City Hospital.'* However, in its response to my Office the Trust stated that patients received *'details and telephone numbers of the team leader responsible for the treatment area where the patient had been assigned.'* The Trust also stated that *'It would be normal practice if a family member wished to contact the Consultant that they could do so by contacting the hospital's switchboard which would then be able to transfer them to the Consultant's secretary.'*

92. The Trust confirmed that on 16 October 2013 the Consultant was *'informed by a secretary that the complainant was trying to contact him and had left her mobile number. He recalls that he rang the number on a number of occasions on two consecutive days, but unfortunately his calls were not answered.'*

93. I note that the Trust's minutes of its meeting with members of the family on 17 May 2016 record that the Consultant apologised *'that he had not been able to get into contact with the complainant'.* He stated that *'he assessed the patient after the phone call was attempted.'* I note also that on 22 October 2013 the information & support radiographer was contacted by the Cancer Centre's reception desk *'asking her to contact the complainant who was in France at the time. [The Radiographer] contacted her and assured her that she would ensure her father was reviewed in our On-Treatment Review (OTR) clinic where the medical staff would assess him regarding admission…He was reviewed by the Consultant the following day.'*

94. The Investigating Officer requested advice from the Oncologist IPA regarding the level of communication between the complainant and medical staff. In response the Oncologist IPA advised that *'From review of the notes there is documentation that the patient's daughter tried to contact the Consultant but was unable to do so. I can see no documentation of communication between the Consultant or any other medical staff and the complainant.'*

95. I have reviewed an Information & Support Service Referral form completed by the information & support radiographer. I note that she recorded a conversation with the complainant on 22 October 2013 during which she discussed with her the possibility of getting her father admitted as an inpatient. I note that the radiographer also recorded that she phoned her again on 22 October 2013 to provide her with an update in relation to her initial call.

Analysis and Findings

96. I have considered the advice of the Oncologist IPA on this issue and the relevant GMC guidelines.

97. I have considered the complaint that the Consultant did not return the call on 16 October 2013. I note that he stated that he did try. I find that, in the absence of

a record in accordance with GMC guidance, I am unable to conclude whether he returned the call.

98. I note that the Trust has not provided me with a contemporaneous record of the Consultant's failed contact with the complainant. I consider that contemporaneous record keeping allows for through independent assessment of the care and treatment provided to patients and helps ensure transparency. This also provides protection to clinicians and nursing staff involved in patient care by providing a clear picture of their actions and reasons for decisions.

99. I consider that this failure in record keeping is contrary to the third principle of Good Administration 'Being open and accountable' which requires a public body to keep proper and appropriate records. I consider that the failure to record this discussion did not meet the standards required and this failing constitutes maladministration. However, I have not identified any injustice suffered by the patient as a result of this failure in record keeping.

100. I have considered the complaint that she did not speak with the information & support radiographer. I note that she reiterated these concerns in her response to the draft report. I have considered the Trust's response and the contemporaneous record provided by the radiographer detailing two conversations with the complainant on 22 October 2013. Having considered all the available evidence, on the balance of probabilities, I am satisfied that the radiographer did speak with the complainant on this date. **I therefore do not uphold this element of the complaint.**

101. I note and welcome that the Trust now provides consultant contact details to patients. I am satisfied that the Trust has taken the necessary step to ensure that patients and relatives of patients have easy access to contact details for the consultant in charge of the patients care.

Issue 3: Was the Trust's handling of the complaint attended by maladministration?

Detail of Complaint

102. The complainant alleged that there were significant delays in the Trust's responses to her complaint about her father's care, treatment and stay at Glenview House.

Evidence Considered

103. The HSC Complaints Procedure is the relevant statutory procedure for all health and social care complaints in Northern Ireland. I have reviewed the HSC Standards and Guidelines which also applied to the Trust's handling of the complaint. I note the following extracts in relation to the timeframe for responding to complaints:

(i) *'Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement.'*

(ii) '*A response must be sent to the complainant within 20 working days of receipt of the complaint or, where that is not possible, the complainant must be advised of the delay and keep them informed of progress*'

104. I note the following HSC standards for complaint handling:

Receiving Complaints – *'All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.'*

Investigation of Complaints – *'All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.'*

Responding to Complaints – *'All complaints will be responded to as promptly as possible and all issues raised will be addressed.'*

105. In response to enquiries regarding the delay in response to the complainant's letters, the Trust responded as follows:

(i) The Trust stated that it *'acknowledges that the delays in responding to each of the letters it received were unacceptable and has apologised for the delays in each letter of response and at the meeting of 17 May 2016.'*

(ii) The delay in issuing the second letter was *'due to a number of factors – the complexity of the issues raised, a genuine desire to fully address all issues…and changes within the Complaints team.'*

(iii) The Consultant apologised for his *'contribution to the delay in providing the Trust responses and the distress it has caused'.*

106. I have examined the Trust's documentation relating to the complaint. On 3 June 2014 the Trust received the complaint. It was not until 29 September 2014 that the Trust issued its response to that letter. In its response the Trust apologised to her for the delay in providing a response. On 12 November 2014 the Trust received a second letter. It was not until 13 November 2015 that the Trust issued a written response to this letter. In that response, the Trust apologised for the delay in providing a reply. On 21 January 2016 the Trust received a third letter. A meeting took place to address the issues raised in the letter on 17 May 2016.

107. I have reviewed the complaints chronology and associated emails provided by the Trust. This documentation records the instances of communication between the Trust Complaints Department, service managers and medical staff who were contacted as part of the investigation. Although it is unclear from the records what caused some of the delays I am satisfied that they were partly caused by delays in receiving responses from members of medical staff.

Analysis and Findings

108. I note the Trust's acknowledgement that there was an '*unacceptable*' delay in providing responses to the complainant as part of the HSC complaints

procedure. I consider that the failure of the Trust to provide timely responses in this case is contrary to the first principle of Good Administration 'Getting it Right' which requires a public body to act in accordance with its policies and guidance. I also find that this failure is contrary to the second principle of Good Administration 'Being Customer Focused' which requires a public body to deal with people promptly and sensitively. **I therefore uphold this element of the complaint.**

109. I consider that the Trust's failure to provide timely responses to the complainant did not meet the standards required by those Principles and these failings constitute maladministration. As a consequence of the maladministration, I am satisfied that she suffered the injustice of uncertainty and frustration due to the excessive delays in the Trust responding to her correspondence. I note that the Trust has provided her with an apology for these delays and I am satisfied that this represented in part an appropriate remedy for the injustice. I will deal with the issue of remedy in the conclusion of this report.

110. Having examined the complaints chronology and associated emails provided by the Trust I am satisfied that a significant factor causing the delays was the time taken by the respondents to assist in the Trust's investigation of the complaint. I also note the Consultant's comments on this issue.

111. In its response to the draft report the Trust informed me that it *'has introduced Trust-wide Key Performance Indicators (KPIs) for the complaints process which include a KPI designed to decrease the number of complaints taking [greater than] 40 working days to provide a response to the complainant and another KPI to increase the number of complaints resolved within 20 working days'*. The Trust also stated that its complaints procedure *'includes an enhanced escalation protocol whereby complaints not responded to within key timeframes are brought to the attention of relevant senior Trust staff.'*

112. I note and welcome the introduction of the KPI's in the Trust's complaints procedure. Having carefully considered this information I have decided that this removes the need for a recommendation for the Trust to establish internal key

performance indicators in its complaints procedure. Had the Trust not made this systemic improvement, I would have recommended internal KPI's for the Trust's complaints handling process in my final report.

CONCLUSION

113. The complainant submitted a complaint to me about the actions of the Trust in relation to a number of issues concerning the care and treatment of her late father at Belfast City Hospital Cancer Centre.

114. She also complained about the level of communication with medical staff, and the Trust's handling of her complaint.

115. The investigation identified the following failure in the care and treatment provided to the complainant's father:

- The Trust failed to provide the 'no treatment' option at the patient's consultation on 27 August 2013.

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

- The Trust's failure to provide alternative contact details for support services to the patient.
- The Trust's failures in record keeping identified in this report.
- The Trust's failure to provide clear information on transport provision to and from the Belfast City Hospital Cancer Centre.
- The delays in the Trust providing a response to the complaint.

The investigation did not uphold elements of the complaint related to:

- The decision to treat the patient as an outpatient
- The provision of support to the patient and his wife in Glenview House
- The Trust's treatment of the patient's mucositis
- The care provided to the patient on his final day of radiotherapy treatment
- The provision of the patient's records to Altnagelvin Hospital
- The communication between medical staff and the complainant during her father's time in hospital.

117. I am satisfied that the maladministration I identified caused the patient to experience the injustice of loss of opportunity, upset and uncertainty and caused his wife to experience the injustice of upset and uncertainty. I am also satisfied that the maladministration I identified caused the complainant the injustice of upset, uncertainty and frustration.

Recommendations for Remedy

118. As the patient has passed away, it is not appropriate to make recommendations directed at remedying the injustice he personally suffered. However, having considered all relevant facts and evidence in this case and the nature and extent of the injustice sustained by his daughter in consequence of the maladministration I have identified, I recommend the following:

- The Trust should apologise to the complainant for the failures identified in this report.
- The complainant should receive a payment of £750 by way of solatium for the injustice I have identified.

119. That the Trust should provide the apology and a payment within one month of the date of my final report.

120. In order to improve the service delivery of the Trust I also recommend the following:

- The Consultant Clinical Oncologist should be reminded of the importance of record keeping in line with GMC guidelines.

121. I recommend that the Trust should provide me with evidence that this recommendation has been actioned within three months of the date of my final report.

122. I acknowledge and welcome the changes made by the Trust in relation to:

- The provision of information to patients in relation to support services
- The Consultant's provision of the 'no treatment' option to patients
- Guidance to patients on transport provision to the Cancer Centre
- Information to residents of Glenview House in relation to changing carers
- The assessment of Glenview House residents midway through a patient's treatment
- The provision of a key worker for patients receiving radiotherapy treatment for head and neck cancer
- The sharing of oncology records between the Health & Social Care Trusts
- The introduction of KPI's in the Trust's complaints procedure.

Marie Anderson

MARIE ANDERSON
Ombudsman **May 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.