Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 18933

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint regarding the actions of the South Eastern Health and Social Care Trust (the Trust). The complaint concerns the Trust's downgrading of the complainants daughter's plastic surgery referral from 'urgent' to 'routine'.

I accepted the following issues of complaint for investigation:

(i) **Did the Trust appropriately manage the complainant's referral by the GP?**

I have found maladministration in relation to the Trust's failure to notify the referring GP of the plastic surgery consultant's decision to downgrade the patient's referral. I have not found any failure in the plastic surgery consultant's decision to downgrade the patient's referral.

In relation to the maladministration and injustice that I have identified in this case, I recommend the Trust pay to the complainant by way of solatium a sum of £100 (within one month of this report in respect of the injustice suffered by the complainant and the patient, who both suffered a degree of distress and inconvenience.

THE COMPLAINT

1. The complaint was about the actions of the South Eastern Health and Social Care Trust (the Trust). The complaint concerned the Trust's decision to downgrade the patient's, surgical referral for hidradenitis suppurativa[1] from 'urgent' to routine'. The complainant felt that the decision failed to consider the patients complex medical history and learning difficulties. The complainant was also concerned that the patient would have to be on long term antibiotics while awaiting a consultation. The complaint also included the decision to downgrade the patient's urgent referral which was not communicated to him or the referring GP.

Issue of complaint

2. The issue of the complaint which I accepted for investigation is:

   Issue 1: Did the Trust appropriately manage the patient's referral by the GP?

INVESTIGATION METHODOLOGY

3. To investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

   - Consultant Plastic Surgeon. This IPA is a consultant plastic surgeon who previously carried out two years of full time research on skin biology. The consultant has also served as the service lead for plastic surgery in a teaching hospital.

[1] Hidradenitis suppurativa is a painful, long term skin condition that causes abscesses and scarring on the skin. www.nhs.uk/conditions

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has provided me with advice. How I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. 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[2]:

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

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

8. The specific standards relevant to this complaint are:
    - The Department of Health, Social Services and Public Safety's Integrated Elective Access Protocol (2008). (The IEAP)

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.

As part of the NIPSO process, a copy of this draft report was shared with the complainant and The Trust for comment on the factual accuracy and the reasonableness of the findings and recommendations.

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

INVESTIGATION

Issue 1: Did the Trust appropriately manage the patient's referral by the GP?

Detail of Complaint

10. The complaint concerned the Trust's decision to downgrade the patient's surgical referral for hidradenitis suppurativa from 'urgent' to 'routine'. The complainant felt that the decision failed to consider the patients complex medical history and learning difficulties. The complainant was also concerned that the patient would have to be on long term antibiotics while awaiting a consultation. The complainant also complained that the decision to downgrade the patient's urgent referral was not communicated to him or the referring GP who were mistakenly under the impression that the Trust were dealing with the matter as urgent.

Relevant Protocols

11. I have reviewed the IEAP. I note that the IEAP places certain obligations on the Healthcare Trusts regarding how they process referrals. In particular I note the following two extracts:

    -1.7.12 (d) refers to urgent referrals and states '*[p]atients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process'.*

    - 1.7.13 (c) refers to routine referrals and states *'[p]atients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow'.*

12. I have also reviewed the targets set by section 1.4.1 of the IEAP, in particular I note that the IEAP states that there should be *'[a] maximum waiting time of 9 weeks for a first outpatient appointment by March 2009'*.

Relevant Medical Records

13. The initial referral from the patient's GP was stamped received on 8 November 2017 by General Surgery in the Belfast Trust who redirected the referral to the

plastic surgery service in the South Eastern Health and Social Care Trust (The South Eastern Trust). The referral was received by the South Eastern Trust on 4 December 2017. The referral documented that the patient had *'cognitive and learning problems associated with having had a malignant brain tumour in childhood and chemo and radiotherapy. [The patient] has a ventriculoperitoneal[3] shunt in place and still attends neurosurgery… Previously [the patient] was taking a lot of axillary infections but these seem to have settled. Over the last 18 months [the patient] has had recurrent groin infections and in the pubic area. [The patient] responds well to Flucloxacillen[4] and then these remain at bay so as she continues with one fluclox nocte. She has now rotated onto Erythromycin.[5]'* The referral from the patients GP requested an 'urgent' status. This referral was stamped received by the South Eastern Trust on 4 December, the stamp has two boxes headed 'consultant urgent' and 'consultant routine'. Once he had finished his review, the triaging consultant ticked the 'routine' box, indicating his decision to downgrade the referral to a routine referral.

14. In a subsequent referral, dated 1 May 2018, the patients GP resubmitted the initial referral form along with a new cover letter explaining that the patient *'had initially been referred to Belfast City Hospital regarding her marked hidradenitits of her groins in November 2017 and our understanding is that this was redirected to you for management. When [the patients] father made enquiries as to the waiting time to be seen, he was told that it would be Autumn 2019 at the earliest*.' The patients GP explained that her '*recurrent and persistent symptoms are causing her some distress and affecting her mental well-being. She has a complex history with a VP Shunt following surgery for a medulla-oblongata tumour, and she also has learning difficulties as a result.'* The letter concluded with '*we would be grateful if you would expedite her appointment'.*

[3] A medical device that relieves pressure on the brain caused by fluid accumulation.
[4] A medication used to treat infections caused by susceptible Gram-positive bacteria.
[5] Erythromycin is used to treat a wide variety of bacterial infections

The Trust's responses to our enquiries

15. The Trust explained that the original referral had come through the general surgery service in the Belfast Trust, who had redirected it to plastic surgery. The referral was received by the South Eastern Trust on 4 December 2017 and was passed to triage. The Trust stated that the referral *'contained all medical information in relation to [the patients] past history'*. The referral also explained that the patient's condition had been ongoing for '*the past 18 months'*. In the referral, the GP explained that the patient '*had responded well to antibiotics'*, but that the patient did not want to be taking antibiotics long term. The Trust explained that the *'consultant triaging this referral determined that the referral was routine. This referral was therefore added to the waiting list as a routine referral. [The patient] was advised, when he telephoned the Trust, that the waiting time was 98 weeks for a routine referral.'* The Trust advised that it '*sought advice from both plastic surgeons and dermatologists for treatment of this condition and for prioritisation of the referral. All [were] in agreement that this condition … should be categorised as a non-urgent referral'.* The Trust further stated that *'it is the clinical opinion that it is reasonable to be on antibiotics for an extended period if the professional responsible for these continues to monitor the effectiveness and side effects, if any. In this case, the GP who prescribed the antibiotics was responsible for the monitoring'.*

16. Regarding the second referral, the Trust explained this *'was received into the Trust on 6 May 2018 and when triaged by a consultant, was upgraded to urgent'.* The Trust stated that a '*further referral was received into the Trust and triaged by a consultant plastic surgeon on 15 May 2018 as an urgent referral. This change in priority was immediately upgraded on the Trust system. The second referral identified that 'her recurrent and persistent symptoms [were] causing her some distress and affecting her mental wellbeing.*' The patient was then assessed '*within 5 weeks'* of being triaged as urgent. In response to a request for any applicable policies or protocols, the Trust also advised that *'National Policies and Guidance relate only to the treatment of severe cases of Hidradenitis Suppurativa and suggest antibiotics that are prescribed by dermatologists.'* The Trust also confirmed its intention to *'share [the complainants] complaint with the Health and Social Care Board…with the*

intention of pursuing improved multiagency coordination and communication in the provision of health care for patients who have multiagency support needs.'

17. The Trust was asked whether any efforts were made to contact the complaint or the GP regarding the decision to downgrade the initial referral. The Trust stated that *'there is no Trust policy for contacting patients or the General Practitioner regarding a referral into the service, nor would it be normal practice to do so.'*

18. In its response to further enquiries, the Trust identified who it believed was the '*initial and subsequent'* triaging consultant and confirmed that '*no additional information' was provided to the triaging consultant beyond the information presented in the referrals.*' I note that the Trust had initially identified to this office wrongly that both referrals were triaged by the same consultant.

19. The Trust also commented that *'[t]here is no policy for contacting patients or the General Practitioner regarding a referral into the service, nor would it be normal practice to do so. The Trust receives over 100,000 referrals per year with the Plastic Surgery Service receiving approximately 6000.'* In regards to the timing of the referrals, the Trust stated that *'[t]he first referral was received into the Trust on 4 December 2017.'* Although the trust could not confirm '*the exact date of triage … it would likely have been between 4 and 7 December 2017.'* The subsequent referral was received on 6 May and was triaged on 15 May 2018.

20. On 3 October 2018, the Trust clarified that there are three categories of referral. The most urgent is for suspected cancer. There are also categories for urgent referrals and routine referrals. The Trust also restated that *'[t]here is no policy for consultants, or anyone from the trust to contact referring physicians or patients regarding decisions on that patient's triage.'* The Trust also confirmed that this policy applies to situations where a patient is referred by their GP as 'urgent', but the referral is downgraded to 'routine' by the triaging consultant. Pursuant to this policy, the Trust confirmed that neither this patient nor her GP were contacted about the consultant's decision to categorise this

patient as a 'non-urgent' referral in December 2017. The Trust confirmed that after being triaged by the responsible consultant, the first contact with patients on behalf of the Trust is to schedule appointments with consultants. The Trust explained that it issues monthly publications which document the approximate waiting times for different types of referrals (suspected cancer; urgent; and non-urgent). To an extent, the Trust relies on the GPs to keep their patients updated about the waiting times. This is the case even though the GP may not be aware that their patient's triage category is not what the GP stated on the referral form. (That the triaging consultant has allocated a different urgency level than what was suggested by the GP).The Trust also confirmed that it does not have any policies, outside of the NICE guidelines for suspected cancer referrals, regarding how patients are triaged by plastic surgery consultants. On 14 January 2019, the Trust advised that '*the triage decision is based upon the clinical judgement...[r]eferrals are triaged, with the information provided by the referrer, taking into account the clinical priority based on clinical judgement and appropriate guidelines.'*

The Trust's Shared Learning Document.

21. During the investigation, the complainant provided a copy of a '*Shared Learning'*[6] document that had been sent to him by the Belfast Trust in October 2018. As the patient had complex care needs, she was receiving care from both the Belfast Trust and the South Eastern Trust. The Shared Learning document indicated that it had been shared regionally, including with the South Eastern Trust, who are the subject of this complaint.

22. Further enquiries were made of the Trust to ascertain whether they had received this document and if so, whether it had been acted upon. In response, the Trust provided a copy of their own Shared Learning Document, which was implemented in December 2018. This document acknowledged that the patients *'referral letters were not viewed in a holistic, person – centred manner and were clinically downgraded from urgent to routine. This caused*

[6] The Healthcare Trusts use the shared learning process to raise awareness amongst staff about issues affecting patients and their families. 'Shared Learning' documents are used to bring a particular matter to the attention of relevant staff in order to ensure that appropriate learning is taken from patients' experiences.

considerable distress to the patient's father as her sole carer.' The Shared Learning Document identified two learning points: *'Clinicians should take into account a patient's full medical and social history when deciding upon the clinical priority of a referral letter'*; and *'[p]atients with profound learning difficulties, complex medical needs and co-morbidities who are referred urgently for assessment should always be considered as urgent.'* This Shared Learning indicates that it was to be *'circulated to all clinicians in the Trust for information and action'.*

Independent Professional Advice

23. As part of the investigation, advice was sought from an independent medical advisor (IPA). The IPA reviewed the medical records and noted that '[a] *referral was made from primary care on 6 November 2017 requesting a new review in a general surgery clinic, this was received on 8 November 2017.* The IPA explained that *'the patient had been troubled by the problem for 18 months [and] that the condition responded to antibiotics but returned when they were stopped.*' The IPA also noted that the patient *'had other problems including impairment of cognition and learning, malignant brain tumour, previous radiotherapy and chemotherapy [and] a ventriculo-peritoneal (VP) shunt.'*

24. This IPA was asked to review the documentation that was submitted as part of the initial referral and comment on whether that referral was appropriately triaged. The IPA explained that '*hidradenitis supprativa is a chronic condition that is usually treated in primary care outside of a hospital setting.'* Regarding the initial referral in December 2017, the IPA commented such '*a referral would not normally be triaged as urgent*', indicating that in general, a '*routine'* categorisation would be appropriate. The IPA explained that '[t*]he referral does not state the presence of an abscess needing urgent surgical drainage*'. Regarding the complainant and the GP not being informed of the decision to downgrade the patient's referral, the IPA stated it is '*not routine to inform a GP or patient that a referral has been downgraded from urgent to routine'*. However, the IPA explained that although the patient's condition would typically be triaged as routine, because of '*the presence of a learning difficulty, the presence of a VP shunt, and the involvement of the patient's father in [the*

patients] care… it would have been good practice for the consultant responsible for triage of the referral to at the very least ask for a manager to inform the GP who can then respond and inform the father of the patient.'

25. The IPA was asked to comment on whether the Trust's failure to inform the GP or the complainant had any medical impact to the patient. The IPA concluded that, from a medical standpoint, *'it is unlikely that there has been any impact to the patient.'* The IPA explained that although *'hydradenitis supprativa is a chronic, frustrating condition, surgery is not the main element of management'.*

26. The IPA noted that the policy of not informing a GP of a change in referral status in circumstances such as this, is *'likely to cause potential for anxiety and worry'.* The IPA recommended that, in these circumstances, *'the Trust should have a formal and published appeal process to allow a GP to appeal if his/her referral on behalf of a patient is downgraded.' The IPA also emphasised the importance of establishing 'a clear pathway for chronic conditions such as this, which involve multiple specialities and tiers of care'.* Finally, the IPA recommended that it should be possible to '*establish a system for GPs and patients to follow a referral'.*

27. The Trust were provided with a copy of this IPA advice. In response, the Trust emphasised that their good practice document has addressed many of the issues raised by the IPA as it '*ensures that referrals of this nature will not be downgraded'.* The Trust therefore believe that there is no need for an 'appeal system'. Similarly, as a referral of this nature will always be treated as urgent, there is no need for a policy to inform GP's or patients of a downgraded status as this could not happen under the new policy.

28. The Trust also highlighted that although it has no ability to implement a system that allows GPs or patients to follow their referrals, *'the Department of Health…has approved a business case for the development of a new information system… called Encompass and the vision for the new information system will include a patient portal, which will individual citizens to access all*

relevant information in respect of their care. This new system should allow patients to follow their progress through the patient journey.'

29. The IPA also commented that sufficient time needed to be allocated from consultants *'to review and triage referrals with potential to respond in such difficult or exceptional circumstances'.* In response, the Trust stated that *'this complaint had nothing to do with consultants' time to review referrals.'* The IPA responded that the Trust had, in its initial response, emphasised that the Plastic Surgery Consultants triage '6000 referrals per year'. The IPA pointed out that this amounts to *'115 per week which is about 23 per week day. The vast majority will be very straightforward - for example basal cell carcinoma or carpal tunnel.'* The IPA explained that '*there will be very few referrals in which the GP has asked for an urgent referral, with explanation and mention of exacerbating factors, which are then downgraded to routine or even rejection. I would expect to be no more than 1-5 at most per day, perhaps less. It would be kind and reasonable to let the GP know that the referral was no longer considered urgent. This could readily be delegated to an administrator or even automated.'*

30. In follow up to his original advice, the IPA reiterated that he was very surprised that no call was placed to the GP based on the patients multiple comorbidities and complex medical history. However, he also appreciated that the Trust had implemented a shared learning document that improved on its service and covered most of the issues that he had raised.

31. The IPA was also asked to clarify whether long term antibiotics would have factored into the triaging plastic surgeon's assessment. The IPA advised that this would not be something the plastic surgeon would consider. It would be discussed between the patient and the GP, or in this case, the patient's father and the GP. From a plastic surgery perspective, it was not a consideration.

Analysis and Findings.

32. I have carefully considered the complaint. The complainant believed the Trust failed to properly consider his daughter's extremely complex medical history, including her history of infections, her long term antibiotic therapy, and her

learning difficulties. The complainant was concerned that the decision to downgrade his daughter's referral was not taken based upon her multiple complex medical issues which he believes should have factored into the determination about whether his daughter should be triaged as routine or urgent.

33. I have considered the triage referrals in November 2017 and May 2018. I note that the initial referral by the patients GP clearly detailed the extent of her comorbidities and her medical history. In particular, the referral noted that the patient *'has certain cognitive and learning difficulties associated with having a malignant brain tumour…'* and that *'over the last 18 months she has had recurrent groin infections and in pubic area.'* I note that this referral also provided the patient's relevant past medical history and medication profile and requested that she be seen urgently. I note that there are no records of how the triaging consultant arrived at his determination to downgrade the patient.

34. I have considered the advice provided by the plastic surgery consultant IPA. The IPA considered the nature of the condition for which the patient was being referred and explained that '*hidradenitis supprativa is a chronic condition that is usually treated outside of a hospital setting'* and that although it is a *'frustrating condition, surgery is not the main element of management.'* I have considered the Trust's response regarding the treatment of hidradenitis supprativa and note that the Trust '*sought advice from both plastic surgeons and dermatologists for treatment of this condition and for prioritisation of the referral. All [were] in agreement that this condition … should be categorised as a non-urgent referral'.* I have reviewed the Trust's position regarding the management of hidradenitis supprativa in the context of the advice provided by the IPA, who agreed that such a condition *'would not normally be triaged as urgent'.* In support of this, the IPA distinguished the patients condition from an *'abscess needing urgent surgical drainage'.*

35. In regards to the complainant's complaint about the effects of long term antibiotics on his daughter, I have considered the Trust's response that it is '*reasonable to be on antibiotics for an extended period if the professional*

responsible for these continues to monitor the effectiveness and side effects, if any'. I have also considered the IPA advice that this would not be something the plastic surgeon would consider. It would be discussed between the patient and the GP, or in this case, the patient's father and the GP. From a plastic surgery perspective, it was not a consideration. I accept the IPA advice that the effect of long term antibiotics should be monitored by the GP would not be a consideration for a plastic surgery consultant.

36. In regards to the complainants complaint that nobody told him or the GP that his daughter's referral had been downgraded, I note the Trust have stated that it does not have a *'policy for contacting patients or the General Practitioner regarding a referral into the service, nor would it be normal practice to do so.'* I have considered the IPA's advice about whether, in general, the Trust should contact a GP or a patient. I note that the IPA stated '*it is not routine to inform a GP or patient that a referral has been downgraded from urgent to routine.*'

37. Although the IPA agreed with the Trust that in general hidradenitis supprativa does not usually require an urgent referral, this does not encompass the totality of the complainant's medical care. The complaint was not about how the Trust manages hidradentitis supprativa in general. The complaint was about the management of his daughter, with her complex care and medical history encompassing multiple different medical specialities and ongoing treatments.

38. As noted in the referral form and by the IPA, the patient had a very complex medical history, including learning difficulties. Based on the totality of her clinical picture and '*the involvement of the patient's father in [the patients] care',* the IPA concluded that *'it would have been good practice for the consultant responsible for triage of the referral to at the very least ask for a manager to inform the GP who can then respond and inform he father of the patient.'* The IPA noted that he was very surprised that no call was placed to the GP by the triaging consultant. I have also considered the IPA's advice that the policy of not informing a GP of a change in referral status in circumstances such as this, is *'likely to cause potential for anxiety and worry'*

39. Having considered the complaint, the two referrals, the Trust's responses and the IPA advice, I accept the IPA's advice that although typically hydradenitis suppurativa would not require an urgent consultation, the patients complex medical history and learning difficulties should have prompted a conversation between the triaging consultant (or his office manager) and either the GP, or the complainant. Accordingly, I find that it was unreasonable for the Trust not to contact the referring GP or the complainant about the decision to downgrade the patient's status in light of her complex medical history. I further find that this constituted a failure in care and treatment.

40. In relation to the impact these failings had on the patient, I have had regard to the IPA's advice that it would be '*likely to cause potential for anxiety and worry'* and note that the complainant has expressed that he was very anxious about the wait for his daughter to be seen. I further note that the patients GP's letter as part of the second referral stated that she was experiencing *'distress'* and that this was *'affecting her mental wellbeing.'* However, the IPA also noted that *'it is unlikely that there has been any impact to [the patient]. Hydradenitis supparativa is a chronic frustrating condition, surgery is not the main element of management.'* I agree that both the patient and her father experienced a degree of distress, frustration and anxiety as a result of the decision to downgrade the patient and the resulting five month delay until she was triaged as an urgent referral, but also agree with the IPA advice that, from a medical perspective, there was unlikely to have been any impact to the patient.

41. The complainant has also complained that his daughter's GP was not informed about the decision to downgrade her referral. I have carefully considered the Trust's policy of not informing patients about a change in referral status. I have also considered the IPA's analysis of the statistical evidence provided by the Trust in support of this policy. The IPA pointed out that 6000 referrals per year, as quoted by the Trust, amounts to *'115 per week which is about 23 per week day. The vast majority will be very straightforward - for example basal cell carcinoma or carpal tunnel.'* The IPA explained that '*there will be very few referrals in which the GP has asked for an urgent referral, with explanation and mention of exacerbating factors, which are then downgraded to routine or even*

rejection. I would expect [there] to be no more than 1-5 at most per day, perhaps less. It would be kind and reasonable to let the GP know that the referral was no longer considered urgent. This could readily be delegated to an administrator or even automated.' I also note that with regards to the notifications required under IEAP sections 1.7.12 (d) and 1.7.13 (c), the Trust have stated that a patient would only be written to when there is an appointment slot available.

42. I have also reviewed the targets set by section 1.4.1 of the IEAP, in particular I note that the IEAP states that there should be *'[a] maximum waiting time of 9 weeks for a first outpatient appointment by March 2009'*. In contrast, I note that the patient's wait time was expected to be approximately 98 weeks when her initial referral was downgraded.

43. It is clear that when issued in 2008, the IEAP envisioned a relatively short wait time between initial GP referral and first appointment, with an outside target of nine weeks for an appointment. When the IEAP was developed there was no need to inform patients about a change in referral status because, pursuant to the nine week outside deadline for a first appointment, patients would have been notified of an appointment within a matter of days or weeks anyway. This is clearly no longer the case as the complainant had waited over five months with no notification from the Trust about when his daughter was to be seen and would have waited longer had he not called for an update. Waiting list times have increased dramatically in the last ten years since the IEAP was first issued to the Trusts by the Department.

44. The Second Principle of Good Administration, *'being customer focused',* requires a public service provider to ensure that people *'can access services easily'* and also requires healthcare providers keep patients informed about '*what they can expect'.* I find that the Trust's failure to ensure that the complainant was notified about the decision to downgrade his daughter's referral was contrary to the Second Principle of Good Administration. Patients are entitled to accurate and up to date information about their referrals and the expected waiting time and it is the responsibility of the Healthcare Trusts to

ensure their patients are appropriately informed. It is my view that the Trust's policy of changing a patient's triage category from urgent to routine without informing them is unacceptable.

45. I have also considered how the Trust's relies on GPs to keep patients informed about wait times. The Trust issues monthly publications documenting the expected wait times for patients expecting that GPs will pass the information on to their patients. I am concerned that the Trust relies on GPs to keep patients informed about their potential wait times, yet does not inform GPs when a patient's referral status is changed. The information published by the Trust regarding waitlist times is of limited use if GPs are not also provided with feedback regarding their patients' referral category (either 'red flag', 'urgent', or 'routine'). This system has the potential to cause uncertainty and frustration as patients do not have access to appropriate and accurate information. In this regard, I welcome the concept behind the new computer system, 'Encompass', and the patient portal which will allow patients to access all relevant information in respect of their care. However I am concerned about the projected timescale for implementing this new system and how patients will continue to be updated about wait times in the short term.

Responses to Draft report.

46. A copy of the Draft Report was shared with the complainant. The complainant provided comments on the IPA advice, the Trust's Shared Learning Document, and the conclusions and recommendations within the report.

47. The complainant commented that he believes the Shared Learning should be more prescriptive. The complainant emphasised that Paragraph 45 of the report states that the Trust's policy of changing a patient triage category from urgent to routine without informing the referring physician, or the patient, to be 'unacceptable'. In particular, the complainant believes the use of the word 'should' *'implies such behaviours maybe acceptable if adequately mitigated for'* and for this reason, he recommends the use of the word *'must'.*

48. I have considered the complainants comments regarding the Trust's shared learning document and I have shared the complainants request with the Trust who agreed to amend the wording of the shared learning document accordingly.

49. The complainant has also commented on the advice provided by the IPA. The complainant suggested obtaining IPA from additional specialities, including a general practitioner and a neurologist. The complainant has also provided articles obtained through his own research regarding the potential impact of long-term antibiotic therapy and has asked that these articles be accepted as IPA advice.

50. I note that the only medical professional subject to the complaint was a plastic surgery consultant. The purpose of IPA advice is to provide a peer-review of the actions and decisions of a similarly qualified medical practitioner. For this reason, advice was sought from a plastic surgeon for the purpose of reviewing the decisions and actions of the plastic surgery consultant who triaged the patients referral. It would be unreasonable to expect a plastic surgery consultant to approach a referral from a GP with the knowledge and experience of a differently qualified medical practitioner, such as a neurologist. This is why peer-review advice was sought from a plastic surgery consultant.

51. Regarding the complainants comments on the long term impact of antibiotics, the IPA advice is clear that this *'would not be something that a plastic surgery consultant would consider. It would be discussed between the GP and the patient, or in this case, the patient's father. From a plastic surgery perspective, it would not be a consideration.* I have considered the complainant comments and I have declined to seek further IPA advice.

52. The Trust indicated that it accepted the findings of the draft report.

CONCLUSION

53. The complainant submitted a complaint to me about the actions of the Trust in relation to the care and treatment provided to his daughter. He complained about the Trust's decision to downgrade his daughter's surgical referral for

hidradenitis suppurativa from ‘urgent’ to routine’. The complainant felt that the decision failed to consider his daughter’s complex medical history and learning difficulties. The complainant was also concerned that his daughter would have to be on long term antibiotics while awaiting a consultation. The complainant also complained that the decision to downgrade his daughter’s urgent referral was not communicated to him or the referring GP.

54. I have investigated the complaint and have found a failure in care and treatment in relation to the following:

(i) Failure to consider the patients complex medical history and inform the referring GP, or the patients father of the decision to downgrade her initial referral.

55. I have not found failure in relation to the complaint that the triaging consultant did not give appropriate consideration to the potential impact of long term antibiotics on the patient.

56. I am satisfied that the failure in care and treatment that I have identified caused the patient and her father to experience the injustice of anxiety, distress, frustration and uncertainty.

57. I commend the Trust for its decision to issue a Shared Learning letter in relation to the issues raised by the complainant. I also commend the Trust for agreeing to update this shared learning document in line with the complainant’s request. I Trust that this will ensure the patient receives timely and appropriate care and treatment in the future.

Recommendations

58. I recommend that the Trust:

(i) Issues the complainant and his daughter with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified, and should be issued within **one month** of the date of my final report.

(ii) Provides the complainant with a payment of £100 by way of solatium for redress in respect of the injustice suffered by the complainant and his daughter, who both suffered a degree of distress and inconvenience. This payment should be made within **one month** of the date of my final report.

59. I welcome the fact that as a result of the complaint, the Trust has developed a Shared Learning Document. The 'safety message' conveyed in the Shared Learning is that *'[p]atients with profound learning difficulties, complex medical needs and co-morbidities who are referred urgently for assessment should always be considered as urgent'.* The Shared Learning acknowledges that the patients *'referral letters were not viewed in a holistic, person – centred manner and were clinically downgraded from urgent to routine. This caused considerable distress to the patient's father as her sole carer.'* I am satisfied that the learning points established by the Shared learning, namely, that: *'Clinicians should take into account a patient's full medical and social history when deciding upon the clinical priority of a referral letter,'* and; *''[p]atients with profound learning difficulties, complex medical need and co-morbidites who are referred urgently for assessment should always be considered as urgent'*, have properly addressed the failings identified by the IPA. Accordingly, I have not made any recommendations beyond those suggested in the shared learning document.

PAUL McFADDEN
Deputy Ombudsman **2 January 2020**

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.