Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Belfast Health and Social Care Trust

NIPSO Reference: 19933

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

SUMMARY

The complainant was suffering from pain in his right shoulder due to a tear of the supraspinatus tendon and osteoarthritic changes. He complained about the delay in his receiving an appointment with a Consultant Orthopaedic Surgeon and subsequent failure to offer appropriate treatment options to address his pain and discomfort.

His GP made an urgent referral which was triaged as routine by Musgrave Park Regional Orthopaedic Service. It is a failing that the complainant and his GP were not informed that the referral was downgraded from urgent to routine. The Trust stated that current practice is that the Orthopaedic Service sends downgrade letters to GPs who send in urgent referrals to notify if their patient's referral is downgraded and to articulate the reason why. The Trust also proposes to set up a text and letter notification process for all patient referrals.

The complainant's first appointment with an Orthopaedic Consultant took place 22 months later. I found that the Consultant Orthopaedic Surgeon carried out an appropriate assessment and that repair of the rotator cuff tendons was not an option at that time. However, it may have been possible had he been reviewed earlier.

I considered that the decision to triage the referral as non-urgent was a failing in care and treatment.

I also considered it a failing that no discussion occurred between the Consultant Orthopaedic Surgeon and the complainant about the risks and benefits of Reverse Geometry Total Shoulder Replacement. I considered that it was an injustice to the complainant that he did not have the opportunity to explore this option further at that time. I note that the complainant was placed on a waiting list for Reverse Geometry Total Shoulder Replacement a year later with the likelihood of surgery three years later. I accept the advice of the Independent Professional Advisor that the complainant's recovery from this surgery is not likely to be impacted by the lengthy delay.

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

I also recommended that the Trust reviews its Guidance for Staff with a view to achieving consistency among orthopaedic consultants regarding the criteria for Reverse Geometry Total Shoulder Replacements and improving public confidence in the process.

THE COMPLAINT

1. The complaint was made on 26 July 2018 to the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant by the Trust. He complained about the delay before he was first seen by an Orthopaedic Consultant. He complained that he was not offered appropriate treatment options to address his pain and discomfort. He remained dissatisfied with the Trust's response to his complaint of 3 December 2018 and complained to this Office.

BACKGROUND

2. The complainant was attending his GP due to pain in his right shoulder due to a tear of the supraspinatus tendon and osteoarthritic changes in the acromioclavicular (AC) joint.[1] He was referred by his GP on 8 August 2016 to Musgrave Park Regional Orthopaedic Service, Outpatient Department. The request stated that this referral was urgent. The referral was triaged as routine by the Musgrave Park Regional Orthopaedic Service. His first appointment with an Orthopaedic Consultant took place on 11 June 2018.

3. The complainant was seen by the Consultant Orthopaedic Surgeon on 11 June 2018. The Consultant Orthopaedic Surgeon decided that surgery would not be appropriate and referred the complainant to the pain clinic. He was subsequently seen by a Consultant Shoulder surgeon on 4 June 2019 and placed on a three year waiting list for surgery.

[1] The joint where the collar bone meets the shoulder blade

ISSUES OF COMPLAINT

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

I. **Whether it was appropriate that the complainant's GP's urgent referral on 8 August 2016 was reclassified as routine when triaged by ICATS (Integrated Clinical Assessment and Training Service)?**

II. **Whether the care and treatment provided to the complainant by the Consultant Orthopaedic Surgeon was appropriate and reasonable?**

III. **Whether the delay in seeing the Consultant Orthopaedic Consultant impacted on the number of options that were by that time available to the complainant?**

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant.

4. No complaint has been made about the complainant's General Practitioner (GP). However, the GP assisted with investigation enquiries and provided supporting documents.

5. After further consideration of the issues, I obtained independent professional advice from a Consultant Orthopaedic and Trauma Surgeon independent professional advisor (IPA).

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

7. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and

recommendations. The complainant accepted my findings and recommendations. I included a response from the Trust at paragraph 91.

RELEVANT STANDARDS

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

9. The general standards are the Ombudsman's Principles[2]:

- The Principles of Good Administration
- The Principles of Good Complaint's Handling
- The Public Services Ombudsman's Principles for Remedy

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

11. The specific standards relevant to this complaint are:

(i) The General Medical Council (GMC)'s guidance 'Good Medical Practice' April 2013 (The Good Medical Practice guidance)

(ii) Department of Health Integrated Elective Access Protocol (2008) (DOH IEAP)

(iii) Belfast Health and Social Care Trust Integrated Elective Access Protocol – Guidance for Staff (2015) (BHSCT 2015 guidance)

(iv) The International Covenant on economic and social and cultural rights (ICECSR) (ratified by the UK in 1976)

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

12. I also refer to the following briefing/research papers:

- Royal College of Surgeons' Briefing: 'Why are waiting times continuing to rise in Northern Ireland?' (October 2017) (RCS briefing).
- https://nipso.org.uk/site/wp- content/uploads/2017/02/NIPSO-Human-Rights- Manual.pdf

13. I did not include all the information obtained in the course of the investigation in this report. I am satisfied, however, that I took into account everything that I consider to be relevant and important in reaching my findings.

THE INVESTIGATION

ISSUE ONE

Whether it was appropriate that the complainant's GP's urgent referral on 8 August 2016 was reclassified as routine when triaged by ICATS?

Background

14. The complainant complained about the delay before he was first seen by an Orthopaedic Consultant. The GP records provided indicate that the complainant attended his GP due to pain in his right shoulder. The complainant was referred by his GP on 8 August 2016 to Musgrave Park Regional Orthopaedic Service, Outpatient Department. I note that he had previously had an x-ray of his right shoulder performed, on 1 April 2016. The GP referral letter *stated 'the X-ray is normal… an USS (ultra sound scan) has shown 1. a full-thickness tear of the supraspinatus tendon with shortening and 2. OA (osteoarthritic) changes in the ac (acromioclavicular joint)'.* The request stated *'please see to advise'*. The GP referral of 8 August 2016 also stated that this referral was urgent. No reason was provided for this categorisation in the 'urgency reason' field. However the GP, in response to enquiries, stated *'the reason for urgent referral is noted in the text of both referrals in that they describe ultrasound proven rotator cuff tears which would be urgent in line*

with the triage protocol provided on the clinical communications gateway (electronic referral system)'.

The referral was triaged as routine by the Musgrave Park Regional Orthopaedic Service.

Evidence considered

15. The GP provided a copy of the triage protocol relating to GP Triage of patients with shoulder symptoms which states:

'Red Flag that necessitates urgent referral:

1. *Trauma*
2. *Suspected malignancy*
3. *Non-mechanical pain*
4. *Any mass/swelling*
5. *Weakness**
6. *Neurological/vascular changes post shoulder trauma/dislocation*

**Weakness indicates damage to either the muscle/tendon unit of the shoulder or its nerve supply. Request x-ray and USS. Request urgent physiotherapy, REFER URGENTLY TO SURGEON (optimise any pre-existing medical conditions whilst waiting for appointment)'*

16. The complainant's GP made a further urgent referral on 30 March 2018 for *'assessment and advice regarding potential tendon repair and on-going rehabilitation as at present this man has severe symptoms and limited movement'*. The GP described the complaint as *'left shoulder injury with multiple full thickness rotator cuff tears'*. The GP indicated that the referral was urgent.

17. The referral was triaged by the Musgrave Park Regional Orthopaedic Service as urgent on 13 April 2018. The complainant was first seen by a Consultant Orthopaedic Surgeon on 11 June 2018, 22 months after first being referred on 8 August 2016.

Department of Health Integrated Elective Access Protocol (2008) (DOH IEAP)

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

'2. 1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto Electronic Referral Management System (ERMS) according to the date received by the Trust.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3. The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).'

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'…

RCS Briefing

19. I refer to the RCS briefing October 2017. The target set was, that by March 2018, 50% of patients should wait no longer than nine weeks for a first outpatient appointment and that no patient should wait longer than 52 weeks. However the RCS noted that by June 2017 over 35% of patients in Northern Ireland were waiting for over 52 weeks for a trauma and orthopaedic appointment. The RCS paper noted that in May 2017, the British Broadcasting Corporation (BBC) published information suggesting that patients in the BHSCT Trust were waiting up to 95 weeks for some orthopaedic treatments.

20. As part of investigation enquiries, the BHSCT 2015 guidance was examined. I consider the following extract from 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…'

The Trust's Response to Investigation Enquiries

21. The Investigating Officer asked the Trust if the process described in section two of the DOH IEP was followed in the complainant's case. The Trust responded: *'The above process described does take place for Belfast Trust ICATS but The complainant is an SET [South Eastern Trust] area patient…Due to resourcing and capacity issues, SET ICATs are unable to accept new outpatient Upper Limb referrals and The complainant's referral from his GP dated 8 August 2016 was triaged by the Musgrave Park Regional Orthopaedic Service and added directly to the Consultant Led Outpatient Waiting list.'*

22. In relation to the first GP referral, the Trust states that *'The Consultant Orthopaedic Surgeon is clear that based on the original information, the referral was appropriately triaged as clinically routine.'* In response to enquiries, the Trust stated (in February 2019) that Orthopaedic Services waiting time for a clinically routine

shoulder appointment is in the region of 128 weeks and 6-8 weeks if triaged as clinically urgent.

23. The Trust wrote to this Office on 18 February 2019 stating:

'There is no policy or procedure within Orthopaedics to determine what constitutes an urgent referral for each sub-specialty. Instead this is a clinical determination based on guidelines agreed with the Department of Health and Clinical Director.'

24. The Trust was asked to describe these guidelines and responded in its letter of 11 November 2019:

'We work within Department of Health Guidelines. These guidelines for Orthopaedic Referrals have been written in conjunction with the Clinical Director, Consultants in Orthopaedics and G.P. representatives.

Our guidelines are that if G.P referrals detail the following information, then the referral will be considered clinically urgent.

- *Infection*
- *Tumour*
- *Neurological compromise*
- *Respiratory compromise*
- *Ulceration*
- *Trauma requiring urgent assessment*

These loose guidelines are used as a core guide for all Orthopaedic sub- specialities and have developed with new pathways since their inception in 2003. The triage of G.P referrals is completed by Senior Orthopaedic Nursing staff who work closely with the clinical leads for each sub-speciality to ensure any referrals that they are querying can be assessed by an Orthopaedic Consultant Surgeon to ensure they are appropriately graded.'

25. The Investigating Officer therefore referred the Trust to the triage protocol relating to GP Triage of patients with shoulder symptoms. This was provided by the complainant's GP who stated that this is the triage protocol provided to GPs on the electronic referral system. This document states:

'Red Flag that necessitates urgent referral

1. *Trauma*
2. *Suspected malignancy*
3. *Non-mechanical pain*
4. *Any mass/swelling*
5. *Weakness**
6. *Neurological/vascular changes post shoulder trauma/dislocation*

**Weakness indicates damage to either the muscle/tendon unit of the shoulder or its nerve supply.'*

26. The Trust explained that electronic referrals did not exist at the time of the development of the orthopaedic referral guidelines. The Trust explained that in this case *'the triage assessment was carried out using the Orthopaedic Services guidelines'*. The Trust did not explain why the GP triage protocol differs from the *'guidelines agreed with the Department of Health and Clinical Director'* but clarified that *'meetings took place between Clinical Leads in Orthopaedics and GPs to discuss referral thresholds and clarify what detail is required to be included in the referral.'*

27. The Trust also stated:

'It is understandable that the GP suggested an urgent referral due to the complete tear however this was not a traumatic tear (no sudden injury) rather a degenerative tear with shortening. The referral also suggested that [the complainant] had continued to work. It is likely that the clinician in August 2016 used the triage criteria to downgrade this referral to routine.'

28. The Trust also explained *'Our ICATS manager has also advised that the guidance you have referred to in your letter which was provided by The complainant's GP appear to be the Banner Guidelines that are on CCG (Clinical Commissioning* Groups)[3] *to assist GPs in making refers.*

3. The Northern Ireland Local Commissioning Group carries out a range of functions with respect to the commissioning of health and social care for people within their area, including:
    a. assessing health and social care needs
    b. planning health and social care to meet current and emerging needs
    c. securing the delivery of health and social care to meet assessed needs.

This simply states "Weakness" but doesn't clarify that this refers to traumatic/younger patients where there is damage of 'health[y]' tissue rather than weakness as a result of degenerative changes. This may be why the GP may have assumed his referral should be urgent'.

29. In relation to the second GP referral the Trust explained:

'The subsequent referral did however contain new clinical information, which detailed marked deterioration in [the complainant's symptoms]. When a follow up referral for a patient comes into the Hospital Registration Office at Musgrave Park Hospital, it is re-triaged with any new clinical information to make a determination on clinical urgency. In [the complainant's] case the re-triage of his referral determined he was now urgent, based on the new information provided and an appointment was organised for [the complainant] within 10 weeks of the determination of his now clinically urgent status.' I note that a letter was sent to the complainant on 2 May 2018 informing him of an outpatient appointment with a Consultant Orthopaedic Surgeon on 11 June 2018.

30. The Investigating Officer asked the Trust to comment on section 2.2.3.of the Elective Access Protocol which states *'The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt)'.* The Trust explained that: *'Primary care including GP referrals to Orthopaedic services do not currently generate a notification letter to either the patient or the GP to advise receipt of the referral due to resource and capacity issues. However, Orthopaedic services are in the process of setting up a text and letter notification process for all patient referrals. In addition, the outcome of clinical triage i.e. urgent or routine status is not currently confirmed to the GP/Patient by letter from any services across the Belfast Trust due to capacity constraints as it would not be possible to do so with the current resources.'*

31. The Trust added *'Nonetheless, Orthopaedic Services are clear that if a patient or a GP contacts the outpatient department to enquire they will be notified immediately of the triage outcome and will be given any information regarding waiting time or position on the waiting list as they require.'*

32. The Trust subsequently advised that *'from 2019, Orthopaedics have been sending downgrade letters to GPs who send in urgent referral to notify if their patient's referral is downgraded and to articulate the reason why'.*

Advice from the IPA

33. The Investigating Officer obtained the complainant's medical notes and records, documenting his care and treatment. These were provided to the IPA along with the Trust's responses to enquiries.

34. The Investigating Officer asked the IPA to comment on the Trust's assertion that *'There is no policy or procedure within Orthopaedics to determine what constitutes an urgent referral for each sub-specialty'.* The IPA advised *'Written policy is not always available in hospitals for triaging patients and it is acceptable to have 'loose guidelines' as long as the triage is performed by competent personnel and with a senior clinician (Consultant) oversight, either within each individual sub-specialty or overall'.*

35. The Investigating Officer asked the IPA whether, based on the information provided by the GP on 8 August 2016, the decision of the Regional Orthopaedic Service at Musgrave Park to assess the complainant for referral to a consultant orthopaedic surgeon as clinically routine was appropriate. The IPA advised *'The GP referral of 8th August 2016 mentions complete tear of the supraspinatus tendon without history of trauma and pain in the shoulder affecting his job. In my opinion, this should have been treated as a more urgent case rather than routine, in order to decide whether the rotator cuff was going to be repairable at that stage… He should have been reviewed earlier and perhaps had an MRI scan to assess whether the tendon was repairable, although I admit that despite this, it may not have been possible to repair the rotator cuff tear.'*

36. The IPA, referring to the Trust's comment that *'The complainant had continued to work'* also advised *'[the GP referral] does indicate the complainant's job was being affected… and it was by no means a conclusive case of degenerative*

tear... although degenerative tear was a possibility. Therefore, he should have received an earlier consultation to assess this'.

37. The Investigating Officer asked the IPA if it is satisfactory that the criteria available to the GP on the electronic referral system is different from the Department of Health guidelines. The IPA quoted the DOH IEP which was developed to encompass the elective pathway within a hospital environment, as follows *'The principles can be applied to primary and community settings, however, it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings'*. He advised:

'It has been mentioned that the ICATS referral guidelines were circulated to all GPs and meetings had taken place between the Orthopaedic Department and GPs to discuss these and presumably these were agreed by all. Therefore, in this case, it is acceptable that the criteria available to GP on the electronic referral system is different from the DoH guidelines.'

38. Referring to the Trust's stated waiting time for a routine shoulder appointment in the region of 128 weeks, the IPA advised *'This is an extra-ordinarily long waiting time' and 'inappropriate'.*

39. The Investigating Officer asked the IPA to identify any learning or service improvements. The IPA advised:

'It is concerning to note the delay in first review of patients from referral and this can cause significant pain and disability for orthopaedic patients. The Trust should consider outsourcing such patients to alternate providers.

Consideration should be given to undertaking an MDT between the different upper limb surgeons in the Trust to discuss complex cases like The complainant, to ensure that patients are being provided with Evidence-Based treatment and are not being denied up-to-date management options.'

40. The Trust received a copy of the IPA advice and made the following comments on the IPA's conclusions:

'Orthopaedic Services have reviewed both of [the complainant's] referrals and feel that the criteria used by the orthopaedic Clinical team in triaging the referrals was

correct and that the original referral was clinically routine and the subsequent referral constituted a grading of clinically urgent.'

41. The Trust also stated:

'The Belfast Trust is aware the outpatient waiting time for upper limb consultations is much greater than the Department of health elective access target and is much longer than we would like for our patients. We realise the impact that this has on patients' lives and would like to apologise for the delay that [the complainant] has faced.'

Orthopaedic services manage this by ensuring all referrals to the upper limb service are appropriately triaged by clinical specialists and graded as clinically routine or clinically urgent. Clinically urgent patients are offered an appointment at outpatients within 10 weeks of the triage. Patients are also seen in order of clinical need and in chronological order. This ensures that those in the greatest of need are prioritised.

In an effort to reduce the waiting times for upper limb consultations, we have recently appointed an upper limb specialist physiotherapist who co-locates at clinics with the Consultant surgeon to add in additional capacity with a view to reduce waiting times for patients.'

42. The Trust also stated that the IPA report *'does not reflect the lengthy waiting times for outpatients within Northern Ireland. These waiting times are outside of the Belfast Trust's control and are a well acknowledged issue within the Health and Social Care Board in Northern Ireland that the demand for orthopaedic services greatly outweighs the capacity available.'*

Analysis and Findings Issue One

43. In issue one, I investigated whether it was appropriate that the complainant's GP's urgent referral on 8 August 2016 was reclassified as routine when triaged by ICATS.

44. The Trust has stated that there is no written policy in terms of triaging patients and deciding who is routine and urgent and that Senior Orthopaedic Nursing staff working closely with the clinical leads for each sub-speciality make a clinical

determination based on Department of Health (DOH) guidelines. The Trust describes these as 'loose guidelines'.

45. I understand that the Triage process should not be unnecessarily fettered by rigid criteria that precludes the exercise of sound professional judgement. However unlike the GP, the triage team does not have the benefit of examining the patient and listening to his concerns. It is therefore important that the triage team has reliable set of guidelines as a starting point, that these reflect the guidelines available to the referring GP and that they are applied consistently across the triage teams.

46. I am concerned that the DOH guidelines differ from the guidelines available to GPs on the electronic referral system. In this case the complainant's GP used his clinical judgement and the CCG electronic referral criteria. On receipt of the referral, the triage team followed 'loose guidelines' based on DOH advice. The triage team also used clinical judgement during the triage process to assess the urgency. The third Principle of Good Administration, 'Being open and accountable' includes:

- 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

47. I note that the Trust has described the GP's decision to designate the complainant's referral on 8 August 2016 as urgent as 'understandable'. This statement highlights the inconsistencies in the GP referral and the Orthopaedic Services triage processes. The Trust has explained that the Orthopaedic referral guidelines were developed prior to the GP electronic referral system. The IPA has noted that the guidelines were developed in accordance with the DOH IEP and circulated to GPs. Therefore, as the Trust has complied with its broad guidelines, I do not consider that this is a failing on the part of the Trust.

48. It is clearly not acceptable for the guidelines available to GPs to differ, however this is not the sole responsibility of the Trust. According to the Trust, the referral guidelines were developed by the CCG and therefore outside the scope of this investigation. Given a backdrop of lengthy waiting lists for upper limb consultations, there is a risk that lack of clarity about referral criteria and potential

outcomes between GPs and Orthopaedic Services may lead to a decline in patient confidence. I consider the inconsistencies in the process is a matter which requires to be addressed and I will write to the Health and Social Care Board to raise this issue.

49. The IPA's opinion is that this should have been triaged as a more urgent case in order to decide whether the rotator cuff was repairable. I note the Trust disagrees with the IPA's opinion. Having considered the opinions of both the IPA and the Trust, I consider that the complainant's referral should not have been downgraded. This failure in professional judgement amounts to a failure in the care and treatment provided to the complainant.

50. At the time of the complainant's referral GPs were not advised when a request for an urgent referral was triaged as routine. 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. Neither the complainant nor his GP was informed of the decision to downgrade this referral to routine. I consider the failure to advise the complainant's GP of the decision not to consider him as an urgent patient does not meet these principles and that this constitutes maladministration. As a consequence of this maladministration, the complainant experienced the injustice of uncertainty and frustration as to the status of his referral. I uphold this element of the complaint.

51. The Trust explained that this practice has changed. This decision was taken after previous NIPSO investigation and engagement. Now *'Orthopaedics have been sending downgrade letters to GPs who send in urgent referral to notify if their patient's referral is downgraded and to articulate the reason why'. The Trust also explained 'that Orthopaedic services are in the process of setting up a text and letter notification process for all patient referrals'.* I consider communication between secondary care, patients and their GPs is an essential element of the provision of effective health and social care and I welcome these initiatives.

ISSUE TWO

Whether the care and treatment provided to the complainant by the Consultant orthopaedic surgeon was appropriate and reasonable?

Background

52. The complainant complained that he was not offered appropriate treatment options to address his pain and discomfort. He complained that the Consultant Orthopaedic Surgeon did not consider with any urgency any follow up appointments for his pain and debility.

53. The complainant's GP referral was for an outpatient appointment at Musgrave Park Regional Orthopaedic Service. The complainant attended his appointment on 11 June 2018 with the Consultant Orthopaedic Surgeon. The Consultant Orthopaedic Surgeon examined both shoulders. The Consultant Orthopaedic Surgeon's discharge letter to the complainant's GP stated:

'Repair of the rotator cuff tendons would not work. The only surgery one could contemplate would be some form of reverse shoulder arthroplasty and this would be inappropriate in a man of this age. He may benefit from going to a Pain Clinic for pain relief.'

The Consultant Orthopaedic Surgeon referred him to the Pain Clinic at the Ulster hospital stating *'Surgical Options would not be indicated for his shoulders'*. The letter is dated 14 August 2018.

54. The Trust subsequently agreed that the complainant would be referred to an Upper Limb Specialist at ICATS for conservative management. He was assessed and referred for physiotherapy which commenced on 10 January 2019. The complainant was seen at outpatients by a Consultant Orthopaedic Surgeon on 4 June 2019 and placed on a waiting list for a bilateral Reverse Geometry Total Shoulder Replacements. The waiting list at present is three years. The complainant complains that too much time was left to pass to make any clear decision about how to proceed with any treatment and that the Consultant Orthopaedic Surgeon did not give his case the consideration it deserved.

Evidence Considered

55. The clinical records provided comprise the Consultant Orthopaedic Surgeon's letter to the GP following his clinic on 11 June 2018, along with the reports of the x-ray imaging.

The Trust's Response to Investigation Enquiries

56. The Trust explained that *'a decision on appropriate management of an orthopaedic condition in terms of surgical intervention can only be made by a specialist Orthopaedic surgeon once the patient is seen at the outpatient appointment.'* The Trust quoted from the Consultant Orthopaedic's clinical note which stated *'Repair of the rotator cuff tendons would not work. The only surgery one could contemplate would be some form of reverse shoulder arthroplasty and this would be inappropriate for a man of his age'.*

Advice from the IPA

57. The Investigating Officer asked the IPA if the Consultant Orthopaedic Surgeon conducted the consultation on 11 June 2018 appropriately in line with good practice standards. The IPA advised:

'The Consultant Orthopaedic Surgeon's clinic letter from 11th June 2018 indicates an appropriate consultation and discussion. His explanation regarding repair of rotator cuff not being an option is appropriate for the left shoulder, given the ultrasound scan findings in March 2018 that the tendon ends were not identified. However, his decision that a reverse shoulder arthroplasty for the left shoulder would be inappropriate in a man of the complainant's age (65 years) could be questioned. Current literature supports reverse shoulder arthroplasty in patients 65 years of age.[4] *I admit that the suitability of a patient for surgery is best decided by the surgeon who is assessing the patient. However, The Consultant Orthopaedic Surgeon only provides the complainant's age as the reason for this surgery being inappropriate and this decision could be challenged based on current literature.'*

4 Leathers MR et al. Do younger patients have better results after reverse total shoulder arthroplasty? J Shoulder Elbow Surg. 2018 Jun; 27(6S): S24-S28.

58. The Investigating Officer asked the IPA's opinion on the Consultant Orthopaedic Surgeon's conclusion that *'Repair of the rotator cuff tendons would not work… He may benefit from going to a Pain Clinic for pain relief'*. The IPA advised:

'I agree with The Consultant Orthopaedic Surgeon's conclusion in that clinic that repair of rotator cuff tendons would not have worked at that stage, given the fact that the tendon ends were not identified in the ultrasound scan of 14.03.18. While I also agree that referral to Pain Clinic was a reasonable option, I question the Consultant Orthopaedic Surgeon's decision that reverse shoulder arthroplasty would be inappropriate for [the complainant]… I believe [the complainant] should have been given the option of this surgery and a full discussion should have occurred regarding this option, if age was the only criteria of withholding this surgery.'

59. I referred the IPA to the Trust's comment that Reverse Shoulder Arthroplasty is 'a relatively new procedure and there is limited literature on the long-term success of the operation and its outcomes'. The IPA advised:

'While I agree that Reverse Shoulder Arthroplasty (RSA) is a relatively new procedure, the results have been encouraging in young patients[5] and if the procedure needed revision then this could be revised with another RSA[6] although this admittedly complex surgery and would require a specialist surgeon. Therefore I can appreciate the Consultant Orthopaedic Surgeon's reluctance to perform the RSA on [the complainant], although I feel that perhaps the Consultant Orthopaedic Surgeon could have perhaps referred [the complainant] on to a colleague with more experience in RSA or at least given [the complainant] the option of being reviewed by a surgeon with more experience in RSA.'

60. The IPA concluded that the complainant *'has unfortunately had to wait an inappropriate length of time for his shoulder problems. This may not have changed his current situation, but he should have been given the option of being outsourced to an alternative provider for his shoulder condition earlier and he should have also been given the option of reverse shoulder arthroplasty earlier'.*

[5] Elia F et al. Clinical and anatomic results of surgical repair of chronic rotator cuff tears at ten-year minimum follow-up. **Int Orthop.** 2017 Jun; 41(6):1219-1226.

[6] Wagner ER. Can a reverse shoulder arthroplasty be used to revise a failed primary reverse shoulder arthroplasty? The Bone & Joint Journal Vol. 100-B, No. 11.

61. The IPA advice was forwarded to the Trust for comment. In relation to outsourcing, the Trust explained:

'Unfortunately, in terms of the ability to outsource to an alternative provider, the Trust would like to note that this is only available when non-recurrent monies are made available from the Health and Social Care Board to send patients to the Independent Sector. This has happened much less frequently since 2014 with the majority of money granted being targeted to the inpatient waiting list. When funding is made available all patients on the waiting list are considered and again taken in strict chronological order.'

62. In the light of the IPA advice the Investigating Officer sought clarification from the Trust about the Consultant Orthopaedic Surgeon's opinion that the complainant, at aged 65 was too young for consideration of Reverse Geometry Total Shoulder Replacements.

63. The Trust explained:

'His rationale is that reverse shoulder arthroplasty is a relatively new procedure and there is limited literature on the long-term success of the operation and its outcomes. The revision rate[7] is at present unclear and given [the complainant's] age at the time, [the Consultant Orthopaedic Surgeon] was concerned that if the procedure needed revised there would be limited options for further treatment.'

64. The Trust was asked to explain why the complainant has now been offered the reverse shoulder arthroplasty procedure, a year after the Consultant Orthopaedic Surgeon declined to treat him. The Trust stated:

'The complainant is now under the care of a different surgeon and surgeons often have different thresholds or criteria for surgery. [His current Consultant Orthopaedic Surgeon] feels content to offer the complainant a reverse geometry shoulder replacement. [His] waiting list is 3 years long and therefore [the complainant] will be 70 years old when he undergoes the procedure.'

[7] The IPA explained '*after a period following the original operation, the components of joint replacement may require to be revised and replaced again, due to various reasons that include loosening, infection and wearing out of the components… The proportion of original surgery that requires this revision procedure within a certain period of time (usually 5 or 10 years) is described as the revision rate of that surgery over that period of time'*.

Analysis and Findings

65. Issue two investigates whether the care and treatment provided to the complainant by the Consultant Orthopaedic Surgeon was appropriate and reasonable.

66. In deciding whether care and treatment is appropriate and reasonable, I consider the applicable clinical standards and guidelines. I then assess whether the relevant care and treatment provided meets those standards. In this case I refer to the GMC Good Medical Practice Guidance which outlines the duties of a doctor.

67. In relation to the key issues of Communication, partnership and teamwork, the GMC guidance states that doctors should:

- *'Treat patients as individuals and respect their dignity.*
- *Treat patients politely and considerately.*
- *Respect patients' right to confidentiality.*
- *Work in partnership with patients.*
- *Listen to, and respond to, their concerns and preferences.*
- *Give patients the information they want or need in a way they can understand*
- *Respect patients' right to reach decisions with you about their treatment and care.*
- *Support patients in caring for themselves to improve and maintain their health.*
- *Work with colleagues in the ways that best serve patients' interests.'*

68. The Consultant Orthopaedic Surgeon's record of his consultation with the complainant on 11 June 2018 is contained within his clinic letter to The Consultant Orthopaedic Surgeon's GP. There are no additional notes relating to this discussion. I accept the advice of the IPA that the clinic letter indicates that an appropriate consultation and discussion took place. The IPA agrees with the Consultant Orthopaedic Surgeon's conclusion that a repair of the rotator cuff was not an option for the left shoulder because the tendon ends were not identified on the ultrasound scan in March 2018.

69. The IPA has questioned the Consultant Orthopaedic Surgeon's decision that reverse shoulder arthroplasty would be inappropriate for the complainant. I accept his advice that *'a full discussion should have occurred regarding this option, if age was the only criteria of withholding this surgery'.*

70. The complainant is currently on a waiting list for bilateral Reverse Geometry Total Shoulder Replacements. The waiting list at present is three years, meaning the complainant will be over seventy years old when the surgery takes place. It is likely that he will have waited around six years from the original GP referral before he receives the bilateral Reverse Geometry Total Shoulder Replacement surgery that has now been planned for him. The Trust explained *'The complainant is now under the care of a different surgeon and surgeons often have different thresholds or criteria for surgery'*. I consider that the lack of clarity among consultants about referral criteria for Reverse Geometry Total Shoulder Replacement surgery is likely to lead to a further decline in patient confidence.

71. I accept the advice of the IPA that during the consultation on 11 June 2018, the Consultant Orthopaedic Surgeon should have discussed with the complainant the option of being reviewed by another surgeon. Instead it appears that he dismissed the option of Reverse Geometry Total Shoulder Replacement surgery based on the complainant's age. This is contrary to the GMC standards of *'Communication, partnership and teamwork'* particularly in relation to respecting the patient's right to reach decisions with the consultant about their treatment and care and working with colleagues in the ways that best serve patients' interests. I consider it is a failing that all available options were not discussed with the complainant.

72. I cannot conclude that the complainant would definitely have been referred for this surgery earlier had the Consultant Orthopaedic Surgeon sought a second opinion at that time. However I consider that it was an injustice to the complainant that he was denied the opportunity to explore this option further. I uphold this element of this issue of complaint.

ISSUE THREE

Whether the delay in seeing the Consultant Orthopaedic Consultant impacted on the number of treatment options that were by that time available to the complainant?

The Complaint

73. The complainant believes that it may have been possible to carry out a surgical repair at an earlier stage if the consultation with the Consultant Orthopaedic Surgeon had not been delayed.

Evidence Considered

74. I refer to the NIPSO Human Rights Manual. This references the International Covenant on Economic and Social and Cultural Rights (ICECSR). This Covenant enshrines the right to the highest attainable standard of physical and mental health. This right complements and is interrelated to the civil and political rights in the ECHR. The right to health includes the right to control of one's own health and body and is therefore linked to Article 8 of the ECHR, *'the Right to respect for private and family life, home and correspondence'.*

The Trust's Response to Enquiries

75. The Consultant Orthopaedic Surgeon stated *'It is just not possible to state with any certainty if he would have had surgery if seen earlier. Indeed I have reviewed his X-rays from 2016 and to my mind they are not normal, with some upward subluxation of the humeral head indicating that the tendons were probably already ruptured'.*

Advice from the IPA

76. I asked the IPA whether the wait until 11 June 2018 for the orthopaedic consultant appointment impacted on the treatment options available to the complainant. The IPA advised:

'The complainant's rotator cuff damage was not a consequence of an acute injury and more likely to have happened over time. Therefore, it is possible that even if he had been reviewed soon after his initial referral in June 2016 it would not have been possible to repair his rotator cuff tears. However, this is somewhat speculative and certainly if [the complainant] had been reviewed in 2016 then further investigations could have been done at that stage including an MRI scan that would have

quantified the tear and established conclusively the state of the tendons and any possible surgical options. Surgical repair of chronic rotator cuff tears has been shown to provide pain relief and improved range of motion and this option could have been discussed with [the complainant] at that stage.'

77. The complainant has been placed on a waiting list for reverse shoulder arthroplasty. I asked the IPA to estimate the likely effect of the delay on his recovery prospects. He advised that *'Outcomes in reverse shoulder arthroplasty have not been shown to be affected by a delay in surgery. In fact, given the risks associated with surgery, an initial trial of non-operative management cannot be criticised. Therefore, I do not expect any effect on his recovery prospect from this surgery.'*

The Trust's response to the IPA advice

78. The Trust provided an update on the complainant's recent care. Following physiotherapy organised by ICATS in January 2019, the complainant received injections for pain relief. Following this, the Trust stated that he had regained a significant amount of shoulder movement and was therefore referred on 4 June 2019 to an Upper Limb Multidisciplinary Clinic at Musgrave Park Hospital.

79. At this appointment, the Trust stated that he was seen by a Consultant shoulder surgeon who added him to his inpatient waiting list for bilateral Reverse Geometry Total Shoulder Replacements.

Analysis and findings

Issue Three

80. Issue three investigates whether the delay in seeing the orthopaedic consultant impacted on the number of options that were by that time available to the complainant. The Orthopaedic Services waiting time for a clinically routine shoulder appointment is in the region of 128 weeks. Having been classed as routine, the complainant's appointment on 11 June 2018 fell within that time scale. The IPA has called this delay extraordinary and inappropriate. Such delays do appear to be extraordinary. I acknowledge, however, that lengthy delays in Northern Ireland are

not unusual, in a system where the demand for orthopaedic services greatly outweighs the capacity available. I also consider that the issue of waiting times in Northern Ireland is a much wider issue which is outside the scope of this specific complaint.

81. The RCS briefing paper noted that in, May 2017 the BBC reported that patients in the BHSCT were waiting up to 95 weeks for some orthopaedic treatments. It is therefore unsatisfactory but not exceptional that the complainant waited 95 weeks to be seen for the first time by an orthopaedic surgeon.

82. I have considered the relevance of the ECHR and ICESCR in relation to this complaint. Express findings of a breach of any relevant laws are not matters for the Ombudsman to consider. These are clearly the domain of the Courts. However, equality and human rights considerations are an important factor to take account of when determining whether there have been failures in maladministration or clinical judgement.

83. I considered whether the length of wait endured by the complainant was sufficient to engage Article 8 of the ECHR, having already found the wait to be unacceptable. I acknowledge that the test set by courts for engaging Article 8 is high and consider on balance that, although finely balanced, it was not engaged in this case.

84. I accept the advice of the IPA that it is speculative to state that a repair of the rotator cuff tendons might have been possible but for the 22 month wait for the complainant to be seen by the Consultant Orthopaedic Surgeon. I am also persuaded that the complainant's recovery is not likely to be affected by the delay in carrying out the surgery. Therefore, I do not uphold this issue of complaint.

CONCLUSION

85. I will consider, in turn, my findings on the issues of complaint which I accepted for investigation.

Issue one, whether it was appropriate that the complainant's GP's urgent referral on 8 August 2016 was reclassified as routine when triaged by ICATS?

86. I carefully considered the detail of the complaint, the responses from the Trust, the clinical records provided by the Trust and the IPA advice.

87. I highlighted inconsistencies in the referral criteria used by the GP and that used by the Orthopaedic Services when triaging the referral. It was not until the complainant's GP resubmitted the referral that he was given an urgent appointment to see a Consultant Orthopaedic Surgeon. I determined that the decision to triage the referral as non-urgent was a failing in care and treatment. This decision also prevented consideration of whether to repair the complainant's tear was an option at that time. (I consider this further under issue 3 of this report).

88. I find that the failure to advise the patient and the patient's GP of the status of the referral was maladministration, causing the complainant the injustice of frustration and inconvenience. I am pleased to note that the Trust now notifies the GP when a referral is downgraded and is in the process of introducing a text and letter notification process for all patient referrals.

Issue two, whether the care and treatment provided to the complainant by the Consultant Orthopaedic Surgeon was appropriate and reasonable?

89. In relation to issue two, I find that the Consultant Orthopaedic Surgeon carried out an appropriate assessment of the complainant and that repair of the rotator cuff tendons was not an option at that time. I note however that no discussion occurred between the Consultant Orthopaedic Surgeon and the complainant about the risks and benefits of Reverse Geometry Total Shoulder Replacement. I consider this discussion should have occurred and the complainant should have been provided with the opportunity to be referred to another consultant who would consider that option if that was his choice. I consider that it was an injustice to the complainant that he was denied the opportunity to explore this option further. I therefore uphold this element of this issue of complaint. I note that the complainant is now on a waiting list for Reverse Geometry Total Shoulder Replacement

Issue three, whether the delay in seeing the Consultant Orthopaedic Consultant impacted on the number of treatment options that were by that time available to the complainant?

90. I am not persuaded that repair of the complainant's rotator cuff tendons would have been possible but for the 22 month wait to be seen by the Consultant Orthopaedic Surgeon. However the possibility cannot be dismissed as the complainant was not reviewed and further scans and tests were not conducted. I accept the advice of the IPA that the complainant's recovery from Reverse Geometry Total Shoulder Replacements is not likely to be affected by the delay in carrying out the surgery. Therefore, I do not uphold this issue of complaint.

The Trust's Response to the Draft Report

91. On receipt of the draft report, the Trust commented on the triaging process of referrals from GPs as follows:

'The Trust believes, if all urgent orthopaedic referrals coming from GPs were confirmed as urgent then this would have a significant impact on the waiting times for those patients waiting for routine appointments.

It is also important to note that whilst the GP has highlighted the referral as urgent, the triage process within the Trust is carried out by specialist orthopaedic practitioners and therefore the grading of the patient is not based on the GP referral alone but by experts in the field of Orthopaedics.

The orthopaedic triage process is in place to ensure that patients in the greatest of need are seen and treated first. This ensures that patients are graded appropriately to ensure patient safety and equity of access'.

Recommendations

92. I recommend that:

- The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused

as a result of the maladministration and failures in care and treatment I have identified within **one month** of the date of this report.

- For service improvement and to prevent future recurrence that the Trust fully implements its proposal *'that Orthopaedic services are in the process of setting up a text and letter notification process for all patient referrals'.*
- The Trust should review its 2015 Guidance for Staff with a view to achieving consistency among orthopaedic consultants regarding the criteria for Reverse Geometry Total Shoulder Replacements and improving public confidence in the process.

93. The Trust has stated that *'Orthopaedics have been sending downgrade letters to GPs who send in urgent referral to notify if their patient's referral is downgraded and to articulate the reason why'.* I welcome this.

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

Margaret Kelly

Ombudsman **15 September 2020**

APPENDIX ONE

ROLE OF THE OMBUDSMAN

The role of the Ombudsman is provided for in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The 2016 Act provides for the Ombudsman to investigate and report on complaints from a 'person aggrieved'. The Ombudsman may investigate and report on alleged maladministration by a listed authority through action taken in the exercise of administrative functions. The Ombudsman 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 in consequence of the exercise of professional judgement, exercisable in connection with the provision of health or social care. In general, the purposes of an investigation are to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the 2016 Act, 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 he must also consider whether this has resulted in an injustice. Injustice is also not defined in the 2016 Act but can include upset, inconvenience, loss of opportunity or frustration. The Ombudsman may recommend a remedy where he finds injustice as a consequence of the failings identified in her report.

Section 30 (6) of the 2016 Act states that *'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case'.* Therefore the Ombudsman has discretion to determine the procedure for investigating a complaint.

APPENDIX TWO

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.