Investigation Report

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

NIPSO Reference: 202000460

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration

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Case Reference: 202000460

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's daughter (the patient) at the Royal Victoria Hospital (the RVH) during the period from 29 June 2020 to 25 September 2020. The patient was suffering from cauda equina syndrome. The complainant was concerned about the length of time it took for the patient to receive spinal surgery following her referral to the Trust from a private healthcare facility on 29 June 2020. The complainant was also concerned that she had to supply the Trust with a copy of the patient's MRI scan, carried out at the private healthcare facility, rather than the Trust carrying out its own MRI scan. In addition, the complainant was concerned that the Trust had not listened to the patient, or taken her seriously during the patient's emergency department attendances on 21 July 2020, 11-12 August 2020 and 25 September 2020.

The investigation examined the details of the complaint, the Trust's response, and relevant local and national guidance. I obtained independent professional advice from a Consultant Neurosurgeon and a Consultant in Emergency Medicine.

The investigation found that there were failings in the care and treatment the Trust's Neurology Department provided to the patient following her referral from the private healthcare facility. Although no failures were identified regarding the ED's actions, learning was identified for the Trust to reflect on regarding the patient's delays in being attended to whilst in the ED on 11-12 August 2020 and 25 September 2020 – in particular regarding communication with the patient during those delays, and the recording of those interactions. The complaint was therefore partially upheld.

The failures identified caused the patient to sustain the injustice of loss of opportunity for earlier surgery, and therefore relief from the pain and other symptoms she suffered with. In addition, the patient sustained the further injustice of uncertainty and frustration regarding her care and treatment – in terms of not knowing how her

symptoms were to be relieved, and having to present to the Hospital’s ED on several occasions. The failures also caused the complainant the time and effort of bringing a complaint to my Office.

I recommended that the Trust provides the complainant with a written apology within one month of the date of the final report. I made three further recommendations for the Trust to address to instigate service improvement and to prevent future reoccurrence of the failings identified – and recommended the Trust put in place an action plan to incorporate these recommendations, and update my Office in this respect within six months of the date of the final report.

THE COMPLAINT

1. This complaint is about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's daughter (the patient) at the Royal Victoria Hospital (the RVH) from 29 June 2020 until 25 September 2020. The patient was suffering from cauda equina syndrome[1]. The first aspect of the complaint relates to length of time the patient waited for spinal surgery following her referral to the Trust from a private healthcare facility on 29 June 2020. The second relates the Trust requiring the complainant to provide it with a copy of the patient's MRI[2] scan results obtained from a scan at the private healthcare facility. The third relates to the treatment the patient received during three attendances at the RVH's Emergency Department (ED) on 21 July 2020, 11-12 August 2020 and 25 September 2020.

Background

2. The patient is a lady aged in her 30s. In March 2019 a vehicle knocked the patient down in Canada, and the patient had subsequently returned to Northern Ireland.

3. In October 2019 the patient began to experience pain in her back and legs, and the patient attended her GP for this reason on 6 June 2020.

4. On 29 June 2020, the patient attended an appointment at a private healthcare facility. She underwent a MRI scan privately, which the complainant paid for. The private healthcare facility then referred the patient to the Trust's Neurosurgery Department at the RVH on a 'red-flag' basis[3].

5. On 7 July 2020, the Trust arranged a telephone appointment for the patient with a Consultant Neurosurgeon (Consultant A) for 30 July 2020. The Trust explained that it arranged a telephone appointment in line with UK-wide advice because of the Coronavirus pandemic (COVID-19).

[1] A rare and severe type of spinal stenosis where all the nerves in the lower back suddenly become severely compressed. Symptoms can include severe lower back pain, pain, numbness or weakness in one or both legs, loss or altered sensation in legs, buttocks, inner thighs, backs of legs and feet that gets worse over time, bladder and bowel problems and sudden sexual dysfunction.

[2] Magnetic Resonance Imaging to provide precise details of body parts via magnetic fields and radio waves.

[3] A term typically used to indicate that the patient is suspected of having cancer.

6. On 21 July 2020 the patient attended the ED at the RVH. The ED noted the appointment with Consultant A, and referred the patient to the spinal team for outpatient follow-up. The ED discharged the patient with pain medication.

7. On 30 July 2020 the patient's telephone consultation with the Consultant took place. The Consultant did not have access to the patient's private MRI scan results at the time of that consultation. The outcome of the consultation was that the Consultant would obtain the MRI scan results and then arrange a face-to-face consultation with the patient.

8. On 11 August 2020 the Trust uploaded the private MRI scan results. Consultant A scheduled a face-to-face consultation with the patient to take place on 27 August 2020, as he was to be on a period of annual leave.

9. Also on 11 August 2020, the patient had a telephone review with the RVH's Orthopaedic Integrated Clinical Assessment and Treatment Service[4] (OICATS), which had been set up following the patient's ED attendance on 21 July 2020. The Orthopaedic team advised the patient to attend the ED on an urgent basis - and she then did so. The Trust then made an urgent appointment with the patient for the following day.

10. On 12 August 2020 the patient attended the RVH again and underwent a new MRI scan. The results concerned the Orthopaedic team, and so on 13 August 2020 the patient underwent spinal surgery to address cauda equina syndrome.

11. The Trust discharged the patient on 15 August 2020.

12. The complainant raised a complaint to the Trust on 15 August 2020 about the care and treatment the Trust provided to the patient, and then raised a supplementary complaint on 2 September 2020.

13. On 25 September 2020, however, the patient attended the ED at the RVH a third time. The ED referred the patient to the spinal outpatient department for

[4] A team of registered healthcare professionals who provide specialist assessment and appropriate management of patients with orthopedic (branch of medicine dealing with the correction of deformities of bones or muscles) conditions.

review management. The complainant subsequently raised concerns with the Trust regarding this attendance also.

14. The Trust responded by letter dated 2 April 2021. The complainant was dissatisfied with this response, and so brought her complaint to my Office.

Issue of complaint

15. The issue of complaint accepted for investigation was:

Was the care and treatment provided to the patient by the Trust at the Royal Victoria Hospital during the period following her referral from the Private Healthcare Facility on 29 June 2020 until 25 September 2020 reasonable, appropriate and in line with relevant standards?

INVESTIGATION METHODOLOGY

16. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. Documentation gathered included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

17. Independent professional advice was obtained from the following independent professional advisors (IPAs):

- **Consultant Neurosurgeon (N IPA)**, MB, BS, FRCS (SN), with over 29 years' experience in the role, and the author of scientific papers looking at the pathology of cauda equina syndrome and patient management in the UK; and
- **Consultant in Emergency Medicine (EM IPA)**, FRCEM, FRCSEd (A&E), MBBS, LLM (Medical Law), RCPathME, with 15 years' experience in the role.

I enclose the clinical advice received at Appendix two to this report.

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

Relevant Standards and Guidance

19. 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. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[5]:

    - The Principles of Good Administration

20. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The National Institute for Health and Care Excellence (NICE) Guideline NG 59 - Low Back Pain and Sciatica in Over 16s: Assessment and Management, November 2016 (NG 59);
    - British Association of Spinal Surgeons (BASS) and the Society of British Neurological Surgeons (SBNS) Standards of Care for Investigation and Management of Cauda Equina Syndrome, January 2019 (Standards of Care);
    - Belfast Health and Social Care Trust Guidance for Staff on Integrated Elective Access Protocol, June 2015 (BHSCT Protocol);
    - Belfast Health and Social Care Trust Guidance for Recording Patients Referred to Outpatient or Inpatient/Daycase as Private to NHS, October 2019 (BHSCT Recording Guidance);

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

- Belfast Health and Social Care Trust: A Guide to the Management of Private Practice within the Belfast Trust, January 2019 (BHSCT Private Practice Guide);
- Royal Victoria Hospital Diagnostic Triage of Spinal Pain: Regional Pathway for Northern Ireland, since updated in February 2021 (Regional Pathway);
- Public Health Agency Letter to Trust Medical Directors re GP/ED Interface, May 2015 (PHA Letter);
- Society of British Neurological Surgeons Guidance on the Transmission of COVID-19 During Neurosurgical Procedures, June 2020 (SBNS COVID Guidance);
- Belfast Health and Social Care Trust Record of Reviewed Risk Assessments for 9B OPD, June 2020 (Risk Assessment Record);
- Belfast Health and Social Care Trust General Health and Safety Risk Assessments re COVID-19 for Staff on 9B OPD, June 2020 (BHSCT General Risk Assessments);
- Belfast Health and Social Care Trust General Risk Assessment Form as required by the Management of Health and Safety Regulations (NI) 2000, as amended, Level 9B Neurology OPC, June 2020 (BHSCT Risk Assessment);
- Belfast Health and Social Care Trust COSHH[6] Risk Assessment Form Regarding COVID-19 for Level 9B at RVH, June 2020 (RVH Risk Assessment);
- Belfast Health and Social Care Trust Guidance: Rebuilding Trust Services – Guidance on Risk Assessment and Completion of Rebuilding Trust Services Checklist, June 2020 (BHSCT Rebuilding Guidance);
- Royal Victoria Hospital Minutes of Neurosciences COVID-19 Preparedness Meeting, 20 March 2020 (Neurosciences Minutes); and
- The General Medical Council's Good Medical Practice, April 2013 (GMC Guidance).

[6] Control of Substances Hazardous to Health Regulations (NI) 20013, as amended 2005

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

22. A draft copy of this report was shared with the complainant, the Trust and Consultants A and B for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Was the care and treatment provided to the patient by the Trust at the Royal Victoria Hospital during the period following her referral from the Private Healthcare Facility on 29 June 2020 until 25 September 2020 reasonable, appropriate and in line with relevant standards?

Detail of Complaint

23. The complainant raised the following concerns regarding the care and treatment the Trust provided to the patient during the period 29 June 2020 to 25 September 2020:

    - That the Trust did not do anything following the referral from the private healthcare facility, and that the patient had to wait '*months*' for her condition to be treated.

    - That the complainant had to provide the Trust with a copy of the patient's MRI scan results obtained from a scan at the private healthcare facility. The complainant said she considered this to be inappropriate, and that the Trust ought to have carried out its own MRI scan.

    - That the Trust did not listen to the patient, or take the patient seriously during her ED attendances on 21 July 2020, 11-12 August 2020 and 25 September 2020. The complainant said that on 21 July 2020 the Trust

did not carry out its own MRI scan on the patient, and instead discharged the patient only with painkillers. The complainant said that on 11-12 August 2020, the ED discharged the patient and asked her to come back the following day for a MRI scan. The complainant also said that on 25 September 2020 the ED discharged the patient with painkillers and referred back to the spinal team for further review. The complainant considered that on each occasion ED staff ought to have listened to the patient and taken her seriously, and treated her accordingly.

Evidence Considered

Legislation/Policies/Guidance

24. I refer to the following policies and guidance which were considered as part of investigation enquiries:
    - NG 59;
    - Standards of Care;
    - BHSCT Protocol;
    - BHSCT Recording Guidance;
    - BHSCT Private Practice Guide;
    - Regional Pathway;
    - PHA Letter;
    - SBNS COVID Guidance;
    - Risk Assessment Record;
    - BHSCT General Risk Assessments;
    - BHSCT Risk Assessment;
    - RVH Risk Assessment;
    - BHSCT Rebuilding Guidance;
    - Neurosciences Minutes; and
    - GMC Guidance.

I enclose extracts from the above at Appendix three of this Report.

The Trust's response to investigation enquiries

Actions of the Trust regarding the Referral of 7 July 2020 and Provision of MRI Scan Results from the Private Healthcare Facility

25. The Trust stated that the private healthcare facility saw the patient on 29 June 2020, and referred the patient to the Trust's Neurosurgery Department. The Trust further stated that it received this referral on 7 July 2020 and that it was marked as '*red flag*'. The Trust said that this was not the correct designation for the patient's referral, as this designation is for suspected cancer only.

26. The Trust said a consultant neurosurgeon (Consultant B) reviewed the referral, categorised it as '*urgent*', and that day arranged a telephone consultation for the patient with Consultant A on 30 July 2020. The Trust said that it arranged a telephone consultation in line with '*UK-wide advice*' to '*safeguard patients in relation to the COVID-19 pandemic*' in order to '*reduce the risks presented with face to face consultations*'.

27. The Trust said before that telephone consultation took place, the patient attended the ED on 21 July 2020. The Trust went on to say that following the patient's ED attendance, the ED referred the patient to its OICATS.

28. The Trust stated that Consultant A became aware of this telephone appointment when he received his clinic list in the morning on 30 July 2020.

29. The Trust further stated that when Consultant A became aware of the patient, he '*tried to obtain her MRI scans urgently*', as they were aware that a MRI scan had been carried out privately. The Trust stated that the scans were not available, as the private healthcare facility had not provided these alongside the referral – it only provided the MRI report. The Trust said that when Consultant A was unable to obtain the scans he '*asked for the scans to be obtained*' and to be '*notified when this occurred*'.

30. The Trust stated that Consultant A did not arrange for a new MRI scan to take place, as this would have been a '*repeat*' of the earlier private scan.

31. The Trust said that Consultant A was aware of the patient's ED attendance on 21 July 2020, and that the decision made at that time was the patient '*did not require emergency admission to hospital*'. The Trust stated because the ED attendance had been a '*face to face consultation*', it was '*clearly a more accurate assessment than could be made over the telephone*'.

32. The Trust said Consultant A had been unable to make a '*fully informed*' decision regarding the patient's case because the MRI scan images were not available on 30 July 2020, and due to the '*restraints*' of the telephone system.

33. The Trust stated that nonetheless, Consultant A arranged to see the patient '*as soon as possible*' after the MRI scans '*had been made available to him*'. The Trust said that the MRI scan images '*became available*' on 11 August 2020, which was just before Consultant A commenced a period of annual leave on 17 August 2020. The Trust stated that Consultant A became aware of the scans just before his leave started, and so Consultant A '*made arrangement to see*' the patient '*as soon as possible after his return*'. Consultant A arranged this consultation for 27 August 2020.

34. The Trust said that on 11 August 2020, before the face to face consultation could take place, a GP with Special Interest from OICATS conducted a telephone review with the patient on foot of the referral made on 21 July 2020. The Trust said the GP with Special Interest was '*unhappy with the current status*' of the patient, and advised the patient to attend the ED '*immediately*' for *'further assessment of suspected cauda Equina Syndrome*'. The Trust said this advice was based on the patient's '*bilateral leg pain*' getting '*worse*' and that the patient was complaining of '*urinary hesitancy (although there was no mentioned of retention or incontinence)*'.

35. The Trust said when the patient attended the ED on the night of 11-12 August 2020, the ED referred the patient to the Trauma and Orthopaedics Department. The Trust went on to say a MRI scan took place the following day (12 August 2020), following which the Trust decided to admit the patient to hospital for spinal surgery – which took place on 13 August 2020.

36. The Trust stated that Consultant A would have '*considered*' the patient for surgery earlier if he had access to the MRI scan results on 30 July 2020. The Trust stated that '*the decision to offer surgery hinges on the scan appearances, which were not available to [Consultant A] at the initial telephone conversation, and on the clinical assessment of the patient*'. The Trust said that the OICATS and ED assessments on 11 August 2020 indicated the patient's condition had deteriorated, and it was on that basis that the Trust arranged surgery.

37. The Trust said that NG 59 states primary care providers should only consider surgery for patients with '*sciatica*' where '*non-surgical treatment has not improved pain or function*' and where scan results '*are consistent with sciatic symptoms*'. The Trust also said '*most surgeons will advise*' initial non-surgical management without being '*exposed to the risks of surgery*'.

38. The Trust rejected the complainant's assertion that it, and Consultant A, did not do anything following the patient's referral to the Trust. Nonetheless, in its response to my Office the Trust set out learning it had identified from a '*clinical record review*' of the patient's case. These were:

    - '*All new urgent and red flag referrals should have face-to-face rather than virtual clinic appointments, to allow physical examination and urgent action to be taken at the outpatients appointment when required*';

    - '*There is a need to ensure urgent and red flag referred patients should have available imaging to the team, to allow for prompt decision-making. This is a particular problem when patients have private scans, which are unavailable for review on NHS systems*'; and

    - '*Patients presenting to the ED with severe spinal pain and symptoms suspicious of 'impending cauda equina' should be considered for admission and/or urgent MRI imaging*'.

39. The Trust undertook to '*give careful consideration to these learning points*' in order to '*inform changes in practice*' and help improve the Neurology Department's '*aim of providing a more responsive, effective, and efficient service*'.

The Patient's ED Attendances

40. Regarding the patient's ED attendance on 21 July 2020, the Trust stated that the patient was recorded as '*GP referral, results from MRI confirm cauda equina a/w (await) appointment with neurosurgery back pain travelling down both legs*' – and was assigned Triage category 3[7].

41. The Trust said an Advanced Clinical Practitioner attended to the patient and discussed the patient's case with an ED Consultant and the orthopaedic team. The Trust went on to say that following those discussions, the patient was referred to the spinal team for outpatient follow-up, was discharged with pain relief medication and advised to return to the ED if her symptoms worsened.

42. Regarding the patient's ED attendance on 11-12 August 2020, the Trust stated that the patient was recorded as '*C/O [complaining of] lower back pain and leg pain. States hx of cauda equine, urinary symptoms worsening, however, still has sensation of pelvic area*'. The Trust said a Foundation Level 2 doctor[8] attended to the patient and referred the patient to the orthopaedic team for further assessment that night at 23:10. The Trust went on to say the orthopaedic doctor assessed the patient at 04:00, and given her MRI scan results and '*new symptom of saddle anaesthesia*', advised the patient to attend the musculoskeletal clinic at 09:00 '*for further assessment and imaging*'.

43. Regarding the patient's ED attendance on 25 September 2020, the Trust stated that the patient was recorded as '*PT states numbness ? all over – ongoing a few days unsure exactly how long – states started as pins and needles in front of legs noted when shaving*' – and was allocated Triage category 4. The Trust said that a locum doctor[9] attended to the patient and noted the patient's recent

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[7] Manchester Triage System is a risk assessment tool to assess patients on arrival at the Emergency Department, and assign a clinical priority according to their presenting complaint. It sorts into five degrees of urgency, each with its own target within which the patient must be seen – as follows:

Category 1	:	Immediate	:	Red	:	0 minutes wait
Category 2	:	Very Urgent	:	Orange	:	10 minute wait
Category 3	:	Urgent	:	Yellow	:	1 hour wait
Category 4	:	Standard	:	Green	:	2 hours wait
Category 5	:	Non-Urgent	:	Blue	:	4 hours wait

[8] A Foundation doctor is a grade of medical practitioner undertaking the compulsory Foundation programme – a two-year postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. A Level 2 doctor is in the second year of this training programme. These doctors remain under clinical supervision, but have increasing responsibility for patient care.

[9] A doctor who temporarily fills a rota gap within a hospital, clinic or practice.

'*decompression back surgery*' and the spinal team's review. The Trust went on to say that the doctor noted '*anxiety with low mood*' and queried '*worsening paraesthesia*[10] *from lower back pathology*'. The Trust stated the locum doctor referred the patient to the '*card before you leave (CBYL) mental health service*' and the spinal outpatient department for '*further review and management*'.

Relevant excerpts from medical records

44. I enclose relevant excerpts from the patient's medical records at Appendix four to this Report.

Relevant Independent Professional Advice

Actions of the Trust regarding the Referral of 7 July 2020 and Provision of MRI Scan Results from the Private Healthcare Facility

Neurosurgeon IPA

45. The N IPA advised that cauda equina syndrome is a '*clinico-radiological syndrome in which the cauda equina is compressed, usually by an acute lumbar disc prolapse*'. The IPA went on to advice that the cauda equina is a collection of nerve roots in the spine which control '*bladder and bowel sphincter function and perennial sensation*' and which affect '*normal sexual function*'. The roots in the cauda equina also '*supply the muscles around the hip, foot and ankle, and subserve sensation below the knee and in the perennial (genital) region, through sacral nerves*'.

46. The N IPA advised that at the time of the private healthcare facility's referral to the Trust, the patient was suffering from '*back pain and bilateral sciatica with an inability to feel sensation whilst passing urine*'. The N IPA referred to the Standards of Care and further advised that '*this is enough to merit consideration of cauda equina syndrome and institute urgent (same day) MR scanning, usually arranged through referral to the ED*'. The N IPA advised that

[10] Pins and Needles sensation.

the private healthcare facility handled this initial element of the patient's care, and then made the referral to the Trust.

47. The N IPA advised that the Trust received the referral from the private healthcare facility on 7 July 2020 – and Consultant B received it. The N IPA advised that the exact content of that referral was unknown, but that it '*likely*' included '*the MR report with its reference to 'red flag' symptoms*'. The N IPA advised that Consultant B '*chose to downgrade the referral to 'urgent', and arranged an outpatient assessment*' for 30 July 2020.

48. The N IPA further advised that '*we do not have direct evidence of the decision making about the referral of 07.07.20 to the on-call Neurosurgeon [Consultant B], in the Neurosurgery Department*' in the patient's medical notes. The N IPA advised that good medical practice, as set out in the GMC Guidance, dictates that such decisions be recorded in writing.

49. Regarding the decision to downgrade the referral to 'urgent', the N IPA advised that it '*could be argued the decision was appropriate for two reasons*'. The first being that '*the clinical information recorded no cauda equina symptoms other than bilateral leg pain*' and that '*sphincter dysfunction was not present, implying that the sacral nerves were functioning normally*'. The second being that '*the imaging report states that some CSF*[11] *was seen on the axial images, which implies that CSF pressures are not particularly high*'.

50. The N IPA further advised that '*by contrast*' when presented with similar symptoms on 11 August 2020 the OICATS doctor '*decided that immediate referral to ED was appropriate*' which led to the patient's surgery taking place.

51. The N IPA advised that '*both these solutions are reasonable*', as the patient did not develop '*complete or severe incomplete cauda equina syndrome*'. The N IPA further advised that '*the reason for surgery is to prevent incontinence, and loss of sexual function, not simply as a relief of pain*'. The N IPA went on to

[11] Cerebrospinal fluid – clear, colourless body fluid found within the tissue that surrounds the brain and spinal cord of all vertebrates.

advise that '*operative complications also must be weighed in this balance of risk of benefit*'.

52. In addition, the N IPA advised that 'red flag' referrals are appropriate for suspected malignant spinal cord compression, rather than cauda equina specifically. However, the N IPA further advised that symptoms between the two conditions are '*similar*' and can '*overlap*'. The N IPA further advised that the pathway for both conditions is to get an MRI scan '*quickly*' and to get surgery if appropriate.

53. In terms of the Trust's actions following its designation of the referral, the N IPA noted that Consultant B set up a telephone consultation for the patient for 30 July 2020 with Consultant A. The N IPA advised that the '*safest thing*' for Consultant B to have done would have been to have arranged to see the patient face to face on the day the Trust received the referral (7 July 2020). The N IPA advised that the Trust '*should*' have assessed the patient again '*carefully*', and '*should*' have had a discussion with the patient at that time about the '*risk and balance*' between surgical and non-surgical treatment pathways.

54. The N IPA further advised that there was '*absolutely no need*' for an urgent operation to take place at that time, but '*an option to have an operation should have been put to her*'. This '*should*' have been in tandem with a conversation about '*careful watching*' and '*advice on what to do if the clinical situation became worse*'. The N IPA advised that Consultant B may have been following the Trust's advice about managing patients during the COVID-19 pandemic – but further advised that by June 2020 it was '*apparent that emergencies still needed to be treated, at some extra risk, but in a timely way'* in order to prevent *'medical catastrophes from inadequate care*'.

55. In terms of the patient's consultation with Consultant A on 30 July 2020, I asked the N IPA about the Trust's decision for this to take place by telephone rather than face to face on the basis of risk associated with COVID-19. The N IPA advised that there were no specific guidelines governing the assessment of patients with suspected cauda equina syndrome during the COVID-19 pandemic. However, the N IPA referred to the SBNS COVID Guidance and

advised that '*most procedures to the head and spine should be safe with routine face and eye protection*'. The N IPA also referred to the Trust's Neurosciences Minutes and advised that it states '*if patient needs to attend as ad-hoc then they should be booked into next face to face clinic*'.

56. The N IPA advised that departments had to '*suddenly adapt*' to the COVID-19 pandemic and '*make judgments*' as to who required a face to face consultation, and who could be assessed over the telephone. The N IPA further advised during the initial months of the pandemic, the Trust was advised to only assess patients with '*urgent*' conditions face to face. The N IPA advised '*suspected cauda equina syndrome*' is considered '*urgent*'.

57. The N IPA advised that the patient had already been assessed by her GP and undergone a MRI scan which showed a '*highly suspicious findings of 'impending' cauda equina syndrome; bilateral pain; and a large disc prolapse*'. The N IPA further advised, as a result and despite the COVID-19 pandemic, the patient '*should*' have been seen face to face. The N IPA advised that a telephone consultation in the prevailing circumstances was '*inadequate*'. The N IPA further reiterated his advice that this face to face consultation '*should*' have taken place earlier than 30 July 2020 – specifically on 7 July 2020 when the Trust received the referral from the private healthcare facility. The N IPA advised '*the assumption seemed to be that the patient's condition was not urgent*'.

58. I asked the N IPA about the patient being required to provide her privately carried out MRI scan results to the Trust, rather than the Trust carrying out its own MRI scan. The N IPA advised that the private healthcare facility had not provided the MRI scan results to the Trust along with the initial referral – only the MRI report was provided. The N IPA advised that Consultant A was '*compromised*' by not having access to the patient's MRI scan results, or notes of the patient's ED attendance on 21 July 2020 when he assessed the patient. The N IPA further advised that Consultant B '*should have arranged transfer of the images urgently when he received the referral, or to arrange a further MR as an NHS patient urgently*'.

59. I asked the N IPA about Consultant A’s actions following the telephone consultation with the patient. The N IPA advised that Consultant A ‘*arranged for his secretary*’ to obtain the patient’s MRI scan results, but that ‘*there was no urgency about this, where there should have been, particularly as he was about to go on holiday*’. The N IPA further advised that Consultant A ‘*should have put a time limit on the transfer of images, or alternatively arranged an urgent MR scan*’.

60. I asked the N IPA specifically about Consultant’s A’s decision to arrange a follow-up face to face consultation with the patient on 27 August 2020, 28 days following the initial telephone consultation. The N IPA advised that Consultant A ‘*should*’ have arranged the follow-up consultation within ‘*24 hours*’. The N IPA advised that ‘*whilst in one department the same condition was dealt with by organising an emergency MR scan and operation within 36 hours, in another department in the same hospital the patient was treated by telephone interview and face to face follow up [28] days later*’.

61. I asked the N IPA about any impact of the delay on obtaining the MRI scan results, or of the decision not to arrange a new urgent MRI scan at the Trust, on the patient. The N IPA advised that ‘*I do not see from the evidence available that the delay did any harm, other than prolong the period the patient was in pain for*’. The N IPA further advised that ‘*as most patients with a disc prolapse get better, rather than deteriorate, there was a chance she would have improved and avoided an operation entirely, as happens in 90% of patients with sciatica from a disc prolapse*’.

Emergency Medicine IPA

62. The EM IPA advised that it was for the ‘*specialist team*’ to obtain any imaging that was required. The EM IPA further advised that on 21 July 2020 the ED staff had all the information that was necessary for them to have, and they ‘*acted upon*’ that information.

The Patient's ED Attendances

EM IPA

63. Regarding the patient's ED attendance on 21 July 2020, the EM IPA advised that the ED triaged the patient on arrival and an ACP[12] subsequently assessed her. The EM IPA advised that '*a clinical history and examination were completed*'. The EM IPA further advised that a physical examination took place, which included '*an examination of the rectum…which was normal*'. The EM IPA advised that the ACP '*fully completed the spinal assessment proforma ASIA chart*' which is '*a clear and well recognised method to identify examination findings*'. The EM IPA further advised that the ACP consulted with an SHO[13] Emergency Doctor and an ED Consultant on the patient's case.

64. The EM IPA advised that there is no record of the ED obtaining or discussing the MRI scan results, only the scan report. The EM IPA further advised that '*it is unlikely that looking at the images would be of any additional clinical benefit during the ED assessment*', and that as a result the EM IPA does not '*consider this this is something that the ED staff should have been expected to consider*'. The EM IPA advised it would be for the '*specialist team*' to obtain any images they required.

65. The EM IPA advised that the Trust recorded the diagnosis as cauda equina, but '*based on the clinical findings, it was felt that there were no acute features that warranted immediate admission for intervention that day*'. The EM IPA further advised '*the attending team considered the symptoms to be ongoing with no new or progressing features*' and as a result, '*the patient required urgent follow up rather than emergency admission for surgery*'. The EM IPA advised the ED discharged the patient with '*advice*' about '*red flag symptoms*', '*power and sensation*' and '*incontinence / bladder and bowel symptoms*'. The ED advised the patient to '*return immediately*' if she developed any of those symptoms.

66. The EM IPA advised that whilst in the ED, the Trust provided the patient with pain medication and stomach-settling medication, and discharged her with

[12] Advanced Care Practitioner – middle grade doctor.
[13] Senior House Officer – the historic title for a Junior Doctor – now referred to ST1, ST2 or ST3, or Clinical Fellow

further pain medication. The EM IPA further advised that the Trust referred the patient '*for spinal assessment*'. The EM IPA also advised that the ED provided this referral with the patient's GP referral and MRI report, which was '*an appropriate course of action*'. The EM IPA advised that the ED noted being aware that a telephone assessment with Consultant A was scheduled, but made no mention of the specific date for it. The EM IPA further advised that nonetheless the fresh referral for spinal assessment was '*appropriate*'.

67. The EM IPA advised the patient's initial assessment at triage, and pathway through the ED that day were '*in line with good practice*', and that the Trust attended to the patient '*promptly*'. The EM IPA further advised the decision the ED staff made on the day '*appears reasonable*', and was in line with NG 59 and the Regional Pathway. The EM IPA also advised that the '*necessary information*' was '*available and acted upon*'.

68. I asked the EM IPA whether the ED ought to have obtained a fresh MRI scan as part of the patient's ED attendance. The EM IPA advised that this would only have been appropriate if '*the team felt the patient's condition had changed significantly, or if the patient had not already had a scan recently completed (3 July 2020)*'. The EM IPA further advised that he did '*not consider that an MRI on the day would have altered the management'.* The EM IPA went on to advise from an ED perspective *'the diagnosis, 'disc herniation' was known and simply repeating the scan would not have added to the assessment or the decisions made by the team which were directed by the clinical examination findings in addition to the MRI report findings*'.

69. I asked the EM IPA if there was evidence regarding whether the ED had listened to patient and taken her seriously during her ED attendance. The EM IPA advised that the record of the ED attendance was '*succinct*' and contains '*pertinent clinical details and examination findings*' – including '*details of the proposed diagnosis, and the advice and treatment given to the patient*'. The EM IPA further advised there was nothing in the medical notes to suggest the patient was unhappy with the clinical decision made on the day, or that the patient felt the ED had not listened to her.

70. Regarding the patient's ED attendance on 11-12 August 2020, the EM IPA advised that the patient arrived at 15:41, and the ED triaged her at 16:03. The EM IPA further advised the ED recorded a NEWS score of one[14] and recorded the patient's pain as *moderate*'. The EM IPA advised the ED should triage patients within 15 minutes of arrival at the ED, and that the ED did not meet this timeframe on this occasion. The EM IPA further advised that '*I do not consider the slight delay to have had a negative impact on the patient*'.

71. The EM IPA advised that triage records show that the patient had a history of cauda equina and was now having worsening urinary symptoms, but still had '*sensation in the pelvic area*'. The notes documented that the patient had '*increasing urinary frequency for the preceding 2 days, but no incontinence*' – and that there had been '*a change in sensation in the left groin which was intermittent for 3 days*'. The EM IPA advised that ED staff noted an '*orthopaedic doctor*' advised the patient to attend the ED. The EM IPA further advised there is no mention of the patient's telephone assessment with Consultant A in the ED notes, but that those events had been somewhat overtaken by the orthopaedic doctor's referral – and it was likely that the patient raised this during her ED attendance.

72. The EM IPA advised the medical records also show the ED physically examined the patient. The ED staff examined the patient's arms and legs which included an assessment of tone, power in reflexes and of sensation. The notes document a '*reduced sensation in the lower left limb in the L4/L5 distribution*[15]' and in the saddle area on the left and behind the left knee.

73. The EM IPA advised '*the areas of altered sensation identified on 11 August were not present in the clinical findings on 21 July 2020*', and that '*these symptoms would constitute a significant difference in the clinical findings on the two attendances*'.

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[14] National Early Warning Score – designed to determine the degree of illness and to alert staff to sick or unstable patients. A score of 1 means low risk.

[15] L4/L5 refer to nerve roots supplying sensation to an area of the skin on the lower leg - this area is the region below the knee on the front and side of the lower leg extending the big toe and 2nd toe.

74. The EM IPA advised that the examination records are noted as being completed at 22:10, which shows that '*the patient waited a long time for medical assessment following the initial triage*' which was a '*significant delay*'. The EM IPA advised the ED should carry out this review within 60 minutes of arrival in the ED, but that on this occasion it was six hours. The EM IPA further advised there was nothing in the medical records to explain why this '*prolonged delay*' had occurred.

75. The EM IPA advised that following the examination at 22:10, the ED referred the patient to the '*orthopaedic team for assessment*', which was '*appropriate*'.

76. The EM IPA advised the patient was discharged following the orthopaedic team's assessment, and advised to return at 09:00 for a fresh MRI scan. The EM IPA further advised that it was the orthopaedic team who made this decision, rather than the ED.

77. I asked the EM IPA if there was evidence regarding whether the ED had listened to patient and taken her seriously during her ED attendance. The EM IPA advised that that ED records are '*brief*', but that there is nothing in the notes to suggest the patient had '*complained*' or '*expressed concern*' about her care at the time of her attendance. The EM IPA reiterated his advice that there had been a '*prolonged delay*' in the ED staff assessing the patient following her triage – and further advised '*there are no records to confirm if the patient was kept informed of the progress of their assessment and offered explanations or apologies for the delays she experienced*'. The EM IPA went on to advise that EDs work on the '*mantra*' of '*if it is not documented it was not done*'. Therefore, '*the lack of documentation would suggest that the patient was not kept informed during her time in the ED*'. The EM IPA advised that this '*could quite easily have left her feeling that she was not being listened to or taken seriously, though I do not believe that this was in any way the intention of staff on the day*'. The EM IPA advised that the patient's pathway that evening may have been more '*efficient*', and have provided a better '*patient experience*' if the orthopaedic doctor had referred the patient directly to the orthopaedic team, rather than passing through the ED first. The EM IPA further advised that the

ED did not make this decision, although in any event, '*the outcome is unlikely to have changed*'.

78. Regarding the patient's ED attendance on 25 September 2020, the EM IPA advised that the patient attended at 19:09 and the ED recorded her as suffering from '*numbness / pins and needles*'. The EM IPA further advised that the ED recorded this as a '*recent problem with no associated pain*'. The patient's triage time was 19:42 with a NEWS score of zero. The EM IPA advised that the ED recorded '*physical observations*' and the patient's position that she was experienced numbness '*all over*' that had started in the front of her legs, but she was '*unsure*' as to how long she had been feeling that way. The EM IPA further advised that the ED assessed the patient again at 23:15 and recorded '*details of the presentation and the examination findings*'.

79. The EM IPA advised that on this occasion also the patient's triage and assessment were outside of the 15 minute and 60 minute timeframes, and that '*there are no records to indicate the patient was kept informed about delay in the pathway through ED*'. The EM IPA further advised '*whilst an inconvenience for the patient I do not think the delays had a negative impact on the treatment provided*'.

80. The EM IPA advised that during the assessment the ED noted the patient was '*suffering with low mood and anxiety in addition to concerns about back pain following recent surgery*'. The EM IPA further advised the records state the patient did not have any '*new neurological symptoms*' was '*very anxious*'. The EM IPA advised the ED doctor '*concluded that the patient had an anxiety disorder and that there was possibly some worsening of paraesthesia after surgery*'. The EM IPA further advised the ED doctor '*offered reassurance and referrals to physiotherapy, mental health services, and a further referral to the spinal services outpatients for review*'. The EM IPA advised that the ED therefore referred the patient to '*appropriate services for ongoing care*'. The EM IPA further advised '*at the time there were no symptoms to suggest that emergency admission or investigation was required, and it is appropriate to ensure the patient's physical and psychological wellbeing is supported by the appropriate services*'.

81. I asked the EM IPA if there was evidence regarding whether the ED had listened to the patient and taken her seriously during her ED attendance. The EM IPA advised that the ED's assessment addressed the '*physical and psychological concerns experienced by the patient*', and '*efforts were made to ensure appropriate onward care was made available*'. The EM IPA further advised there was nothing in the medical notes to suggest that the ED did not take the patient's concerns seriously.

Analysis and Findings

Actions of the Trust regarding the Referral of 7 July 2020 and Provision of MRI Scan Results from the Private Healthcare Facility

82. The complainant was concerned that the Trust did not do anything following the patient's referral from the private healthcare facility, and that the patient had to wait "*months*" for her condition to be treated. In addition, the complainant was concerned that she had to provide the Trust with a copy of the patient's MRI scan results obtained from a scan at the private healthcare facility, rather the Trust carrying out its own scan.

83. The Trust's position was that it correctly downgraded the patient's referral from '*red flag*' to urgent, and that on receipt of the referral, an appointment was made for the patient for a telephone assessment with Consultant A. The Trust's position was that this was in line with COVID-19 guidance in place at the time. The Trust's position was that Consultant A took appropriate action to obtain the privately carried out MRI scan results following the telephone assessment, and that this was more appropriate than repeating the same MRI scan again. The Trust said that a follow-up face to face appointment with Consultant A was set up for the patient on Consultant A's planned return from holiday, but that intervening events resulted in earlier and alternative treatment.

Downgrade of referral from red flag to urgent

84. I note the Trust's position that the '*red flag*' pathway is specific to suspicions of cancer cases. I further note the N IPA's advice which supports that position, but also the N IPA's advice that there can be a level of overlap between symptoms

for cauda equina syndrome and certain spinal cancers. I also note the contents of the private healthcare facility's referral (relevant extracts of which are contained in Appendix four to this report) which states that the patient was suffering from compression of the cauda equina due to a disc prolapse, with no mention of suspected or potential cancers. Taking all of these factors into consideration, I accept the N IPA's advice that it was reasonable for the Trust to re-categorise the patient's referral from '*red flag*' to urgent upon receipt.

85. However, I also note the N IPA's advice that the Trust's rationale for making this decision was not recorded in the patient's medical notes. I refer to the GMC Guidance. *Paragraph 9* states that '*documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterward*'. In my view the clinical records should record the rationale for a decision in order to ensure clarity for the clinicians who will later rely on the information that is recorded in the patient's medical records.

86. I find this record keeping failing to be a service failure. Nevertheless, I find that the decision made regarding re-categorisation of the patient's referral was ultimately reasonable in the circumstances and did not adversely affect the patient's clinical condition.

Arrangement of a telephone assessment instead of a face to face assessment

87. I note the N IPA's advice that, to ensure compliance with the Standards of Care (set out in full in Appendix three to this report), Consultant B ought to have arranged an urgent face to face consultation with the patient at the point the Trust received the referral - ideally within 24 hours of the referral. I further note the N IPA's advice that at this consultation, the Trust ought to have had a discussion with the patient at that time about the '*risk and balance*' between surgical and non-surgical treatment pathways. I also note the N IPA's advice that whilst it may not have been the case that the patient required urgent surgery at that time (7 July 2020) given her symptoms, an urgent face to face consultation should nonetheless have taken place at that stage.

88. Regarding the impact of COVID-19, I note the Trust's position that a telephone assessment was set up for the patient to ensure compliance with COVID-19 guidance and the Hospital's own rules, as set out in the Neurosciences Minutes (relevant extracts of which are set out in Appendix three to this report). I accept the Trust had to make difficult decisions and take serious precautions to limit the spread of the virus, and that these precautions inevitably had an impact on the care and treatment it was possible to provide to patients.

89. However, the Neurosciences Minutes state that '*if a patient needs to attend as ad hoc then they should be booked into the next face to face clinic*'. I also note the N IPA's advice that it was '*apparent that emergencies still needed to be treated, at some extra risk, but in a timely way'* in order to prevent *'medical catastrophes from inadequate care*'. I accept the N IPA's advice in this respect. I also note and accept the N IPA's advice that the Trust could only assess patients with urgent conditions face to face at that stage in the pandemic - and that cauda equina syndrome was considered by the BASS and the SBNS to be an urgent condition, irrespective of whether urgent surgery was required.

90. Having reviewed all relevant evidence, I am satisfied that a face to face consultation should have been arranged with the patient on an urgent basis following the Trust's receipt of the patient's referral – via the neurology department directly. Should this not have been attainable, I consider the neurology department ought to have arranged contact with the patient and advised her to present to ED to ensure more urgent attention. I accept the N IPA's advice in this respect, and I also accept the N IPA's advice that this assessment should have included a discussion with the patient about the risks and benefits of surgical and non-surgical treatment pathways. I accept the N IPA's advice that this did not happen. I consider that the Trust should have taken these actions, rather than arranging for a telephone assessment to take place on 30 July 2020, some 23 days after receipt of the patient's referral. I note the patient's symptoms as of 7 July 2020 may not have been sufficiently serious to warrant urgent or immediate surgery. However, I consider that the urgent face to face assessment should have taken place – especially in the absence of the imaging results from the privately carried out MRI scan. I refer

to *Paragraph 15* of the GMC Guidance in support of this position which states a clinician ought to *'promptly provide or arrange suitable advice, investigations, or treatment where necessary*'.

91. I am satisfied although it was reasonable and appropriate for the Trust to have put precautions in place to limit the spread of COVID-19, it was inappropriate for the patient not to have an urgent face to face assessment due to the urgency of her condition.

92. I consider the Trust's actions in this respect to be a failure in the care and treatment it provided to the patient.

93. I note that in the Trust's response to my Office, it identified as a learning point from the patient's case that urgent referrals should have face to face appointments rather than virtual ones to allow for physical examination to take place and any urgent action required to be taken. I commend the Trust for identifying this learning and for undertaking to amend its practices accordingly.

Decisions regarding the MRI scan results

94. I note the patient had already undergone a MRI scan privately prior to being referred to the Trust for onward care. I also note the Trust's position that to carry out another MRI scan at the point of receipt of the referral would only result in a repeat of the first scan. However, I accept the N IPA's advice that, in the absence of the results from the first MRI scan being available to the Trust urgently following the referral, the Trust ought to have carried out its own fresh scan - to ensure that it had all the relevant and necessary information to treat the patient, and to ensure compliance with the Standards of Care.

95. The Standards of Care state that '*the reliability of clinical diagnosis of threatened or actual CES*[16] *is low and there should be a low threshold for investigation with an emergency MRI scan at the request of the examining clinician*'. The Standards of Care further state that '*the MRI must be undertaken*

[16] Cauda Equina Syndrome

as an emergency in the patient's local hospital and a diagnosis achieved prior to any discussion with the spinal services'.

96. I also note and accept the EM IPA's advice that the decision regarding a fresh scan was the responsibility of the Neurology Department, and not the ED. I find that in choosing not to carry out the fresh MRI scan in the circumstances, the Trust failed in the care and treatment it provided to the patient. It should not have been necessary for the patient, or for the complainant, to provide the scan results themselves on 4 August 2020, almost a month after the private healthcare facility made the initial referral. I acknowledge that the scan results not being provided along with the private healthcare facility's referral was outside the Trust's control. However, given the nature of the condition being investigated, I consider Consultant B ought to have proactively taken steps to ensure the Trust carried out a MRI scan to obtain results at the earliest available opportunity. I refer in this respect also to *Paragraph 15* of the GMC Guidance regarding the importance of prompt investigation.

97. I consider the Trust's actions in this respect to be a failure in the care and treatment it provided to the patient.

98. I also note that in the Trust's response to my Office, it identified that patients presenting with cauda equina symptoms should be considered for admission and/or urgent MRI imaging, and that imaging from private sources be available to allow for prompt decision-making. I commend the Trust for identifying this learning and for undertaking to amend its practices accordingly – and refer also to the relevance of the recent report from the Independent Neurology Enquiry, chaired by Mr B Lockhart QC[17] regarding interactions between private healthcare facilities and the NHS.

Telephone assessment with Consultant A on 30 July 2020 and subsequent actions

99. I note and accept the N IPA's advice that Consultant A was compromised in his ability to assess the patient due to the virtual nature of the appointment, and the absence of the MRI scan results. I also note and accept the N IPA's advice that

[17] Which can be read in full at http://www.neurologyenquiry.org.uk

these factors were outside of Consultant A's control, as Consultant A only became aware of the patient's case on the morning of 30 July 2020. I further note and accept the N IPA's advice that Consultant A should not be criticised for his actions in this respect.

100. However, regarding Consultant A's actions following the telephone assessment, I note the N IPA's advice that whilst it was reasonable for Consultant A to seek to obtain the MRI scan results, there was no urgency to the request. This meant the Trust did not make the images available until 11 August 2020 - just before Consultant A went on holiday - and so Consultant A could not assess the patient face to face until his return to work. The N IPA advised Consultant A ought to have put a time limit on the imaging results being obtained, or alternatively arranged for a fresh MRI scan to be conducted. I accept the Trust's position that it would not have been reasonable for Consultant A to have taken on administrative duties in respect of obtaining the scan results. However, I consider Consultant A ought to have informed the Trust's administrative staff of a timeframe within which those staff should either obtain the existing scan results, or make provision to carry out a fresh scan. I note the Trust's position that Consultant A was unable to make an accurate assessment of the patient's condition due to the absence of the imaging results. Whilst I acknowledge the Trust's position that there can be a "*significant waiting time*" for MRI scans to be carried out, I nonetheless consider that the appropriate course of action would have been to take all reasonable steps to obtain images by the quickest possible route – whether these were the original images, or fresh ones. I consider there to have been a lack of urgency in the approach taken.

101. I note the follow-up face-to-face consultation was arranged to take place on 27 August 2020, which was 28 days after the telephone consultation. Whilst I consider this was a long period of time for the patient to have to wait, given the urgency of her condition, I accept the Trust's position that due to pressure on waiting lists at the time, the consultation could not reasonably have been arranged any sooner. Whilst I accept the N IPA's advice that it would have been preferable for the patient to have been seen face-to-face more urgently, I

nonetheless also accept the reality of waiting list pressures, which is outside of the Trust's, and therefore Consultant A's, control.

102. I acknowledge that the face-to-face assessment and urgent imaging ought to have taken place on immediate receipt of the referral on 7 July 2020 and Consultant A only became aware of the patient on 30 July 2020. Nonetheless, I consider that Consultant A failed to take appropriate steps to ensure urgent access to MRI imaging results when he became involved in the patient's care. In reaching this conclusion I refer to *Paragraph 15* of the GMC Guidance.

103. I consider this to be a failure in the care and treatment the Trust provided to the patient.

Summary

104. Although it cannot be said that the Trust did not do anything following its receipt of the patient's referral, I find that the Trust did not act with sufficient urgency to ensure the patient received reasonable and appropriate care that was in line with relevant standards. This includes taking sufficient steps to ensure MRI scan results were available for consideration – whether by obtaining the privately carried out scans more efficiently, or arranging for a fresh scan to take place.

105. Regarding the impact of the delays in the MRI images being obtained by the Trust on the patient, I note and accept the N IPA's advice that '*I do not see from the evidence available that the delay did any harm, other than prolong the period the patient was in pain for*'. I also note the Trust's position that the delay did not have an impact on the patient's subsequent recovery. However, I consider that the patient's pain being prolonged had a relevant and negative impact on the patient.

106. I find the failures in care and treatment provided to the patient caused the injustice of loss of opportunity for the patient in terms of an initial face to face consultation with the availability of relevant images. It also resulted in the loss of the opportunity for the patient to potentially have received earlier surgery to improve her condition and ease her pain and symptoms. In addition, the failures

identified caused the patient the injustice of uncertainty, upset and frustration regarding her condition, ongoing pain and symptoms, and treatment pathway. Whilst I note the N IPA's advice that a prolapsed disc can heal without surgery in time, I nonetheless accept the N IPA's advice that surgery ought to have been discussed at the earliest available opportunity. The failures identified also caused the complainant the time and trouble of bringing a complaint to my Office.

107. Therefore I uphold this element of the complaint.

The Patient's ED Attendances

108. The complainant was concerned that the ED had not listened to the patient, or taken her seriously, during the patient's ED attendances on 21 July 2020, 11-12 August 2020 and 25 September 2020.

The Trust's position was that the ED listened to the patient, took her seriously, and provided appropriate treatment on each occasion.

ED attendance on 21 July 2020

109. I reviewed the ED records for this attendance. I note that the ED triaged the patient, recorded her medical history and conducted a physical examination. I note the EM IPA's advice that it was reasonable for the ED to have determined that, given the patient's symptoms at the time, she did not require '*immediate admission*' for medical intervention that day. I note the EM IPA's further advice that a referral for urgent follow-up was appropriate.

110. I note and accept the EM IPA's advice that the patient's initial assessment at triage, and pathway through the ED that day were '*in line with good practice*', and that the Trust attended to the patient '*promptly*'. I further accept the EM IPA's advice that the decisions the ED staff made on the day appeared '*reasonable*' and '*appropriate*'. These included the decisions made to discharge the patient with support on what to do if her symptoms worsened, and with pain relief medication - as well as to refer the patient for further specialist spinal assessment.

111. In addition, I note and accept the EM IPA's advice that it was the specialist teams' responsibility to determine whether or not a fresh MRI scan was required, and not the ED's responsibility. I further note and accept the EM IPA's advice that the MRI scan report that was available to the ED on 21 July 2020 was sufficient to allow appropriate onward referral.

112. Having reviewed the patient's ED pathway on 21 July 2020, together with the EM IPA's advice, I am satisfied that the patient received reasonable and appropriate care and treatment that was in line with relevant standards. I am further satisfied that this indicates the ED listened to the patient and took her concerns seriously.

ED attendance on 11-12 August 2020

113. I reviewed the ED records for this attendance. I note the ED triaged the patient, assigned a NEWS score, and recorded the patient's medical history and current symptoms. I further note that the ED physically examined the patient before discharging her with advice to return the following morning for a MRI scan.

114. I note and accept the EM IPA's advice that the physical examination included an assessment of tone, power in reflexes and of sensation in the patient's arms and legs. I further note and accept the EM IPA's advice that these assessments were significantly different from those the patient presented with on 21 July 2020.

115. I further note and accept the EM IPA's advice that the ED's decision following the physical examination to refer the patient to the Trust's orthopaedic team for assessment was '*appropriate*'. I note the EM IPA queried whether the ED ought to have admitted the patient to hospital at 04:00 rather than discharge her and ask her to return at 09:00 for a MRI scan. However, I accept the EM IPA's advice that this was a decision made by the orthopaedic team, rather than the ED.

116. Having reviewed the ED records and the EM IPA's advice, I am satisfied that the ED's decisions were reasonable and appropriate in the prevailing

circumstances. I am further satisfied that this indicates the ED listened to the patient and took her concerns seriously.

ED attendance on 25 September 2020

117. I reviewed the ED records for this attendance. I note that the ED triaged the patient, assigned a NEWS score, and recorded physical observations and the patient's medical history. I further note that the patient subsequently underwent a physical examination, and that the ED recorded details of that examination. I note the ED diagnosed the patient as suffering from an '*anxiety disorder*' with the possibility of '*worsening of paraesthesia after surgery*'. The ED discharged the patient with '*referrals to physiotherapy, mental health services, and a further referral to the spinal services outpatients for review*'.

118. I note the EM IPA's advice that the patient was '*reassured*' and that the onward referrals were for '*appropriate services for ongoing care*'. I further note the EM IPA's advice '*at the time there were no symptoms to suggest that emergency admission or investigation was required, and it is appropriate to ensure the patient's physical and psychological wellbeing is supported by the appropriate services*'.

119. Having reviewed the ED records and the EM IPA's advice, I am satisfied the ED's decisions were reasonable and appropriate in the circumstances to address both the patient's physical and psychological symptoms. I am further satisfied this indicates the ED listened to the patient and took her concerns seriously.

Summary

120. I find that the ED's actions on 21 July 2020, 11-12 August 2020 and 25 September 2020 indicate that the Trust did listen to the patient and took her seriously during her ED attendances.

121. Therefore, I do not uphold this element of the complaint.

Observations

122. Despite my finding on this element, I nonetheless note the ED IPA's advice that there was a "*slight*" delay in the ED triaging the patient following her arrival at the ED on 11 August 2020, and a "*prolonged delay*" in the ED assessing the patient following her triage. I also note the ED IPA's advice that there were delays in the ED triaging the patient, and in the ED assessing the patient following triage on 25 September 2020. I note the EM IPA's advice that each of these delays were outside of the accepted timeframes of 15 minutes and 60 minutes for triage and assessment respectively.

123. I further note the EM IPA's advice that on each occasion there was no record of the ED updating the patient on progress during those delays. I note the EM IPA's advice that the second delay on 11-12 August 2020, in particular, may have given the patient the impression that she was not being listened to or taken seriously - even though the EM IPA advised that she was.

124. In terms of impact on the patient, I note the EM IPA's advice that on 11-12 August 2020 the first delay did not have any negative impact on the patient, and that the second delay was '*unlikely*' to have changed any of the outcomes from the ED attendance. I also note the EM IPA's advice that on 25 September 2020 "*whilst an inconvenience for the patient I do not think the delays had a negative impact on the treatment provided*".

125. I accept that hospitals in Northern Ireland were under significant pressure at that time due to the ongoing and developing COVID-19 pandemic. I also accept that an unfortunate consequence of that pressure was an increase in waiting times for patients presenting to EDs across Northern Ireland. I am satisfied that it is likely these pressures were outside of this ED's control at that time. On this basis, and taking into consideration the EM IPA's ultimate advice regarding the impact of the delays on the patient, I find that the delays identified do not constitute a failure in the overall care and treatment provided to the patient on 11-12 August 2020. However, I accept the EM IPA's advice that the Trust ought to have maintained communication with the patient during the delays, to ensure compliance with the GMC Guidelines. I consider the Trust ought to reflect on this learning.

CONCLUSION

126. I received a complaint about the care and treatment the Trust provided to the patient during the period 29 June 2020 to 25 September 2020.

127. The Investigation established that the ED's actions were reasonable, appropriate and in line with relevant standards. However, the investigation also established there were failings in the care and treatment the Trust's Neurology Department provided to the patient following her referral from the private healthcare facility. Therefore this complaint is upheld in part.

128. The failures identified caused the patient to sustain the injustice of loss of opportunity for earlier treatment and relief from her symptoms and pain. In addition, the patient sustained the injustice of uncertainty, upset and frustration regarding her care and treatment. It is noted the patient's symptoms and pain worsened over the period 7 July 2020 to 12 August 2020. I acknowledge this would undoubtedly have been a worrying, confusing and frightening time for the patient, which was likely exacerbated by increasing pain, and having to make several trips to the ED.

Recommendations

129. 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 injustices caused as a result of the failures identified within **one month** of the date of the final report.

130. I note the Trust has indicated that it has taken learning from the patient's case. I commend the Trust for the steps it has taken in this respect.

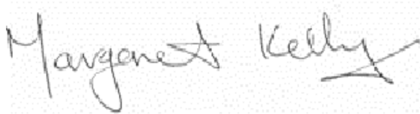
131. Nonetheless, I further recommend, for service improvement and to prevent future reoccurrence, that the Trust:

    I. brings the contents of this report, and the learnings identified in it, to the attention of Consultant A, and Consultant B, so that these can be discussed with them as part of their next performance appraisals;

II. provides my Office with evidence of the Trust's work to implement the three learning points it identified from the patient's case, set out in its response to my Office; and

III. implements an action plan to incorporate these recommendations and provide me with an update within **six months** of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any relevant policies).

132. In addition, I consider the Trust should reflect on the EM IPA's observations regarding the delays the patient experienced in the ED on 11-12 August 2020 and 25 September 2020.



MARGARET KELLY
OMBUDSMAN
01 February 2023

Appendix 1

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.