Investigation Report

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

NIPSO Reference: 17200 &17201

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The Role of the Ombudsman

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

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

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

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

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

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

Reporting in the Public Interest

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

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

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EXECUTIVE SUMMARY

1. I received a complaint regarding the actions of the South Eastern Health and Social Care Trust (SEHSCT) and the Belfast Health and Social Care Trust (BHSCT) concerning the care and treatment afforded to the complainant's late husband from May to August 2014.

Issues of Complaint

2. I investigated the following issues:

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

Issue 2: The communication between the SEHSCT and the BHSCT in respect of the patient's care and treatment; and communication between the Trusts and the patient and his family.

Issue 3: The handling by SEHSCT and the BHSCT of the complaint.

Findings and Conclusion

3. The investigation of the complaint identified a failure in the care and treatment the patient received in respect of:

- The failure of the SEHSCT to transfer him to specialised care
- The failure of the SEHSCT and the BHSCT to adequately communicate with the patient regarding lymph node spread

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

- The failure of the BHSCT to take an adequate record of MDT meeting
- The failure of the SEHSCT to communicate the outcome of the MDT meeting to LVH

- Delay by the SEHSCT and the BHSCT in responding to the complaint

5. I have not found a failure in care and treatment or maladministration in respect of:

- Emergency Department (ED) attendance on 21 May 2014 (SEHSCT)
- Cancellation of abdominal MRI Scan (SEHSCT)
- Delay in CT guided biopsy (SEHSCT)
- SEHSCT transfer of care to BHSCT (SEHSCT)
- Communication by BHSCT with the patient regarding the purpose of the surgery

6. I am satisfied that the failures in care and treatment, and the maladministration which I identified, caused the patient to experience the injustice of distress, uncertainty and upset. I am also satisfied that the complainant experienced the injustice of uncertainty and frustration.

Recommendations

7. I recommended that:

- The Chief Executives of the SEHSCT and the BHSCT provide the complainant with an apology for the failings identified within three months of the date of my final report
- The SEHSCT make a payment of £1750 and the BHSCT make a payment of £1250 to the complainant within three months of the date of my final report, by way of solatium for the injustice of upset, distress, uncertainty and frustration
- The BHSCT implement changes to the recording of outcomes of the Urology MDT so that the patient's treatment plan is recorded in full
- The BHSCT implement changes to the reporting procedures regarding the Urology MDT so that treating Trusts are informed of the MDT outcome at the same time as the MDT report is sent to GPs

I am pleased to note that both the SEHSCT and the BHSCT accepted my findings and recommendations.

THE COMPLAINT

8. The patient attended the Emergency Department (ED) of Lagan Valley Hospital on 21 May 2014 complaining of left sided pain and nausea. He was assessed and discharged home with antibiotics and advised to return in one week if the symptoms did not improve. He returned on 29 May 2014, when a CT scan was carried out which showed a mass on his left kidney. A diagnosis of renal cell carcinoma was made on 18 June 2014 and the case was discussed at the Regional Urology Multidisciplinary (MDT) Meeting on 26 June 2014. The patient was then reviewed as an outpatient at the Ulster Hospital, Dundonald on 4 July 2014, when his care was transferred to Belfast City Hospital and he was reviewed there as an outpatient on 31 July 2014. The patient was scheduled for surgery to remove his kidney on 25 August 2014. However CT scans which were carried out on 26 August 2014 showed that the cancer had spread and the surgery did not proceed. The patient sadly passed away on 15 November 2014.

9. The patient's wife complained about the care and treatment provided to her late husband by both the South Eastern Health and Social Care Trust (SEHSCT) and the Belfast Health and Social Care Trust (BHSCT). The complainant also complained that there was poor communication between the two Trusts in relation to her husband's care and that neither Trust communicated well with her husband or her family.

Issues of complaint

10. I investigated the following issues:

Issue 1: Was the care and treatment provided to the patient in the SEHSCT and the BHSCT appropriate and reasonable?

Issue 2: The communication between the SEHSCT and the BHSCT in respect of the patient's care and treatment; and communication between the Trusts and the patient and his family.

Issue 3: How the SEHSCT and the BHSCT handled the complaint.

INVESTIGATION METHODOLOGY

11. In order to investigate the complaint, the Investigating Officer obtained from both Trusts all relevant documentation together with the Trusts' comments on the issues raised by the complainant. This documentation included information relating to the Trusts' handling of the complaint.

12. I determined to issue a composite report of the investigation in order to provide a clear and complete explanation to all parties to the events complained of. I am also mindful of the need to provide a full explanation as to how I reached my conclusions. I have informed both the SEHSCT and BHSCT of my determination in this regard.

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

- A Consultant in Emergency Medicine with experience in a large Teaching Hospital and Major Trauma Centre (ED IPA)

- A Consultant Radiologist with over 24 years' experience in a district General Hospital (Radiology IPA)

- A Consultant Gastroenterologist with experience in a central teaching hospital (G IPA). Advice was obtained from this IPA as the patient's treatment was managed by a Consultant Gastroenterologist in Lagan Valley Hospital

- A Consultant Urologist (Urology IPA)

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

15. 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.

16. The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration
- The Principles of Good Complaint Handling

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

18. The specific standards relevant to this complaint are:

- Management of Acute Diverticulitis and its Complications. (Authors: Hannah L. Welbourn and John E. Hartley)
- Department of Health, Social Services and Public Safety (DHSSPS), Integrated Elective Access Protocol
- BHSCT Tissue Pathology User Manual
- Procedure for Tracking Cancer Patients Transferring Between HSC Trusts on Cancer Waiting Time Pathways
- Northern Ireland Cancer Network (NiCan) Regional Urology Group – Urology Care Pathways
- Operational Policy for Belfast Trust and South Eastern Trust Specialist Urology Cancer MDT 2014/2015
- GMC 'Good Medical Practice'(2013)

19. I have not included all of the information obtained in the course of the investigation in this report. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

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

MY INVESTIGATION

Issue 1: Was the care and treatment provided to the patient by the SEHSCT and the BHSCT appropriate and reasonable?

20. The complainant stated that when her late husband attended the Emergency Department (ED) of Lagan Valley Hospital on 21 May 2014, he ought to have been admitted for further assessment. The complainant also complained there was unreasonable delay in reaching a diagnosis of renal (kidney) cancer and that an abdominal MRI[2] was cancelled, only to be requested again some weeks later. She further complained that her late husband's care ought to have been transferred to the BHSCT sooner so that he would have been on a specialist ward and failure to do this compromised his treatment. In relation to the care provided in the BHSCT, the complainant stated that they ought to have taken over the care of her husband's case at the MDT meeting on 26 June 2014. The complainant also raised concerns about the ward on which her husband was placed when he was an in-patient in Belfast City Hospital (BCH) between 25 August 2014 and 9 September 2014.

I will address each aspect of this complaint in turn:

i. Attendance at the Emergency Department of Lagan Valley Hospital

21. The patient attended Lagan Valley Hospital on 21 May 2014 complaining of left sided abdominal pain and nausea. He was assessed and discharged with antibiotics and advised to return if his symptoms persisted. The patient did return on 29 May 2014 when he was referred for a CT scan which showed a shadow on his left kidney. The complainant believed that her late husband should not have been discharged from the hospital on 21 May 2014.

22. The SEHSCT stated in response to investigation enquiries that '*The patient presented to the Emergency Department with symptoms and urinalysis in keeping*

[2] Magnetic Resonance Imaging – a diagnostic imaging technique

with a Urinary Tract Infection[3] (UTI). He was prescribed treatment accordingly and appropriately advised to return if his condition did not improve'.

23. Following a request for clarification, the SEHSCT stated '*The patient's symptoms were in keeping with an infection. The differential diagnosis would have included a UTI or diverticulitis*[4]'.

24. The Trust provided ED records from Lagan Valley Hospital dated 21 May 2014 and 29 May 2014, which I have examined. I note the following relevant extract from the records dated 21 May 2014:

'*Diagnosis: Diverticulitis*
Review arrangements: Colonoscopy[5] as outpatient. Asked to return if ↑ [increased] pain / unwell'

25. I also note the patient underwent a physical examination and blood tests were carried out on this date. I further note within the clinical records an 'Internal Referral for Colonoscopy' form dated 21 May 2014.

26. I note the following extract from the record dated 29 May 2014:

'*Care given*
19:50 – for medical admission – IV[6] paracetamol & regular routine bloods done on arrival. Gentamicin[7] commenced 20:10. Patient weighed as per protocol. Sent for CT. CT renal – no stone, no obstruction. Retroperitoneal[8] mass – probably lymphadenopathy[9]'

[3] A UTI is an infection that affects part of the urinary tract
[4] Diverticulitis is a condition where one or more of the diverticula (pouches of the large intestine) become inflamed and infected
[5] A colonoscopy is an endoscopic examination of the large intestine
[6] Intravenous - within a vein
[7] Gentamicin is an antibiotic used to treat bacterial infections
[8] A mass located behind the membrane of the abdominal cavity
[9] Lymphadenopathy is disease of the lymph nodes, in which they are abnormal in size, number, or consistency

27. The ED IPA confirmed that the investigations carried out in the ED of Lagan Valley Hospital on 21 May 2014 were reasonable and the results of all tests were noted in the documentation. He also advised that he did '*not think that any reasonable tests were missed'*.

28. As part of the investigation, the ED IPA was asked to advise on UTIs and diverticulitis. He explained that a differential diagnosis is '*the distinguishing of a disease or condition from others presenting with similar signs and symptoms*'. He advised that the patient's presenting symptoms were '*more in keeping with diverticulitis*.' The ED IPA advised '*it is not clear from the available documentation if a differential diagnosis was being considered – this is not clearly laid out in the notes*'. He further advised '*the diagnosis is clearly documented and a management plan recorded…there is a clear safety net to return if unwell*'. The IPA also advised '*it was appropriate and reasonable for the F2 doctor to have discharged the patient*'.

My Analysis and Findings

29. The records reflect that the patient reported symptoms of back pain, nausea and a high temperature. The records also state that he was treated with antibiotics and discharged home. The patient returned to the ED of Lagan Valley Hospital eight days later, on 29 May 2014, as he was continuing to experience symptoms.

30. I also note that the patient underwent a number of assessments in the ED on 21 May 2014. I accept the ED IPA's advice that his symptoms were appropriately assessed and investigated in the ED. The investigation has not uncovered evidence that a differential diagnosis was being considered by medical staff treating the patient. I therefore do not accept that a differential diagnosis was being considered and I am critical of the SEHSCT for asserting same in response to my investigation enquiries. The effect of this unfounded assertion has caused delay in completing this investigation.

31. I conclude that the patient was treated for diverticulitis and a referral was made for him to undergo a colonoscopy as an outpatient. I consider this was an appropriate course of action. Given the unfortunate findings of the CT scan when the patient

attended the ED on 29 May 2014 I fully understand the complainant's view that her late husband ought to have been admitted on his first ED attendance. However, I accept the IPA advice that the ED treated the most likely diagnosis given the patient's presentation. I accept the advice of the ED IPA that this most likely diagnosis was diverticulitis. I therefore conclude that SEHSCT's actions were appropriate. I am satisfied that the patient's care and treatment on 21 May 2014 was appropriate and reasonable.

32. Given my findings outlined above, I accept the advice of the ED IPA that it was both appropriate and reasonable for the particular grade of doctor to have discharged the patient on 21 May 2014, following consultation with a senior clinician. **I therefore do not uphold this aspect of the complaint.**

ii. Abdominal MRI scan

33. The patient's wife complained that when her husband was first admitted on 29 May 2014, he should have undergone an abdominal MRI scan, instead of a biopsy, as it would have shown spread of the cancer to the lymph nodes. The complainant stated this issue became particularly pertinent when a renal / inferior vena cava (IVC)[10] MRI scan was subsequently requested on 4 July 2014, prior to care being transferred from the SEHSCT to the BHSCT. The complainant further complained about the time it took for the renal/IVC MRI scan after the MDT and that the referral for the MRI was not 'red flagged'.

34. I have considered the Department of Health, Social Services and Public Safety (DHSSPS), Integrated Elective Access Protocol (30 April 2008) (the DHSSPS Protocol). I note at section 1.7.11 of the DHSSPS Protocol, the principles for booking cancer pathway patients are listed as follows:

a) *'All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral'*

[10] The inferior vena cava is a large vein that carries blood from the lower body to the heart

35. As part of the investigation of the complaint, enquiries were made of the SEHSCT regarding the cancellation of the abdominal MRI scan and a subsequent request for an MRI of the kidneys and vena cava. The SEHSCT stated '*the MRI scan was cancelled by the MRI Radiologist as the patient had already had a CT guided biopsy performed. There was no added benefit in having an MRI performed at this time'*.

36. The SEHSCT also stated '*it was suggested that an MRI scan may be useful and was duly requested at that time. Following further review of the CT films, it was felt that a biopsy would be more beneficial. The MRI scan was cancelled at this point*'. When asked regarding the subsequent MRI scan requested on 4 July 2014, the SEHSCT responded '*an MRI scan of the kidney and inferior vena cava was requested to provide the team with more detailed information'*.

37. In relation to the time taken to carry out the MRI, the SEHSCT further stated '*the multidisciplinary meeting was held on 26 June 2014. A red flag MRI scan was requested on 4 July 2014… the MRI request was registered in the Department of Radiology on Wednesday 9 July 2014. The MRI was undertaken and reported on 23 July 2014. A red flag target is 2 weeks from receipt of referral and therefore the target was met and there was no delay in the imaging'*.

38. The SEHSCT provided records in relation to scans and images requested in relation to the patient. I note the following relevant extracts:

Report of Renal CT scan

'*29/05/2014 – There is a large retroperitoneal soft tissue density mass…the aetiology [source] of this retroperitoneal tumour is uncertain. Possibilities could include a left para-aortic lymph node mass*
Addendum 30/05/14 – Advise referral for MRI and left retro peritoneal mass biopsy…lymph node mass remains possible'

19 June 2014 – MRI Abdomen

This examination has been cancelled by the Consultant Radiologist. Biopsy – renal cell ca – MRI not needed
Requested date: 30/05/2014

Requested examination(s): MRI Abdomen'

39. I also note that the patient was reviewed by a Consultant Urological Surgeon at the Ulster Hospital, Dundonald on 4 July 2014. I note within the record of this review a note stating '*MRI – renal / IVC'*.

40. Finally, I note an MRI scan request dated 4 July 2014 from the Ulster Hospital which is marked 'red flag' and an '*Abdominal MRI report*' dated 23 July 2014, which states the requested date was 9 July 2014.

41. As part of the investigation, advice was sought from the Radiology IPA regarding the request for the abdominal MRI scan in relation the patient on 30 May 2014. The Radiology IPA reviewed the CT images taken on 29 May 2014 and advised that in his opinion, the findings '*would be most in keeping with a renal carcinoma that had spread to lymph nodes and into the left renal vein*'. The Radiology IPA further advised that it was appropriate to advise for a biopsy, however an MRI would '*not have produced a pathological diagnosis'* and '*it would not be common practice to perform an MRI in all patients diagnosed with renal cell carcinoma'*.

42. The Radiology IPA was also asked questions regarding the cancellation of the abdominal MRI on 19 June 2014. The Radiology IPA stated '*at the time of review of the MRI request (19 June 2014) the histopathology biopsy report of 18 June 2014 was available'* and therefore '*the diagnosis was already made and MRI at this stage would not have provided any additional information to support the pathological diagnosis*'. He further advised he considered it was appropriate for the Consultant Radiologist to have cancelled the MRI.

43. The Urology IPA was asked questions regarding the renal/IVC MRI which was requested at a later date (4 July 2014). The Urology IPA advised it was appropriate for an MRI to have been requested by the Consultant Urological Surgeon at that time as it was being requested for a different reason than the MRI requested on 30 May 2014. The Urology IPA clarified that in making the referral on 4 July 2014, the Consultant Urological Surgeon '*wished to determine the precise extent of venous*

tumour thrombus[11] *to facilitate surgical planning…MRI is the recommended investigation for assessing the extent of venous involvement in these cases*'. The Urology IPA further advised the cancellation of the first MRI (19 June 2014) had no adverse effect on the patient's prognosis.

44. The Urology IPA was asked to comment on the spread of the patient's cancer to the lymph nodes. The Urology IPA advised '*lymph node spread was present at initial presentation'*.

45. I have examined the medical records in this case as part of the investigation. I note that following a renal CT scan on 29 May 2014, advice was provided by a Consultant Radiologist that the patient be referred for an MRI scan and a biopsy. I also note that a CT guided biopsy was carried out on 6 June 2014, the results of which were made known on 18 June 2014. I shall discuss the CT guided biopsy in more detail at a later stage in this report. I note the abdominal MRI scan was cancelled by a Consultant Radiologist on 19 June 2014.

46. I accept the advice of the Radiology IPA that it was appropriate that a biopsy was advised on 30 May 2014, in order to further inform the medical staff treating the patient. I accept that the initial decision to undertake an MRI may not have been common practice. However, this is indicative of a thorough response to the findings of the CT scan. With an expectation that both tests would be carried out, I understand the complainant's dismay when the abdominal MRI was subsequently cancelled. However, I note there were clinical reasons for the cancellation of this test. However, the investigation has not found evidence of this decision and its reasons being communicated to the patient or his family, which may have gone some way to alleviating their apparent confusion and concern regarding the issue. I shall discuss communication between clinicians and the patient at a later stage in this report. I accept the advice of the Radiology IPA that carrying out an MRI at that stage would not have given the medical team any additional information, given that the final results of the CT guided biopsy were known. I also accept the advice of the Urology IPA that the reason for the request of the MRI on 4 July 2014 was different

[11] The extent of the tumour's spread into / along the vein

than that for which it was requested in June 2014. I also accept the Urology IPA advice that the cancellation of the MRI on 19 June 2014 had no effect on the patient's prognosis.

47. Further, I note the complainant's view that the spread of her husband's cancer to the lymph nodes could have been detected had the MRI not been cancelled on 19 June 2014. I accept the advice of the Urology IPA that the spread of cancer to the lymph nodes was known in June, prior to the MRI having been cancelled. Therefore I do not consider that the MRI was required in order to diagnose lymph node spread. I will discuss the communication of lymph node spread to the patient and his family at a later point in this report.

48. I note the complaint about the length of time taken to carry out the MRI scan '*after the MDM [MDT]*'. However, the investigation has concluded that it was the Consultant Urological Surgeon in the Ulster Hospital who referred the patient for the MRI scan, not the MDT. The MDT meeting will also be discussed in more detail later in this report. I note the MRI was request on 4 July 2014 and the investigation has uncovered clear evidence that the request was 'red flagged'. I further note the MRI was completed and reported on, on 23 July 2014. This is 13 working days from the date the referral was made and 10 working days from the date the referral was received by the relevant department. I conclude there was no delay in the carrying out or reporting on the MRI.

49. **I therefore find no failings in the care and treatment in relation to the MRI and I do not uphold this issue of the complaint.**

iii. Diagnosis of renal cancer

50. The patient's wife complained that there was a delay in carrying out a biopsy and receipt of its results which was undertaken at Lagan Valley Hospital on 6 June 2014, resulting in a delay in the diagnosis of kidney cancer. She complained this delay was unreasonable and had an effect on her husband's prognosis.

51. I refer to the BHSCT Tissue Pathology User Manual (21 November 2013) (the Pathology Manual). I note within the Pathology Manual under the heading

'Repertoire', turnaround times are listed according to specialty. I also note under the specialty 'Surgical Pathology' the turnaround time states '*the majority of all small diagnostic specimens are reported between 2-6 days* ***of receipt*** *(my emphasis) (excluding Saturdays and Sundays). A further 2-4 days is usually required for the reporting of larger specimens. When special or further investigations are required an additional 24-48 hrs is often required'*.

52. I refer to the Northern Ireland Cancer Network (NiCan) Regional Urology Group – Urology Care Pathways[12] (29 January 2009) (the cancer pathway). I note the cancer pathway for renal tumours outlines a sixty two day maximum wait time, commencing with a GP referral. The Cancer Pathway states by day twenty eight, the patient is discussed at the MDT meeting and thereafter (by day thirty one), an outpatients appointment is to take place where treatment options are discussed and a decision is made how to treat him. I also note the treatment options listed are dependent on the staging of the cancer, with five different options listed.

53. In response to investigation enquiries, the SEHSCT stated following the result of the CT scan on 29 May 2014, '*the medical team were in consultation with Radiology to seek advice on how to best proceed. A CT guided biopsy[13] was arranged and performed on 6 June 2014 from which samples were sent to the Laboratory for testing. The few days wait for the biopsy to take place allowed discussion of the patient's case to ensure that the next appropriate investigation took place'*. The SEHSCT further stated '*an initial report was available on 18 June 2014 with a confirmed diagnosis of Renal Cell Carcinoma made on 2 July 2014. Several Pathologists were involved in this case due to the complex nature of the biopsy which contributed to the delay'*.

54. The SEHSCT stated it does not have a policy regarding turnaround times for biopsies as the BHSCT provides tissue pathology services. The SEHSCT also stated it consulted BHSCT regarding the CT guided biopsy sample in relation to the patient and it advised that the sample was received on 9 June 2014, was received by

[12] Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care
[13] A procedure using a CT scanner to take images of the biopsy needle during collection of the sample

the Consultant (Pathologist) on 10 June 2014, and an initial report was issued on 18 June 2014. The BHSCT stated the turnaround time for the sample was nine days.

55. I note it is recorded in the patient's clinical notes and records that a CT guided biopsy was performed on 6 June 2014.

56. In the CT guided biopsy report dated 18 June 2014 it is noted that '*the appearances on light microscopy are suggestive of a papillary renal cell carcinoma…immunochemistry*[14] *is being carried out for further confirmation and a further report will follow'*.

57. I have considered the supplementary CT guided biopsy report dated 2 July 2014. I note the author of this report is the same Consultant Pathologist who submitted the earlier report on 18 June 2014. I note the following extract:
'*the appearances are in keeping with papillary carcinoma which may be Type II*'.

58. I also note within the clinical records from 9 June 2014 until 18 June 2014, reference is made by various clinicians treating the patient, to awaiting the biopsy results.

59. I further note on 3 June 2014, a record entered during a ward round stating '*explained for biopsy on Friday… wait likely 10-14 days for results*'.

60. The G IPA was asked about whether there was unreasonable delay in carrying out, and reporting on, the CT guided biopsy performed on 6 June 2014. The G IPA did not identify unreasonable delay in the performing of the biopsy. However, he advised that '*there was an excessive delay in the biopsy results becoming available'* and he *'would expect results earlier than the 12 days it took on this occasion'*.

My Analysis and Findings

61. The complainant alleged there was a delay in the performance and reporting of a CT guided biopsy. I note that this was requested on 30 May 2014, and completed on 6 June 2014 at Lagan Valley Hospital. The investigation established there was an

[14] A specific type of chemical test on the biopsy relating to components of the immune system

initial report on the biopsy on 18 June 2014 with a diagnosis of renal cell carcinoma. There is also an indication that a further report would be provided after immunohistochemistry was carried out.

62. I also note the SEHSCT stated that the biopsy was complex in nature, however the investigation did not uncover evidence of this within the patient's clinical records. I note that during the period between the biopsy being carried out and the initial results being made available, the records indicate that the patient's further treatment was awaiting the results of the biopsy before moving forward. The investigation has uncovered that the clinical staff treating the patient informed him that the results of the biopsy would take ten to fourteen days. However, it is not clear from the clinical records how this timescale was arrived at. I also note that the biopsy report dated 18 June 2014 was considered the 'diagnosis' of renal cancer.

63. I acknowledge the advice of the G IPA who stated there was delay in the processing of the biopsy results, however I weigh this against the evidence provided by the SEHSCT relating to the BHSCT target turnaround times contained within the Pathology Manual. I further note the Pathology Manual discounts weekends in calculating the turnaround time and that the effective date is the date of receipt (not the extraction) of the sample. I therefore accept the SEHSCT's stance that the biopsy took nine days to process. I conclude this timeframe was just outside of that which is a target contained within the Pathology Manual. In consideration of the Urology IPA advice, I conclude there was minimal overall impact as a result of this minor delay.

64. I note that the decision to treat the patient was taken on 3 August 2014, some weeks after the MDT meeting. I note this is contrary to the Cancer Pathway. However, for the reasons outlined above, I do not find this delay to have been unreasonable. I am therefore unable to conclude that there was unnecessary delay at this point in the patient's care and treatment. **I therefore do not uphold this element of the complaint.**

iv. Transfer to BHSCT

65. The complainant alleged that her husband's care ought to have been transferred to the BHSCT sooner than was the case because she believes this would have made a difference to his prognosis.

66. I refer to the Procedure for Tracking Cancer Patients Transferring Between HSC Trusts on Cancer Waiting Time Pathways (5 February 2014) (the Pathway Transfer Procedure). I note section 3 outlines the key principles of the Pathway Transfer Procedure. The following extract is relevant:
'*3.1 Responsibility of referring Trust prior to Intertrust Transfer (ITT)*
Patients should be diagnosed and staged in line with the agreed care pathways and/or NICE guidelines…if a patient requires further investigations at a referring unit following regional MDT discussion, ITT cannot be initiated until all investigations have been carried out and the patient has been re-discussed at the regional MDT and/or the patient accepted for treatment'

67. I refer to the Operational Policy for Belfast Trust and South Eastern Trust Specialist Urology Cancer MDT 2014/2015 (the MDT Policy)[15]. At section 1 of the MDT policy it states that the Urology Specialist Multidisciplinary Team (MDT) is based at BCH and it serves as a local MDT for the Belfast and South Eastern HSC Trusts and acts as a '*Regional Cancer Treatment unit for the delivery of complex treatments'*. The MDT Policy outlines that the MDT meets each Thursday at BCH.

68. I note that section 4 of the MDT policy outlines the typical composition of professionals sitting on the team and the following are listed: a clinical oncologist, a consultant uro-oncology surgeon, a consultant radiologist, a consultant pathologist and a uro-oncology nurse.

69. I note that section 5 of the MDT Policy states '*all patients for discussion are added to the MDT list by 12 noon on the Tuesday prior to that meeting'*.

[15] The BHSCT stated that at the time of the patient's treatment, this was a 'working document'

70. I further note section 6 states '*patients with a new diagnosis of malignancy confirmed via pathology are added to the next MDT for discussion. Patients can then be reviewed at a subsequent urology results clinic to allow discussion of results and of the treatment plan'*.

71. I have examined the patient's clinical notes and records. In those records there is an email containing a referral to the Urology MDT meeting dated 19 June 2014. This referral was sent by the specialist registrar treating the patient at Lagan Valley Hospital.

72. I have examined the MDM Report from the Urology MDM at Belfast City Hospital on 26 June 2014. I note this report contains the patient's details and a short paragraph entitled '*MDM update'*. Under the heading 'MDM Action', I note '*[Ulster Hospital Consultant Urological Surgeon] to refer following clinic review'*. I also note the Consultant Urological Surgeon was present at the MDM.

73. I also note the following extracts in the patient's medical records:

'27 June 2014 – Informed patient [Consultant Urological Surgeon] is going to assess in clinic. Not sure if that is surgical / oncological'

1 July 2014 – For [Consultant Urologist] 12.30 Friday UHD

4 July 2014 – Review by Consultant Urologist at UHD
Large RP (retroperitoneal) mass 12x5
Left renal vein
Biopsy papillary (renal in origin)…
Left radical nephrectomy MRI renal / IVC
Refer BCH'

74. In the letter referring the patient to Belfast City Hospital of 7 July 2014 (dictated on 4 July 2014) it states:
'*[The patient] was discussed at the Urology MDM and felt to be a potential candidate for radical surgery…I have requested an MRI of kidney and IVC. Given vascular involvement I would be grateful if you would see him urgently to consider left radical nephrectomy'*.

75. In response to investigation enquiries, the SEHSCT stated that the LVH medical team registrar discussed the patient's case with the Urology Team in the BHSCT on 19 June 2014. As a result, he was advised to refer him to the Urology Department of the Ulster Hospital in Dundonald. The SEHSCT also stated this referral was made on the same date and '*The patient's case was discussed at the next Urology multi-disciplinary meeting in the Belfast City Hospital on 26 June 2014*'. The SEHSCT clarified this referral took place by telephone on 19 June 2014 and a handwritten '*follow up summary letter'* was sent to the consultant urological surgeon from the Lagan Valley Hospital's specialist registrar at an unknown date thereafter.

76. The SEHSCT further stated that following the MDT meeting, it was '*confirmed that he was to be reviewed at the [Urology] outpatient clinic at the [UHD]. An appointment was made for him to attend the Consultant Urological Surgeon's next results clinic on 4 July 2014'*. Finally, the SEHSCT stated '*following the patient's attendance at [the Urology] clinic, a referral letter was dictated on the same day to [Consultant Uro-oncologist], Belfast Trust, requesting him to be seen urgently for consideration for a left radical nephrectomy[16]'*.

77. As part of the investigation, the BHSCT was also asked the reason for its not taking responsibility for the patient's care after the MDT meeting on 26 June 2014. It stated it was '*standard clinical practice at the time*' for the patient's care to remain under the Ulster Hospital's Consultant Urological Surgeon and this practice was subsequently incorporated into the MDT Policy. The BHSCT further stated this practice is '*in accordance with the NICaN Urology Care Pathways*'.

78. As part of the investigation, advice from the Urology IPA was sought relating to the patient's referral to the MDT meeting. The IPA advised that he believed it was '*essential*' that his case was referred to the MDT meeting. The Urology IPA also advised that it may have been a consideration for medical staff to have referred the patient in May 2014 when the mass was first detected. However, the IPA considered that '*it would have been difficult to know which [MDT] to refer to. The possibilities would have included: haematology, colorectal, upper gi and urology'*. The Urology

[16] Surgical removal of left kidney

IPA advised that, on balance, it was reasonable and appropriate for the medical team to have awaited the outcome of the biopsy prior to referral to the MDT meeting.

79. The Investigating Officer also sought advice from the Urology IPA about the MDT record. The advice stated '*The MDT record dated 26th June 2014 was very unhelpful. It reported the histology of the biopsy but gave no comment about the stage of this locally advanced tumour and there was no recommendation about treatment'*.

80. The G IPA stated he believed the procedure outlined in the Cancer Pathway was '*largely followed'*. The G IPA further stated '*my reading of this situation is that it was very clear shortly after admission that the patient had cancer and this originated from the kidney. If transfer had taken place to a urology service early in the course of his disease, then frequent and difficult communication[17] would have been avoided'*.

81. In response to the IPA advice above, the SEHSCT stated '*urological input was organised as soon as pathological diagnosis was made…after referral, his management (including his bed location) was guided by the Urology Team*'.

My Analysis and findings

82. The complaint related to the timing of the referral and the outcome of the MDT meeting.

83. I have considered the Cancer Pathway. I accept the Urology IPA's advice that it was necessary for the patient's case to have been referred to the MDT meeting. I further accept the advice of the Urology IPA that on balance, it was necessary to wait for the CT guided biopsy results before the referral could be made. I note the reason for this was to ensure that the patient was considered promptly by the most appropriate professionals. I also note that in order to comply with the MDT Policy, a diagnosis of malignancy was required before referral, and this diagnosis was made in the biopsy results.

[17] Issues regarding communication will be addressed under issue 2 of this report

84. I note the decision of the MDT meeting was for the Ulster Hospital's consultant urological surgeon to refer the patient to Belfast City Hospital following his review at the outpatients' clinic. However the MDT meeting report does not outline the reasons for this decision[18]. I further note that when he was reviewed by the consultant urological surgeon on 4 July 2014, a red flag MRI scan was deemed necessary and requested. The Urology IPA has advised that this was carried out in order to determine the extent of the tumour. I have carefully considered this advice. In consideration of the Pathway Transfer Procedure, which states that any further assessments must be carried out prior to transfer, I accept that it would have been contrary to the Pathway Transfer Procedure had the patient been transferred to the BHSCT before this was requested. I note however that the letter transferring him to the BHSCT was dated the next working day (7 July 2014), meaning his care was transferred immediately after the Urology review appointment.

85. The complainant is concerned that had her husband been transferred to the BHSCT sooner, there may have been an improvement in his prognosis. The investigation has not uncovered evidence that his remaining within the SEHSCT had any effect on his overall prognosis. **I therefore do not uphold this element of the complaint**.

86. The complainant commented on this issue of complaint in response to my draft investigation report. She stated that she considered the only reason the consultant urological surgeon assessed her husband was because her son *'made the decision to drive alone to Dundonald Hospital. The staff he spoke to were shocked when realising the surgery had not taken place. We were given an emergency appointment for Friday 4th July.'*

87. The SEHSCT was asked to comment on these remarks. The Trust stated the appointment was booked on the appointments system on 1 July 2014 and provided a 'screen shot' from the appointments system reflecting this. The SEHSCT referred to the clinical records which refer to the appointment having been arranged. The SEHSCT finally stated *'there is no documentation to either support or refute that the*

[18] The decision of the MDT meeting will be discussed at a later point in this report

appointment was given in response to the patient's son's enquiry and not in response to the referral made by the Lagan Valley medical team.'

88. I have carefully considered the complainant's comments and views. The investigation did not uncover evidence to support her view that her son attended the Ulster Hospital to make enquiries about his treatment plan. There is evidence that the appointment was arranged on 1 July 2014 and this reflected in the clinical records. I am unable to conclude whether the appointment was arranged as a result of enquiries made by her son.

v. Ward placement in Lagan Valley Hospital

89. As part of her complaint the patient's wife stated that due to the failure to transfer his care to the BHSCT, her husband was placed on an unsuitable ward in Lagan Valley Hospital. As part of the investigation enquiries were made relating to the ward placement during the period 29 May 2014 to 4 July 2014.

90. In response to this issue of complaint the SEHSCT stated after the results of the biopsy were known on 18 June 2014, the patient's treatment from this point '*was guided by the Urology Team (this included attendance at the Urology Outpatients Clinic, Ulster Hospital). The decision to transfer the care of [the patient] to the Urology Team would have had to come from the Urology Team. The Medical Team in Lagan Valley continued to appraise the Urology Team of [the patient's] progress throughout his admission*'. The SEHSCT also clarified that Lagan Valley does not have an Oncology or Urology Ward.

91. I note that the patient was admitted to the medical admissions unit (MAU). I further note that he was transferred to the Coronary Care Unit (CCU) on 30 May 2014. He was transferred to a medical ward (1B) of Lagan Valley on 2 June 2014, where he remained until 4 July 2014.

92. In relation to this issue of complaint, the G IPA stated '*in the patient's case it was fairly rapidly clear that he had a urological malignancy. This became abundantly clear after the CT scan that was performed on 29th May 2014 and resulted at a time*

of 19:58. In my opinion the best care is provided by the clinical team with a direct specialist interest in this subject area. If patients are looked after by clinical teams who do not have dedicated expertise in the underlying condition, there is inevitably going to be increased delay and less effective management'. The G IPA continued '*my opinion is that the patient should have been moved to a renal ward when the diagnosis of renal cancer was established…I think the date of transfer should have been the 19th of June at the latest*'.

93. The Urology IPA advised '*he should have been treated in an Oncology ward in May 2014. In August 2014, it was too late*'. The Urology IPA also clarified '*physically it didn't matter where he was, his day to day care would have been the same. The issue is there was nobody involved in his care to identify how it should have been managed. He was denied the best supportive care*'.

94. In response to the IPA advice above, the SEHSCT stated '*there is no oncology inpatient ward available except in the Cancer Centre, which is used for acute treatment and not diagnostics'*. It further stated '*there was a focus on exhausting all treatment options'*.

My analysis and findings

95. I note that following his attendance at the ED on 29 May 2014, the patient was admitted as an inpatient in Lagan Valley on the same date. I also note he was primarily cared for on a medical ward during the period of his inpatient stay.

96. I also note the G IPAs' advice that he ought to have been treated on a more specialist ward; either a urology ward or an oncology ward and that this ought to have happened soon after his admission to hospital**.** I further note the fact that Lagan Valley Hospital does not have a ward of either of these specialisms and it would have been a matter for the Urology team to request the transfer of his care to their service. I also note the Trust's comments that the only oncology inpatient ward available in the Cancer Centre, which is based at Belfast City Hospital.

97. There is no evidence to explain why the patient could not have been transferred to a

Urology Service, within the SEHSCT (outside of Lagan Valley) during his period of inpatient stay. I have considered all available evidence and the IPA advice in relation to this issue. I conclude that the SEHSCT ought to have transferred him to a specialist ward, within the same Trust. The investigation has not uncovered evidence that had the patient been transferred to the BHSCT, he would have been placed on a more specialised ward. Furthermore, I have not been presented with evidence that the BHSCT ought to have taken over his care. In response to my draft report, the SEHSCT stated *'the Ulster Hospital does not have a specialist urology ward but uses beds on general surgical wards. The only "specialist urology ward" is in the Belfast Trust. However, it is the opinion of the [sic.] both the Urology and Physician medical teams that the patient's symptoms were being appropriately managed in the Lagan Valley Hospital.*'

98. I conclude that the patient's care ought to have been transferred so that his care was directly managed by a Consultant Urologist. I consider this would have allowed him and his family the opportunity to ask questions and seek advice from a specialist. The investigation did not uncover evidence that this was considered by the clinicians in Lagan Valley. However, I do not conclude that doing so would have led to a more positive outcome in respect of the patient's prognosis. Having considered all available evidence, I conclude this may have afforded him earlier supportive care in terms of his diagnosis, suited to his particular condition. An appropriate transfer may also have afforded him the care and treatment that specially trained and experienced staff could provide to someone with his condition. **I therefore consider this to be a failure in care and treatment and uphold this element of the complaint.**

VI. Liver ultrasound

99. As part of the investigation I have considered the cancellation of an ultrasound examination of the patient's liver by medical staff on 30 May 2014. The Investigating Officer asked the G IPA for advice on the cancellation of the liver ultrasound assessment. The G IPA stated '*the liver ultrasound being cancelled was entirely reasonable*' and the patient '*had undergone a CT scan of the abdomen on the 29th of May and this gave very detailed and adequate views of the liver*'. The Urology IPA

also commented that '*imaging had already shown extensive lymph node spread'*. I therefore make no finding of failure in care and treatment in relation to this issue.

100. A complaint was also made about the ward placement in Belfast City Hospital. The investigation considered the wards on which the patient was placed during his inpatient stay between 25 August 2014 and 9 September 2014. The patient was placed on a urology ward. In advising on this issue, the Urology IPA stated '*The patient appears to have been well cared for on this ward*' and raises no concerns about ward placement. I therefore make no finding of failure in care and treatment in relation to this issue.

101. However, I conclude as stated above there was a failure not to place the patient under more specialised care. I consider that he sustained the injustice of a lack of opportunity to have specialist care.

102. As part of the investigation into complaint, I received IPA advice from the Urology IPA and the G IPA regarding the MDT meeting, which disclosed the issue of the potential failing in the operation of the MDT meeting.

103. I have also considered the Operational Policy for Belfast Trust and South Eastern Trust Specialist Urology Cancer MDT 2014/15 (the MDT Policy). I note the following relevant extract from Section 5 of the MDT policy:
'*MDT decisions are recorded by the MDT Co-ordinator on CaPPS (Cancer Patient Pathway System)…the MDM report acts as the individual patient's treatment plan. The record includes:*
The identity of the patient
The multidisciplinary planning decision including which modality of treatment
Any relevant information in relation to the patient's holistic needs'.

104. In response to investigation enquiries, the BHSCT stated '*the MRI scan organised through the South Eastern Trust completed the staging of the patient's disease'*.

105. The Urology IPA advised there is no '*reference to TNM staging in the notes'*. The Urology IPA advised '*the MDT would have confirmed the staging'*, adding, 'the

pathway shows that staging should be defined before the MDT'. The Urology IPA further advised *'[the MDT]'s purpose is a verification of the diagnosis and plan'*.

106. I have also considered the Radiology IPA. He advised '*it was still possible to plan the optimum treatment without having formally recorded the patient TNM stage'*.

107. In response to the IPA advice outlined above, the SEHSCT stated '*the cancer was not formally staged but [Ulster Hospital Consultant Urological Surgeon]'s letter of 7/7/14 notes lymph node positive disease confirmed after MDT discussion. Biopsy had shown a papillary carcinoma. The bulk of the disease was in the kidney and as a young man, the plan was to explore surgical de-bulking'.* The SEHSCT also stated '*the staging had been done as part of a discussion at the MDT meeting rather than documented*'.

108. In relation to the Urology IPA's advice regarding the MDT record, the SEHSCT stated '*the Urology MDT record is a summary of the outcome of the discussion and the planned action, not a detailed report of actual discussion'*. The Urology IPA was asked for advice relating to the effect of not staging the patient's tumour. The advice was '*he would have died just as quickly. He was denied the best supportive care, care at home*.'

109. In response to the Urology IPA advice, the BHSCT stated '*The patient was referred for consideration for CN (Cytoreductive Nephrectomy) from an MDT on 26 June 2014 which had three radiologists in attendance (two from Belfast Trust and one from South Eastern Trust) and although the MDT letter does not state the stage, implicit in that referral is that the staging was not radiologically T4 or that the tumour was considered to be inoperable'*.

My analysis and findings

110. I have considered the content of the MDT record dated 26 June 2014 which is contained within the patient's clinical records. I note the Urology IPA's advice that the note of the MDT meeting was '*unhelpful*'. I also consider the content of the letter transferring the patient's care from the Ulster Hospital to Belfast City Hospital. It is

clear in that correspondence that the patient was being considered for surgery. However, this position is not clear from the record of the MDT, which simply records that he is to be reviewed by the Ulster Hospital's Consultant Urological Surgeon. I refer to the MDT Policy which states that the record is to reflect the patient's treatment plan. There is no evidence that the MDT considered the staging of his renal tumour, or how his treatment would fit into the Urology Care Pathway. I consider this is contrary to the Pathway Transfer Procedure. I also accept the advice of the Urology IPA that the failure to note the staging of the tumour (although a failing) had minimal effect on the patient's overall prognosis. I further note there is no record of the treatment plan for the patient.

111. An examination of the clinical notes and records indicate that the communication of the outcome of the MDT meeting to the clinicians treating the patient, was inadequate. I have reviewed the clinical records which indicate it was not clear if he was being transferred to urological or oncological service. There is no record of this in the MDT meeting. The MDT record is inadequate because it fails to outline the plan of treatment. Neither does it set out the reasons for this. However, the investigation has not uncovered evidence that this had any effect on the treatment. I consider the failure to make an adequate record of the MDT meeting is contrary to the third Principle of Good Administration, which requires public bodies to keep '*proper and appropriate records'*. I consider this failing constitutes maladministration. Communications in relation to the MDT will be discussed under issue 2 of this report.

112. I am satisfied that due to the maladministration outlined above, the patient, the complainant and his family suffered the injustice of upset, distress and uncertainty regarding the treatment plan in relation to his cancer.

Issue 2: Communication between the SEHSCT and the BHSCT, and between the Trusts and the patient's family.

113. The complainant stated that there was lack of communication between the SEHSCT and the BHSCT and as a result of this her husband's care was compromised. She also complained that the BHSCT did not seem to know anything about her husband at the time of his outpatient's appointment on 31 July 2014.

114. I have considered the Operational Policy for Belfast Trust and South Eastern Trust Specialist Urology Cancer MDT 2014/15 (the MDT Policy). I note the following relevant extract in section 6 of the MDT Policy:
'*Patients with a new diagnosis of malignancy confirmed via pathology are added to the next MDT for discussion. Patients can then be reviewed at a subsequent urology results clinic to allow discussion of results and of the treatment plan'*.

SEHSCT's Response to investigation enquiries

115. The SEHSCT stated the patient's case was discussed '*with the Urology Team in the Belfast Trust on 19 June 2014. All further communications with the Belfast Trust Urology Team were from the Ulster Hospital Urology Team*'. The SEHSCT also stated that at the MDT meeting '*a plan was agreed by the two Urology Teams along with the other members of the multi-disciplinary team present*'. The SEHSCT further stated that the Consultant Uro-onclogist in the BHSCT was '*copied into a results letter which [Ulster Hospital Consultant Urological Surgeon] had completed for the patient's GP. All results and communication were available on the Northern Ireland Electronic Care Record*'.

116. As part of the investigation enquiries, the SEHSCT was also requested to provide any policy or guidance on communication when there are two HSC Trusts involved in the care of a patient. The SEHSCT responded *'there is currently no Trust policy relating to communication between Trusts involved in a patient's care'*. The SEHSCT's response to my draft investigation report stated *'it is accepted that the MDT outcome was emailed to the SEHSCT [by the BHSCT], the information was sent to the Urology Consultant. The tracking team would not routinely check if patients being discussed are inpatients.'*

117. I have examined the patient's clinical records. I note the following entries relevant to the issue of communication:

'SEHSCT Records

19 June 2014 – BCH urology advised UHD Urology contact
D/W (discussed with) [UHD Consultant Urological Surgeon]
Likely not curative if diagnosis proven
Will discuss patient at MDM
Temps could be disease driven
Email to UHD Urology

26 June 2014 – Telephone call [UHD Consultant Urological Surgeon]'s secretary
Advised contact patient tracker
No answer
[UHD Consultant Urological Surgeon]'s secretary says that they should have word tomorrow and phone urology secretary (tomorrow)

27 June 2014 – Telephone call patient tracker
[UHD Consultant Urological Surgeon] to see at clinic and refer on ? to (word unclear) MDM doesn't state. Assumes oncology

30 June 2014 – Telephone call [ULSTER HOSPITAL, DUNDONALD Consultant Urological Surgeon]'s secretary. No answer.
Left message on voicemail to contact me…regarding follow up

4 July 2014 – Review at ULSTER HOSPITAL, DUNDONALD Urology outpatients
Refer BCH'

118. The Lagan Valley Hospital medical team wrote to the Ulster Hospital's Consultant Urological Surgeon stating '*as discussed on phone thanks for adding this 56 yr old man to your MDM'*. The clinical records also contain a handwritten letter from the specialist registrar at Lagan Valley to the Ulster Hosptial consultant urological surgeon, undated, which states '*thanks for seeing the patient, history as is described. He has remained inpatient since we spoke. He is aware of diagnosis but unwilling at present to engage in possibility of poor prognosis until he has spoken to yourself. I would be grateful if you could let us know plan for the patient so we could get him discharged home*'.

119. I also note within the medical records, a letter dated 4 July 2014 from the consultant urological surgeon to a Belfast City Hospital consultant uro-oncologist surgeon. In particular I note the following relevant extract from this letter '*He [The patient] was discussed at the Urology MDM and felt to be a potential candidate for radical surgery…Given vascular involvement I would be grateful if you would see him urgently to consider left radical nephrectomy'*.

120. There is no specific record of the patient's consultation with the consultant uro-oncologist at Belfast City Hospital on 23 July 2014. However I note that the findings are recorded in a letter to his GP.

121. In response to investigation enquiries, I note that the Urology IPA stated the referral letter dated 4 July 2014 provided enough information for the patient to have been reviewed by Belfast City Hospital.

My analysis and findings

122. The complainant alleges that the communication between the SEHSCT and the BHSCT in relation to her husband's care and treatment was inadequate. The investigation has disclosed that the first communication was made to the BHSCT from Lagan Valley on 19 June 2014, the date the biopsy results became available. I note this communication was by telephone and the clinician who made the phonecall was advised to contact the Ulster Hospital in the first instance. I note there is a record of this discussion within the clinical records and a referral to the MDT was discussed.

123. I also note the content of the MDT Policy and evidence within the clinical records that the referral to the MDT was carried out on the same day that the biopsy results were made available (18 June 2014). I consider in order to comply with the MDT policy, clinicians were required to await a *'diagnosis of malignancy'* prior to referral to MDT/BHSCT. I note this was carried out expeditiously after the diagnosis was made.

124. I further note the position as outlined by SEHSCT that the patient's care from 18 June 2014 was 'guided' by the Urology team. The investigation has uncovered evidence of communications being made to both the BHSCT and the Ulster Hospital once the biopsy results were available. However there is no evidence of guidance being provided, apart from the initial advice on 19 June 2014 to refer the patient to the Ulster Hospital to support the SEHSCT's position.

125. The investigation has not uncovered evidence that clinicians in Lagan Valley were required to communicate with BHSCT prior to this diagnosis. Moreover, prior to the MDT meeting on 26 June 2014, I consider it reasonable that there was limited communication as it was accepted that the MDT meeting was making the decision in relation to the patient's future care. However, the investigation has found that after the MDT meeting, there were repeated attempts by clinical staff in the SEHSCT to contact the Urology Team in an effort to find out what the treatment plan was. This included a handwritten letter (undated), which I have previously made reference to and referred to by the SEHSCT as a '*follow up summary letter*'. I have considered all the evidence available to me on this issue and conclude that the MDT outcome was sent from the BHSCT to the SEHSCT, however this information was not forwarded to the clinicians treating the patient in Lagan Valley. I conclude from this and other findings that there was insufficient communication from the Ulster Hosptial to Lagan Valley regarding the outcome of the MDT meeting, despite a SEHSCT staff being present at that meeting. I consider this failure in communication to be contrary to the second Principle of Good Administration, 'being customer focused' which requires public bodies to '*deal with customers in a co-ordinated way with other providers to ensure their needs are met*'.

126. The complaint also alleged that when the patient presented to Belfast City Hospital on 31 July 2014, the Consultant did not know anything about him. I note that the letter to the patient's GP following this review contains details of the consultation which took place. I note the Urology IPA's advice is that there was sufficient information contained within the referral letter for an outpatient review to be carried out. I also note the BHSCT state the information was recorded on the Northern Ireland Electronic Care Record. **I therefore do not uphold this element of the complaint**.

127. I am critical of the SEHSCT for stating there were no policies relevant to communications between two Trusts involved in a patients care. As previously noted, the BHSCT produced the Pathway Transfer Procedure which outlines how the Trusts work together in such circumstances. It may be useful for the SEHSCT to remind staff of this procedure in relation to future complaints.

128. I am satisfied that as a result of the maladministration outlined above, the patient suffered the injustice of uncertainty regarding his future treatment plan. Further, his wife, the complainant, suffered upset and uncertainty in relation to the care of her loved one.

129. The man's wife complained that the family were not informed that her husband '*only had limited time'* and she feels this could have avoided a lot of trauma for the family. She stated the fact her husband was being given surgery '*indicted to [the family] that there was hope*'. She further complained that she was not aware of the spread of cancer to the lymph nodes until the meeting held as part of the BHSCT's complaints process on 29 February 2016.

i. Purpose of surgery

130. I note within the MDT policy, reference is made to the role of the MDT Nurse Specialist Members. Page 10 of the MDT policy outlines part of this role is to '*act as the patient's advocate and counsel when informed discussion may lead to choices being made concerning treatment options*'.

131. In response to investigation enquiries, the BHSCT stated '*when the Consultant Uro-Oncologist reviewed the patient it was apparent that he was very sick and that his renal cancer was extensive. At the consultation it was explained to the patient and his wife, with the support of [Uro-Oncology Clinical Nurse Specialist], that the patient had extensive renal cell carcinoma which was incurable. The proposed surgery…was a debulking procedure (to surgically remove as much tumour as possible). Surgery was not a curative procedure. It was hoped that following surgery he would be considered for immunotherapy, in the hope that this would give*

longer life'.

132. I note the following relevant records from the patient's clinical records prior to the outpatient review at the Ulster Hospital:

'27 June 2014 - Ward Round notes
Discussion with patient and patient's brother regarding advanced nature of disease

3 July 2014 - I have discussed with [the patient] he is unwilling to discuss potential poor prognosis until he has seen [UHD Consultant Urological Surgeon]

133. I also note the following relevant records from the patient's admission to Lagan Valley after his review at the Ulster Hospital and before his review at Belfast City Hospital:

31 July 2014 – referred to palliative care team[19]
1 August 2014 - Ward Round notes
Awaiting surgery BCH
For nephrectomy – likely not curative procedure
Will need some chemotherapy also. Will be oncology after
Prognosis is unclear until operation is performed

6 August 2014 - Ward Round notes
For left nephrectomy for debulking
Not curative'

134. I refer to correspondence to the patient's GP from the consultant uro-oncologist at BCH dated 3 August 2014. I note the following relevant extract from that correspondence:

[19] Palliative treatment is treatment that relieves the symptoms of a disorder but does not cure it

'*He [the patient] has a very extensive renal cell carcinoma which is incurable and I have explained this to him today.*
I do not think that we can clear his lymph node disease but we should be able to get the kidney out and then consider him for immunotherapy and I have explained all that today. The operation will essentially [be] a debulking issue'

135. I further note the following relevant record relating to the patient's subsequent admission to Belfast City Hospital:

26 August 2014 - *Elective admission for debulking Mx (metastasis[20]) left nephrectomy…*
Procedure / alternatives / risks discussed understands it is not curative risk of being inoperable
Given opportunity to ask questions
Informed consent obtained

136. The Urology IPA advised in relation to this issue *'it seems that no one was prepared to have an honest conversation with [the patient] and say that surgery was very unlikely to be of benefit'.*

137. In response to this IPA advice, the BHSCT stated '*[BCH Uro-Oncologist] rejects the idea that he failed to have an honest discussion with the patient as he was advised of all the potential implications of the operation and told he was incurable…the Urology IPA considers it wrong to have offered him the hope of cure which is completely at odds with [BCH Uro-Oncolgist]'s conversation with him when he was told the disease was incurable'.*

My analysis and findings

138. I note that the complainant, the patient and his family were given false hope about the reason for the surgery which had been scheduled for 25 August 2014 to remove the patient's left kidney. The complainant stated that because surgery was being

[20] Metastasis is a secondary cancerous tumour (one which has spread from a primary cancer to another part of the body)

offered, both she and her husband believed there was a possibility that his cancer could have been curable.

139. From review of the medical notes, I conclude that the purpose of the surgery was a 'debulking' exercise, that is, to reduce as much of the bulk (volume) of a tumour as possible. There are several references to this term within the patient's clinical notes. The investigation of the complaint has disclosed a record stating this was discussed with the patient on 31 July 2014 during his review by a Consultant Uro-Oncologist at Belfast City Hospital. I also note reference to the likely limited effect of the surgery in the clinical records of the patient's inpatient stay in Lagan Valley. However, there is no record that this issue was discussed with the patient and his family. On 26 August 2014, when consent was being obtained for the surgery from the patient, I note there is a clinical record that the risks and purpose of the surgery were explained to him.

140. I note the advice of the Urology IPA that offering the patient surgery at all may not have been the best option for him. However, the investigation is not considering this decision, but rather, whether the purpose and risks of the surgery were appropriately communicated to him. After thorough investigation, I conclude that he was appropriately informed that his cancer was non-curable and the purpose of the surgery was to offer him the possibility of more time with his family.

141. The investigation has not found evidence of a MDT Nurse specialist being involved in the patient's care and treatment, and draws the conclusion that if this individual had been involved, there may have been improved communication regarding all aspects of the patient's care, including communication regarding the purpose of the surgery being offered to him.

ii. Lymph node spread

142. I refer to GMC 'Good Medical Practice' guidance dated 25 March 2013. I note 'Domain 3: communication, partnership and teamwork', contains the following guidance:

'32 you must give patients the information they want or need to know in a way they

can understand'

Clinical records

143. I note the following relevant entries in the clinical records:

30 May 2014 - CT Renal report (addendum)
Lymph node mass remains possible

23 July 2014 – MRI Abdomen report
There is a prominent lymph node mass lying adjacent to the left and posterior aspects of the aorta…there are further small lymph nodes lying posterior to the IVC at the level of the right renal veins. These lymph nodes do not appear significantly enlarged since examination of 29 May 2014

27 July 2014 - Ward Round notes
Papillary cell carcinoma left kidney with local spread

144. I also note in the undated letter previously referred to, the Specialist Registrar in Lagan Valley stated '*[the patient] proceeded to CT which revealed a large retroperitoneal mass involved the left kidney, left renal vein and para-aortic lymph nodes'*.

145. In relation to the complaint regarding the spread of cancer to the lymph nodes, the BHSCT responded as follows:
'*An MRI scan on 23 July 2014 confirmed lymph node spread. It is documented in the clinic letter from the consultation on 31 July 2014…that it was explained to the patient [by the Consultant Uro-oncologist] that he had extensive renal cell carcinoma and that he could not guarantee that surgery would clear his lymph node spread*'.

Relevant Independent Professional Advice (including Trust's response to IPA)

146. The Urology IPA stated there was evidence within the medical records of the Belfast City Hospital consultant uro-oncologist consulting with the patient on his prognosis.

147. The Urology IPA stated '*lymph node spread was present at initial presentation. It is not clear from the notes when the patient was first given this information*'.

148. In response to the IPA advice above, the SEHSCT stated '*at the MDT discussion, concern about lymph node involvement was raised. [UHD Consultant Urological Surgeon] does not recall if the patient had this information before the consultation but the presence of nodes would have been shared with him at this consultation*'.

My analysis and findings

149. I note the complaint that the patient and the family were not made aware of the spread of his cancer to the lymph nodes until a meeting in the BHSCT on 29 February 2016. That meeting was arranged as part of the complaints procedure.

150. I also note within the clinical records, the renal CT report dated 29 May 2014 makes reference to lymph node spread. I also note the Urology IPA advice which indicated that lymph node spread was present at initial presentation. However, I accept the Urology IPA advice that the first record of this being discussed with the patient was 3 August 2014, in the Consultant Uro-oncologist's letter to the patient's GP. I am satisfied that the patient was informed of cancer in the lymph nodes on this date.

151. Having reviewed all of the information, I consider that the patient was informed of the spread of his cancer to the lymph nodes, but at a later stage than he ought to have been. In light of the record of lymph node spread referred to in a letter to the Ulster Hospital, prior to the MDT meeting in June 2014, I consider the discussion ought to have taken place with the patient while he was an inpatient in Lagan Valley at this time. I therefore conclude there was a failure in the communication of this diagnostic information to him. I consider that as good communication is inextricably linked to the care afforded to a patient, the delay in communication in this instance constitutes a failure in care and treatment. I have also considered the contents of the GMC guidance and consider there was ineffective communication as required by

that guidance. I refer also to the Patient and Client Experience Standards which reflect human rights principles of fairness, respect, equality, dignity and autonomy (FREDA). The human rights values and principles outlined in the Patient and Client Experience standards and in the FREDA principles are relevant in this case. I am satisfied that the SEHSCT did not have regard for the patient's dignity in failing to adequately communicate important information to him about his condition, and I find this constitutes maladministration. **I therefore uphold this element of the complaint**.

152. I am satisfied that as a result of the failure in care and treatment I have identified, the patient suffered the injustice of uncertainty, distress and upset. I am also satisfied that the complainant suffered the injustice of uncertainty and frustration regarding her husband's treatment.

Issue 3: <u>The handling of the complaint by SEHSCT and BHSCT</u>

153. The investigation into the complaint has prompted a consideration of a further issue which was not the subject of a complaint to my Office. This is on the manner in which the two Trusts handled the complaint made to them by the patient's wife.

154. As part of the investigation, the Trusts' complaints files were examined and a chronology of events was prepared.

My Analysis and findings

155. Having carefully examined all the information provided to me I consider there was a delay in dealing with the complaint through the Trusts' complaints procedures. I note that the complainant made her initial complaint to both Trusts in March 2015. I also note a joint written response was issued to her on 9 July 2015, some four months later. However, during this period, the SEHSCT had forwarded update letters to the complainant. I further note the two Trusts' meetings took place on 22 January 2016 (SEHSCT) and 29 February 2016 (BHSCT). This was a period of almost one year. The HSC Complaints Procedure (2013) states at Section 1.4 '*Where possible, complaints should be dealt with immediately. Where this is not possible, local*

resolution should be completed within 20 working days of receipt of a complaint'. The HSC Complaints Procedure also states at Section 3.7 that '*a complaint should be acknowledged in writing within 2 working days*' and at Section 3.39 that '*where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person)*'. In consideration of time taken to respond to the complaint, I am mindful that the complaint was complex and involved two Trusts and three different service areas (ED, Gastroenterology and Urology). I also note evidence within the complaints file that the complainant requested a joint meeting. I further note that the initial intention of both Trusts was that after the second stage complaint, a joint meeting would take place however this was not practical given the attendees' conflicting schedules.

156. I note that a considerable period of time was taken up in the arranging of a meeting following the second stage complaint letter (12 August 2015). The SEHSCT meeting was arranged in over 12 weeks from receipt of the correspondence (22 January 2016), and the BHSCT meeting was arranged 22 weeks from receipt of the correspondence (29 January 2016). In this regard, I note within the complaints file numerous exchanges of emails attempting to arrange the meetings. However I also note during this time that the complainant was provided with regular updates by the SEHSCT, which had been agreed. I consider that in order to have maximum benefit to all those involved, the meetings ought to have happened much sooner than they did. I would also have expected both the BHSCT and the SEHSCT to contact the complainant to discuss the delay and ensure she was satisfied with the explanation.

157. The investigation has not found evidence of either Trust giving consideration to alternative methods of responding to complaints, as is also outlined in the HSC Complaints Procedure.

158. I have considered the first Principle of Good Complaint Handling 'Getting it right' which requires a public body to act in accordance with its own policy and guidance. I accept that it may not always be possible for the Trusts to respond fully to a complainant within the stated 20 working day timeframe, where complaints are complex and multifaceted. However, the HSC Complaints Procedure provides a

timeframe within which complaints will be responded to and concluded by bodies. I note the time taken to arrange the complaints meetings were considerably more than the timeframe outlined for resolution of the complaint by the HSC complaints procedure. The investigation has found no reason why the complaint was not acknowledged by either Trust, within two working days. **I therefore conclude that both the SEHSCT's and the BHSCT's handling of the complaint did not meet the requisite standard and I consider this constitutes maladministration.**

159. I am satisfied that as a result of the maladministration I have identified above, the complainant experience the injustice of upset, frustration and uncertainty in the complaints handling process.

CONCLUSION

160. The complainant submitted a complaint to me about the actions of the SEHSCT and the BHSCT.

161. I have investigated this complaint and have found a failure in the care and treatment the complainant's husband received in respect of:

- The failure of SEHSCT to transfer him to specialised care
- The failure of the SEHSCT and the BHSCT to adequately communicate with the patient and his family regarding lymph node spread

162. I have found maladministration in respect of the following:

- The failure of BHSCT to take an adequate record of MDT meeting
- The failure of SEHSCT to communicate the outcome of the MDT meeting to Lagan Valley Hospital
- The delay by the SEHSCT and the BHSCT in responding to the complaint

163. I am satisfied that the maladministration identified in this report caused the patient

to experience the injustice of distress, frustration, uncertainty and upset. I am also satisfied that the maladministration I identified caused the complainant to experience the injustice of upset, distress, uncertainty and frustration.

164. I have not found a failure in care and treatment or maladministration in respect of:

- Emergency Department (ED) attendance on 21 May 2014 (SEHSCT)
- Cancellation of abdominal MRI Scan (SEHSCT)
- Delay in CT guided biopsy (SEHSCT)
- SEHSCT transfer of care to BHSCT (SEHSCT)
- Communication by BHSCT with the patient regarding the purpose of surgery

Recommendations

I recommend that:

- The Chief Executives of the SEHSCT and the BHSCT provide the complainant with an apology for the failings identified, within three months of the date of my final report
- The SEHSCT make a payment of £1750 and the BHSCT make a payment of £1250 to the complainant by way of solatium for the injustice of upset, distress, uncertainty and frustration, within three months of the date of my final report
- The BHSCT implement changes to the recording of outcomes of the Urology MDT so that the patient's treatment plan is recorded in full
- The BHSCT Review the operation of the Urology MDT with a view to improving record keeping and communication between the Trusts involved, and provide evidence of same within three months of the date of my final report.

165. I am pleased to note that both the SEHSCT and the BHSCT accepted my findings and recommendations.

Marie Anderson

MARIE ANDERSON
Ombudsman

May 2018

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.