# Investigation Report

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

**NIPSO Reference: 18023**

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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 about the actions of Belfast Health and Social Care Trust (the Trust). The complainant alleged that his 87 year old father had sustained injustice because of the Trust's failure to clinically assess him as 'urgent' for his total right hip replacement.

I accepted the following issue of complaint for investigation:

- Was the Trust's assessment for total hip replacement surgery as 'clinically routine' appropriate in the circumstances?

My investigation did not find any evidence of a failure in the assessment of the patient. I have found maladministration in relation to the failure to advise the patient's GP of the decision not to reconsider him as an urgent patient.

I recommended the Trust pay the patient a sum of £150 in respect of the uncertainty and frustration sustained by him on failing to be advised of the consultant's consideration of his referral. I also recommended that the Trust revises its practice to ensure GP's and patients are advised of the outcome of all referrals, including requests made by a GP to reconsider a patient's referral category.

# THE COMPLAINT

1. The complainant alleged that his father had not been appropriately assessed for hip replacement surgery. He complained his father ought to have been assessed as an urgent case for replacement of his right hip. The Trust had assessed his father as routine. He also complained that the period between his first referral on 21 November 2016 to expected surgery in June 2018 (some 20 months) was an unreasonable time to wait.

2. The issue of complaint which I accepted for investigation was;

   - Issue 1: Was the Trust's assessment of the patient for total hip replacement surgery as 'clinically routine' appropriate in the circumstances?

# INVESTIGATION METHODOLOGY

3. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the complaint. This documentation included the patient medical records together with information relating to the Trust's investigation of the complaint.

4. A copy of the draft report was shared with both the Trust and the complainant. The Trust provided additional information in its response. The complainant did not provide a response to the draft report. I have carefully considered the Trust's response in light of the additional information obtained.

5. After further consideration of this complaint, independent professional advice (IPA) from a Consultant Orthopaedic Surgeon was sought. The IPA is a Consultant Trauma & Orthopaedic Surgeon in the NHS with over 15 years' experience in clinical orthopaedics. Following receipt of the Trust's comments to the draft report, additional IPA was sought.

6. The information and advice which have informed my findings and conclusions are included within the body of this report. The IPA has provided me with advice. However how I have weighed this advice, within the facts of this case, is a matter for my discretion.

**Relevant Standards**

7. 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[1]:

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

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

   The specific standards relevant to this complaint are:

   - Department of Health Integrated Elective Access Protocol (2008) (DOH IEAP)
   - Belfast Health and Social Care Trust Integrated Elective Access Protocol – Guidance for Staff (2015) (2015 guidance)

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.

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

# THE INVESTIGATION

**Issue 1: Was the Trust's assessment of the patient for total hip replacement surgery as clinically routine appropriate in the circumstances?**

10. The complainant stated that his father was assessed as 'clinically routine' by a Consultant Orthopaedic Surgeon in June 2017. He complained that his father ought to have been assessed as 'urgent'. Further, he complained that as a result of this failing he had sustained an injustice. His father was placed on the waiting list as a clinically routine patient with an expected date for operation of June 2018. The complainant stated that the period between his father's first referral on 21 November 2016 to expected surgery in June 2018 (some 20 months) was unreasonable. He confirmed that his father's GP forwarded a report marked 'urgent' to the Consultant Orthopaedic Surgeon on 21 June 2017 prior to his formal complaint. He states the GP's report on his father's needs was ignored by the Trust. The complainant seeks an explanation as to the Trust's criteria for determining how 'urgent patients' are prioritised for orthopaedic surgery and clarification as to how an 'urgent patient' is defined by the Trust.

11. I note from an examination of the records that the patient's GP Practice forwarded referrals to Musgrave Orthopaedics (ICATS) on 21 November 2016 and 2 December 2016. Both referrals were classed as 'routine' by the GP Practice. Following an assessment, the Trust's ICATS team referred him on 4 April 2017 for consideration for a 'right total hip replacement'. He was examined by the Consultant on 20 June 2017 as having *'a stiff and irritable right hip, and attempted movements reproduce his symptoms. His x-rays confirm that he has bone on bone changes in the right hip."* He was placed on the waiting list for right total hip replacement. On 21 June 2017 his GP forwarded a third referral to ICATS advising that he believed *"that there is a serious risk of irreversible deterioration in this patient's physical and mental health, which could be prevented by him having a hip replacement and appropriate rehabilitation following this."* The GP therefore requested that consideration should be given to making this an 'urgent' case. The Trust wrote to the complainant on 13 July 2017 advising that a letter was received from his father's GP on 23 June 2017.

This was reviewed by the consultant. The complainant was subsequently informed his father's condition remained as clinically 'routine'.

12. As part of the investigation enquiries, I have considered the Department of Health Integrated Elective Access Protocol (2008) (DOH IEAP). I consider the following extracts of this protocol to be of particular relevance:

Regional Targets

*'The targets in respect of elective treatments are:*

*…a maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009…'*

Underpinning Principles

*1.2.1 'Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by speciality/procedure/service.*

*1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients'…*

Guidance for Management of Outpatient Services

Key Principles

*3.3.2 'All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine'…*

3.3.5 *'Patients of equal clinical priority will be selected for booking in strict chronological order. Trust must ensure that Department waiting and booking targets and standards are met'…*

Protocol Guidance For Management Of Elective Admissions

Calculation of the Waiting Time

*'The starting point for waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic*

*intervention, and that the patient is medically fit to undergo such a procedure.'*

13. As part of investigation enquiries, the Belfast Health and Social Care Trust Integrated Elective Access Protocol – Guidance for Staff (2015) was examined. I consider the following extracts of this guidance to be of particular relevance:

    Prioritisation
    *'Each referral letter should be seen and prioritised on clinical grounds by the clinician or their authorised deputy. The clinician should indicate clearly on the referral letter whether the case is urgent, routine or red-flag suspect cancer…**ALERT: ENSURE CONSULTANT PRIORITY RECORDED e.g. GP URGENT REFERRAL PRIORITISED BY CONSULTANT AS RED FLAG.**'*

    New Outpatient Referrals – added to Inpatient/Day Case Waiting List
    *'The clinician or authorised deputy may decide to add a referral directly to a waiting list for inpatient or day case treatment.*

    Adding a Patient to the Waiting List
    *'Consultant indicates the appropriate priority category. All patients added must:*
    - *Be medically fit for their procedure at the time of boarding*
    - *Be available and willing to attend for their procedure*
    - *Not be awaiting results of either treatment or diagnostic tests in relation to their procedure*

    *Priority Category: Urgent, Routine, Suspect Cancer…Date added to waiting list = date of decision to admit…'*

14. In response to investigation enquiries, the Trust stated the patient's referral was assessed by ICATS on 23 November 2016. At this point, the patient's referral was graded as a routine referral based on the information provided in the referral form and available imaging. The Trust stated it is not uncommon for patients who are referred for an outpatient appointment as an urgent patient by their primary care clinician to be downgraded to routine once assessed by an Orthopaedic specialist. The consultant assessed the patient as a routine case on 20 June 2017. He then

added him to the inpatient surgical waiting list for right total hip replacement. The Trust stated that all patients are triaged through the ICATS service to ensure only those patients who may require surgery are seen by an orthopaedic consultant, as many patients are effectively treated through non-surgical methods in the ICATS service. The Trust clarified the referrals are graded as either routine or urgent to ensure those patients who are in the greatest need are given priority. The complainant's father was initially directed to ICATS and it was then determined he required further assessment by an Orthopaedic Consultant Surgeon at Musgrave Park Hospital. The Trust explained that the decision to proceed with surgery is based on clinical presentation, radiological findings and medical history. Therefore it was only during the consultation that the decision was made for him to be added to the inpatient waiting list.

15. In relation to waiting times, the Trust stated that unfortunately across the Trust there is a very high demand for orthopaedic surgery and that the demand currently exceeds the Trust's available capacity. This resource gap has led to increased waiting times for appointments that are extended longer than the Trust would wish. In response to this complaint the Trust apologised for the delay experienced by the complainant's father. However the Trust confirmed it is required to ensure urgent patients are treated as priority in order to protect patient safety. The Trust confirmed that it is also required to ensure that all patients are seen and treated in chronological order in compliance with DoH IEAP guidelines. The Trust stated unfortunately the current waiting time for routine surgery is presently 12-13 months. Therefore a date for surgery was expected for approximately June 2018.

16. In his complaint to my office the complainant sought an explanation and production of evidence as to the criteria used to assess a patient as urgent, and a transparent definition as to how 'urgent patient' is defined by the Trust. In relation to the criteria for urgent patients, the Trust stated patients are only considered as 'urgent' for hip replacement if they meet the following criteria:

- *'Revision of a Primary Joint is required*
- *The patient presents with rapidly progressing Osteoarthritis (RPO)*
- *Clinical assessment deems that the patient is imminently immobile or unable*

*to walk.'*

The Trust also clarified that in very rare circumstances, a patient may be considered urgent who lies outside of the above. However, the Trust also stated that these cases are carefully considered by the consultant on a case-by-case basis. The Trust stated that the consultant concluded that the complainant's father did not warrant urgent status as he did not meet the above criteria and that this decision was based on the consultant's knowledge and experience. The Trust also confirmed it does not use any formal psychosocial assessments in grading of patients for hip replacement surgery. The Trust stated that a letter was received from the GP on 23 June 2017 asking for him to be considered as an urgent patient. This GP request was based on medical and psychological grounds. His condition was reassessed by the consultant who determined he was to remain as clinically routine. The Trust stated to ensure an equitable service, routine patients are appointed a date for surgery based on the date they were added to the inpatient waiting list in compliance with the DOH IEAP guidance. The Trust stated the consultant's waiting time for surgery for routine patients is approximately 12-13 months and there is a four month waiting time for urgent patients.

17. In relation to targets for routine and urgent referrals, the Trust stated that *'By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.'* However the Trust added it does not have sufficient capacity to see all patients within the current targets. The Trust stated a patient's waiting time for surgery does not begin when the primary care clinician refers the patient to a consultant orthopaedic surgeon, as the referring clinician is not an Orthopaedic Surgeon. In this case, the waiting time for surgery began from when he was added to the inpatient waiting list on 20 June 2017. In relation to ICATS targets, the Trust stated the current target to be seen by ICATS following a GP referral is 13 weeks. However the complainant's father waited a total of 17 weeks.

18. In relation to whether it was appropriate for him to be assessed by the consultant as clinically routine, the IPA advised *'There is no mention in the clinic letter of any particular reason why [he] should be considered an urgent case and I have not seen*

*anything in the medical notes to suggest this would be an urgent situation.'* The IPA further advised *'Unless there are clinical indications of urgency like revision surgery or rapidly progressing destructive arthritis, there is no indication of labelling [his] condition as urgent.'* The IPA acknowledged the large volume of referrals received by the Trust and advised that putting this down *'as an urgent case would push back another patient who is equally debilitated with pain.'*

19. In relation to the waiting time for orthopaedic surgery, the IPA advised *'the current patient charter for the NHS states that for non-urgent referrals (ie not cancer) patients should expect a referral to definitive treatment time of 18 weeks…However due to extreme pressures and lack of resources within the NHS, these recommended times are currently frequently breached.'* The IPA clarified that the waiting time should be calculated from 5 April 2017 and not November 2016 as the GP initially referred him to ICATS. The IPA further advised, *'Therefore while it is unreasonable to expect an 87 year old gentleman to wait over a year for a hip replacement surgery, it is sadly not uncommon in the current state, particularly in Northern Ireland. However as per the NHS patients charter[2], the Trust should have taken steps to arrange for this service to be provided by an alternative provider, if patient requests so. I have not seen any indication of this having happened in present case.'*

20. In relation to the criteria for assessing patients as either routine or urgent, the IPA advised that those patients suspected of cancer are prioritised for treatment. The IPA outlined a number of factors that would make some cases more urgent than others such as; revision hip surgery, particularly aggressive arthritis that is destroying the bone rapidly and if a patient is significantly debilitated and imminently immobile. In relation to the criteria used by the Trust to assess patients for hip replacement surgery, the IPA concluded *'In my opinion the Trust has been reasonable and appropriate in assessing and grading [the] condition.'* The IPA acknowledged the lack of resources within the NHS to provide life changing treatments such as hip replacements and that the situation in Northern Ireland is particularly difficult. The IPA suggested *'The Trust could perhaps look into alternative providers to outsource care of patients who are waiting unusually long for their surgery.'*

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[2] This right only applies to services commissioned by the NHS in England

21. In response to the IPA, the Trust was asked whether consideration was given to referring the complainant's father to an alternative provider due to his lengthy wait for surgery. The Trust stated that it works closely with the Health and Social Care Board (HSCB) to regularly secure additional funding to establish additional theatre lists to try to reduce waiting times. However the Trust stated that demand currently exceeds capacity. The Trust stated it obtained funding from the HSCB in 2017. However the first allocation of funds between January and March 2017 was prior to the patient's addition to the waiting list. The second allocation from HSCB was obtained late 2017. The Trust added that as part of both allocation of funds, the longest waiting patients were selected and sent out to external independent sector providers working on behalf of the Trust. The Trust stated that all patients who were sent out were selected based on their position on the inpatient waiting list and had been waiting longer for surgery than the complainant's father. The Trust provided evidence of those patients on the waiting list who were referred for surgery to external independent providers. I have examined an extract from this list and note that those patients who were sent to independent providers for treatment in late 2017 had been added to the waiting list in May and June 2016. These patients had therefore been waiting for surgery for a period of over a year longer than the patient's father.

22. The Trust also stated it received a message in February 2018 that the patient had undergone his operation and should be removed from the waiting list. The Trust added it could not confirm the source of the operation but were informed of this after sending him an appointment for a pre-operative assessment. The Trust also stated it accepted the IPA comment that it is unreasonable to expect an 87 year old patient to wait over a year. The Trust apologised for this but commented that unfortunately this is currently not uncommon in Northern Ireland.

The Trust's response to the draft report

23. In relation to the Trust's failure to meet the 13 week target for ICATS referrals, the Trust stated that the patient's referrals were appropriately prioritised as routine and his referrals were managed in line with DoH and IEAP principles. The waiting times at that time were 17 weeks and the patient was treated in chronological order alongside other routine referrals. The Trust stated ICATS are not meeting the 13

week target as they have been accepting an increased volume of referrals from the Consultant-Led outpatient service as part of Orthopaedic waiting list initiatives aimed at reducing the lengthy wait to see a Consultant. This decision was taken by the Trust and the HSCB to try to address inequality of waiting times within Orthopaedics for different conditions. This is line with the Principles of Good Administration, to ensure fairness.

24. The Trust further stated waiting times for neck, back and upper limb conditions are considerably longer than those for hip and knee conditions. New ways of working including a Regional Spine Pathway, co-location of ICATS alongside Orthopaedic Consultants and the Transfer Out of referrals on the Outpatient Waiting List to ICATS were introduced to help provide additional capacity and improve elective access within the Orthopaedic Service. This has enabled the longest waiting patients to be seen more quickly but regrettably has resulted in failing to meet the 13 week target by approximately 4 weeks.

25. In relation to the consideration of second referral from the patient's GP, the Trust explained that GP referrals to Orthopaedic Services are assessed by a clinical specialist and graded as clinically urgent or clinically routine. At the first stage the referrals are usually triaged by Orthopaedic specialist nurses with the assistance of the criteria (Para 16 refers). The Trust stated what usually constitutes urgent for a hip/knee referral is tumour, ulceration, respiratory or neurological compromise, Rapidly Progressing Osteoarthritis. However pain is not a factor in determining the urgency of a referral. If further referrals come in with updated information from the GP or another source such as a letter from family/patient, the information is presented to the consultant to make a determination on whether this impacts on the clinical grading. The Trust stated the consultant has signed and dated the GP referral. The Trust also provided a screenshot from its Information system on 23 June 2017. I note this record states *"Letter and email received from GP and patient's son asking for patient to be considered as urgent, seen by [the consultant] and he has said to remain routine."*

26. The Trust added that across orthopaedics service in Northern Ireland the demand for surgery greatly outweighs the capacity of the service. The Trust stated it continues to look for innovative ways of improving the service in order to reduce the extended waiting times. The Trust stated it has worked with commissioners and other Trusts in order to introduce pathways such as the ICATS pathway as outlined above. The Trust explained it is currently working with the HSCB to agree funding for a business case to fund five new consultant appointments for Orthopaedics in a bid to increase capacity and reduce waiting times. The Trust further stated it has already processes in place for outsourcing patients to an alternative provider to reduce waiting times and this happens under direction from the HSCB when ad-hoc funding is obtained.

27. The Investigating Officer sought clarification from the Trust in relation to whether communication was issued to the patient's GP advising of the consultant's consideration of the revised referral on 23 June 2017. The Trust confirmed that no such communication was issued to the GP. The Trust stated given the number of patients it receives multiple referrals for, it would not be practical to communicate with the GP to update them especially as in this case the clinical urgency had not changed. The Trust further stated that if the surgeon reviews the patient and decides they are in fact clinically urgent, in this case the usual practice is that the secretary will communicate this to the patient themselves and advised of a revised timescale.

28. As part of this investigation, the Investigating Officer shared the Trust's view with the IPA and sought clarification on this issue. The IPA noted that the consultant had considered the case to be routine and there had been no interim change in the situation when the GP letter was received on 23 June 2017. The IPA advised he could understand why the consultant did not consider it necessary to further document his clinical reasoning as to why the patient was to remain clinically routine. The IPA advised *"However, I think a communication to the GP to this effect would constitute good medical practice as well as professionalism."* The IPA referred to GMC standards for record-keeping and although the consultant had recorded 'noted' on the referral letter, there is no further documentation to support this decision. The IPA advised *"This is not ideal record-keeping and it would have been advisable for the consultant or a team member to respond to the GP as to the reason why the GP's request to expedite [the patient] was being declined. Apart from being in*

*accordance with GMC's standards of record-keeping, this also constitutes professionalism and common courtesy."*

29. The IPA did not agree with the Trust's comments and further advised *"While I understand that the Trust receives a lot of referrals, not all of them attract secondary comments from the GPs. GPs also have a busy practice and if a concerned GP has written to a clinician in secondary care regarding a patient, it would constitute common professionalism and etiquette to acknowledge the GP's communication and respond to him appropriately. Being busy is not a good enough reason not to respond to a GP's query. The clinician does not necessarily have to agree with the GP's request or decision, but this needs to be communicated appropriately."* The IPA concluded that the Trust's communication with primary care physicians needs to be improved given they are currently unable to provide a service according to National guidelines and recommendations. The IPA advised *"It is the Trust's responsibility to to ensure they are able to reassure patients and GPs adequately when a concern is being raised, more-so as the level of care being provided is far from ideal."*

**Analysis and Findings**

30. The complainant was concerned that his father was not considered to be an 'urgent' patient, and about the lengthy wait he had for surgery. I note consideration was given to the GP's request for his father to be re-assessed as an urgent patient. However the consultant confirmed his original decision that he was assessed as 'clinically routine'. It is clear from the DOH IEAP that although the primary care clinician can make a recommendation of this nature, the Orthopaedic Consultant ultimately decides where a patient will be placed based on their clinical assessment of a patient. The Trust has clarified the criteria used by it for the assessment of urgent patients, which has been acknowledged as appropriate by the IPA. I therefore accept the advice of the IPA that *'the Trust has been reasonable and appropriate in assessing and grading [the patient's] condition as routine'.* I therefore do not uphold this issue of complaint.

31. In relation to the wait for hip replacement surgery, I note the overall waiting time does not include the processing of a referral by ICATS. I am concerned that in this instance there was delay in the time taken to be seen by ICATS to have exceeded the target time of 13 weeks by a further four weeks. However I acknowledge the difficult position currently faced by ICATS due to the increased volume of referrals and that the waiting times for routine referrals at that time were 17 weeks. The Trust has also stated that recent initiatives aimed at enabling the longest waiting patients to be seen more quickly has regrettably resulted in failing to meet the 13 week target for ICATS waiting times.

32. I note that according to DOH IEAP, the time should begin from the decision to add him to the waiting list, which was on 20 June 2017. He was expected to wait 12 months for his surgery. The DOH IEAP requires that patients are added to the waiting list in chronological order in a fair and equitable fashion, which from the evidence available I consider has occurred in this particular case. The Trust has also confirmed that unfortunately the patient was not selected for external health care as he was not one of the longest waiting patients. I have found that those patients who were selected for surgery from an external provider had been added to the waiting list over a year earlier than him. I therefore find there was no maladministration in this regard.

33. In the Trust's response to the investigating officer on 20 October 2017, the Trust stared that *'in very rare circumstances, a patient may be considered urgent who lies outside of the above, however these are carefully considered by the consultant on a case by case basis*.' This investigation has established that the patient's GP sent a further referral on 23 June 2017 requesting that consideration be given to making the referral urgent. Although there is evidence that the consultant noted this revised referral, the Trust has confirmed that there was no communication back to the GP following the referral on 23 June 2017. I accept the advice of the IPA that the failure to communicate back to the GP to advise why the request to expedite the patient's treatment was being declined is not in accordance with GMC standards of record keeping. I consider communication to the GP to this effect would constitute good medical practice, professionalism and common courtesy. In considering this issue I have had regard to the Principles of Good Administration. The First Principle requires

public bodies to ‘Get it Right’ by taking account of established quality standards and good practice. The Third Principle requires public bodies to be ‘open and accountable’ by stating the criteria for decision making and give full reasons to their customers for their decisions. I consider the failure to advise the patient’s GP of the decision not to reconsider him as an urgent patient does not meet these principles, which constitutes maladministration. As a consequence of this maladministration, the patient experienced the injustice of uncertainty and frustration as to the status of his referral.

# CONCLUSION

34. I note that the complainant sought by way of remedy an explanation as to the criteria for urgent orthopedic surgery. Further he sought the Trusts’ definition of an urgent patient. I hope this report provides that explanation. Further in relation to the maladministration and injustice that I have identified in this case, I recommend the Trust pay the patient a sum of £150 in respect of the uncertainty and frustration sustained by him on failing to be advised of the consultant’s consideration of his referral. I also recommend that the Trust revises its practice to ensure GP’s and patients are advised of the outcome of all referrals, including requests made by a GP to reconsider a patient’s referral category.

**General Comment**

35. It is wholly unacceptable and a matter of grave concern that an 87 year old man should have to wait for replacement hip surgery within the timeframes in this case. As the IPA has concluded, the patient *has ‘unfortunately become a victim of the current crisis in the NHS arising from increasing numbers of patients requiring life changing surgery and the lack of resources to provide these treatments*.’ The IPA has recognised that the position is particularly acute in Northern Ireland and has suggested that the Trust should have in place a process for routinely outsourcing long wait patients to another provider given there is no immediate solution in sight. I am mindful however of the particular funding challenges facing this and other Trusts

in Northern Ireland. I am also mindful that this issue does not form any part of this complaint to my Office. I will **not** therefore recommend that consideration be given to this proposal at this time.

Marie Anderson

**MARIE ANDERSON**
**Ombudsman** **May 2019**

**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.