Investigation of a complaint against the Northern Health and Social Care Trust

Report Reference: 202001198

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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

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202001198

Listed Authority: Northern Health and Social Care Trust

SUMMARY

This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The patient raised concerns about care and treatment the Trust provided to him during the period April 2019 to April 2021. The patient was dissatisfied with the time taken for the Trust to arrange an appointment for an MRI[1] scan and disputes his December 2020 scan results. The patient raised further concerns about how the Pain Clinician managed his pain during his appointment in January 2021. He also raised concerns about the care and treatment he received when he attended the Emergency Department (ED) in April 2021 and how the Trust handled the subsequent complaint.

The investigation established the Trust failed to offer the patient an MRI scan appointment within the targeted timescale.

The investigation also established the Radiologist appropriately interpreted the patient's scan results in December 2020, and the Clinician in Pain Medicine provided the patient with appropriate care and treatment during his consultation on 13 January 2021. The investigation found the Trust provided the patient appropriate care and treatment during his ED attendance on 23 and 24 April 2021.

However the investigation established the Trust failed to address all issues of the patient's complaint in its response on 14 July 2021. I considered this maladministration and recommended the Trust apologises to the patient and ensures learning from this example of poor complaints handling.

[1] Magnetic resonance imagining is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). The complaint is about care and treatment the Trust provided to the patient during the period April 2019 to April 2021. The complaint was also about how the Trust handled the subsequent complaint.

Background

2. In March 2019 the patient experienced an accident at work. As a result the patient said he suffers with severe pain and is unable to walk. The patient's GP referred the patient for an MRI[2] on 5 April 2019 which he subsequently received on 26 January 2020. On 25 November 2020 the patient attended his GP presenting with back pain. The GP referred the patient to the Emergency Department (ED), which he attended on the same day. During the patient's ED attendance, an Orthopaedic Consultant reviewed and referred the patient for an MRI scan. Medical staff discharged the patient on the same day.

3. The patient attended an appointment with a Clinician in Pain Medicine on 13 January 2021. At that time the patient was prescribed co-codamol and amitriptyline[3] to manage his pain. During this appointment the Clinician was unable to access his computer to view the patient's diagnostic tests. However, he viewed the relevant records following the consultation. The Clinician discharged the patient during this appointment and referred him to the care of the Trust's Pain Management Programme.

4. The patient said he attended ED within Causeway Hospital on 23 April 2021 following a self-inflicted overdose. During this attendance, an ED Consultant attended to the patient and discharged him from the ED to the care of the Crisis Response Team (CRT) the same day.

5. The patient submitted a complaint to the Trust on 29 December 2020. The Trust issued its final response to the patient on 14 July 2021.

Issues of complaint

[2] Magnetic resonance imagining is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body.
[3] Amitriptyline is used to treat depression, nerve pain, headaches, and migraines.

6. I accepted the following issues of complaint for investigation:

Issue 1: Whether the Trust provided appropriate care and treatment to the patient from April 2019 to April 2021.

Issue 2: Whether the Trust addressed all issues of the complaint in its written response issued on 14 July 2021 in accordance with its policy and relevant standards.

INVESTIGATION METHODOLOGY

7. 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. This documentation included information relating to the Trust's complaints procedure.

Independent Professional Advice Sought

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

   - A Radiology Consultant with 24 years' experience (R IPA);
   - A Consultant in Pain Medicine with clinical expertise in this area of complaint (P IPA); and
   - An ED Consultant with over 20 years' experience working in emergency medicine (ED IPA).

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

Relevant Standards and Guidance

10. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[4]:

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

11. 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 of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - General Medical Council Good Medical Practice April 2014 (GMC guidance);
    - National Institute for Health and Care Excellence (NICE) Low back pain and sciatica in over 16s: assessment and management NICE guideline NG59 30 November 2016 (NICE Back Pain Guidance);
    - National Institute for Health and Care Excellence (NICE) Drug misuse in over 16s psychosocial interventions. Clinical guideline [CG51] 25 July 2007 (NICE Drug Misuse guidance);
    - National Institute for Health and Care Excellence (NICE) Scenario: Management of poisoning or overdose June 2017 (NICE Overdose Guidance); and
    - Department of Health Guidance in Relation to the Health and Social Care Complaints Procedure Revised April 2019 (DoH Guidance).

12. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

13. I shared a draft of this report with the complainant, the Trust and the clinicians whose actions are the subject of the complaint to enable them to comment on the findings and recommendations. The complainant submitted comments in response. I gave careful consideration to his comments before finalising this report.

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

THE INVESTIGATION

Issue 1: Whether the Trust provided appropriate care and treatment to the patient in April 2019 to April 2021.

In particular this will consider:

- Arrangement of MRI scan;
- Scan results;
- Pain management; and
- Discharge from ED April 2021.

Detail of Complaint

Arrangement of MRI scan

14. The patient is dissatisfied with the time taken for the Trust to arrange an MRI scan for him. The complainant stated his GP referred him for an MRI scan on 5 April 2019 which he received on 26 January 2020.

Evidence Considered

Legislation/Policies/Guidance

15. The Health and Social Care Board (now known as the Strategic Planning and Performance Group – SPPG) set out a Commissioning Plan each year. This Plan sets out priorities and targets that are included in the Department of Health (DoH) Commissioning Plan Direction (CPD). In April 2019 the CPD targets for 2019/20 had not yet been confirmed, and 2018/19 targets were being used to monitor performance in the interim. There were two diagnostic waiting time targets in place at that time:
    - By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test; and
    - By March 2019, no patients should wait no longer than 26 weeks for a diagnostic test.

16. In January 2020 the status of the 2019/20 CPD document remained in draft with advice that it may be revised at a later point subject to Ministerial consideration. The draft diagnostic targets in place at that time effectively remained the same, and were:

- By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test; and
- By March 2020, no patients should wait no longer than 26 weeks for a diagnostic test.

The Trust's response to investigation enquiries

17. The Trust stated it received a routine referral from the patient's GP on 5 April 2019. The Consultant Radiologist triaged this referral as routine, and the patient attended his MRI scan on 26 January 2020.

18. The Trust stated if the patient's GP completed the referral as urgent and the Trust downgraded it to routine, its administrative staff would have written to the patient's GP to advise and/or request clarification/additional information.

Relevant Records

19. The Trust provided this Office with a copy of the GP's MRI referral sent on 5 April 2019. I also obtained the patient's GP records for the period 1 April 2019 to 26 January 2020.

Relevant Independent Professional Advice

20. The R IPA advised *'on the clinical request form the scan was vetted appropriately for a routine study'*. The R IPA advised the time taken for a routine scan is determined between the referrer and the imaging services contract.

Analysis and Findings

21. The records document the patient's GP made a routine referral for an MRI on 5 April 2019. The records document the Trust triaged this referral as routine. The R IPA advised *'on the clinical request form the scan was vetted appropriately for a routine study'*. I accept this advice and consider the Trust triaged the referral appropriately.

22. The medical records document the Trust performed the MRI scan on 26 January 2020. I note this is 42 weeks and two days after the GP's referral. As referred to in paragraph 15 and 16 above both the CPD targets for March 2019 and March 2020

were that patients should wait no longer than 26 weeks for a diagnostic test. I do not consider the Trust met their target on this occasion.

23. It is most unfortunate the patient waited over 42 weeks for a routine MRI appointment. This example of a lengthy waiting time is typical across the NHS especially in Northern Ireland. Unfortunately, delays in outpatient appointments and in other areas of health service provision has been the reality for several years. Rather than a failure to apply policy, it is regrettably a sign of the longer-term disparity between increasing (and more costly) patient needs and the limits on health service resourcing.

24. Whilst I sympathise with the patient, it would not be conducive to general NHS morale to define this as maladministration since all those enduring a lengthy wait for treatment could conceivably raise the same complaint. I consider the protracted timescale which the patient had to endure is a symptom of the reality of there being insufficient public funds to meet the demands currently being placed on the health service. I therefore do not uphold this element of the complaint.

Detail of Complaint

Scan results

25. The patient disputed his December 2020 scan results. The Orthopaedic Consultant referred the patient for an MRI scan following his ED attendance in November 2020. The patient said the medical staff informed him the results of this scan showed no bone related injuries. At the time of his accident in March 2019, the patient said he sustained a compression fracture and considers this may have been undetectable at the time of his scan in December 2020.

Evidence Considered

Legislation/Policies/Guidance

26. I considered the following policies/guidance:
    - GMC Guidance.

The Trust's response to investigation enquiries

27. The Trust stated *'there is no clinical or radiological evidence that [the patient] ever sustained a fracture to his back'*.

Relevant Trust records

28. The Trust provided the relevant ED records for the patient's attendance on 25 November 2020. The Trust's records document the patient's GP referred the patient to ED for possible Cauda Equina syndrome[5]. The ED records document an Orthopaedic ICATS[6] Consultant attended to the patient during his ED attendance and that the patient was keen to pursue the surgical option. The records document the ED staff arranged an MRI scan for the patient. The records evidence the patient received this scan in December 2020. The Trust provided this Office with images from this scan.

Relevant Independent Professional Advice

29. The R IPA advised *'a bone injury is a break in the bone as a result of trauma, infection, or tumour'*.

30. The R IPA advised upon review of the patient's MRI results *'there is no evidence of a recent or previous bone injury…the STIR[7] MRI sequence is very sensitive to subtle injuries and is completely normal with respect to the bones. The T1 sequence[8] would demonstrate an old injury and is also completely normal'*.

31. The R IPA advised the transcript of the MRI report *'mentions that the radiologist report showed no bone injury…the MRI did not demonstrate any acute or old bony injury'*.

Analysis and Findings

32. The patient's MRI scan performed in December 2020 did not show any bone related injuries. He disputes this outcome.

33. I asked the R IPA to review the patient's MRI scan and its results. He advised that while the scan showed the patient had degenerate disc disease between two of his discs, the R IPA did not identify '*any acute or old bony injury'*.

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[5] Cauda equina syndrome is a rare and severe type of spinal stenosis where all of the nerves in the lower back suddenly become severely compressed.

[6] Orthopaedic Integrated Clinical Assessment and Treatment Services are a team of registered health care professionals who will assess a patient's condition at the request of their GP. This service provides specialist assessment and appropriate management of patients with orthopedic conditions.

[7] STIR (Short Tau Inversion Recovery) images is an MRI sequence that provides high contrast between tissue and lesion.

[8] Sequences of MRI images.

34. The patient was concerned the scan may not have detected a compression fracture in his back. However, the R IPA advised the Trust used the STIR with T1 sequence for his MRI, which *'is very sensitive to subtle injuries'* and would identify an old injury. I accept his advice. Therefore, I am satisfied the Trust used the appropriate sequence to identify an injury.

35. I recognise the patient's concern, especially given the pain he experienced. However, I have not identified any evidence that leads me to question the Trust's findings of the patient's MRI scan performed in December 2020. I hope this provides the complainant some reassurance. I do not uphold this element of the complaint.

Detail of Complaint

Pain management

36. The patient said the Clinician refused *'to offer any pain relief such as steroid injections[9]'*. He was dissatisfied the Clinician was unable to view his medical files during his appointment on 13 January 2021.

Evidence Considered

Legislation/Policies/Guidance

37. I considered the following policies/guidance:
    - NICE Back Pain Guidance; and
    - GMC Guidance.

The Trust's response to investigation enquiries

38. The Trust stated the Clinician experienced technical difficulties during the patient's consultation on 13 January 2021. However, the Clinician *'did view the MRI scans following the consultation'*. The Clinician arranged for the patient *'to be followed up at the Pain Management Programme[10]'*. The Trust did not provide a response in relation to the patient's complaint about steroid injections.

Relevant Trust records

[9] Anti-inflammatory medicines used to treat problems such as joint pain, arthritis, sciatica and inflammatory bowel disease.

[10] This is a multidisciplinary service that aims to help participants with chronic musculoskeletal pain to better manage their condition to improve their quality of life.

39. The Trust provided this Office with the clinical records for the patient's pain clinic appointment on 13 January 2021. The Trust also provided records of the patient's referral to the Pain Management Programme.

Relevant Independent Professional Advice

40. The P IPA advised as the patient was *'not using much medication and was already under the care of a surgeon, it was not appropriate to offer him more medication'*. He referred to NICE Back Pain Guidance which states *'do not offer spinal injections for the managing of low back pain'*. The P IPA advised *'it was entirely appropriate not to offer spinal injections for [the patient's] low back pain'*.

41. The P IPA advised the Clinician's assessment *'was entirely clinically appropriate…the only other aspect that would be reasonably considered would be psychological support and this was entirely appropriately done by referring him to a Pain Management Programme'*.

42. The P IPA advised *'it was not necessary for the Pain Consultant at that stage to review the imaging'*. The P IPA advised this is because the patient was under the care of an Orthopaedic Surgeon within a different Trust area, who had already reviewed the imaging.

43. The P IPA advised *'it is good medical practice to have access to the prior notes though we all recognise that these are not always possible…there was no impact of not having availability of the notes on [the patient]'*.

Analysis and Findings

44. The patient said the Clinician refused '*to offer any pain relief such as steroid injections'* to help him manage his pain. The P IPA advised the patient *'did not seem to report high levels of pain in the consultation'*. I note the medical records document at the time of his appointment the patient was working and had not missed time off work due to his symptoms. The medical records also document on 13 January 2021 the patient was not using regular analgesics[11] and was under the care of an Orthopaedic Surgeon within the Belfast Trust.

[11] A group of medication used to relieve and kill pain.

45. I note the medical records evidence the Clinician did not prescribe steroid injections for the patient. I refer to the NICE Back Pain Guidance which states *‘do not offer spinal injections for the managing of low back pain’*. The P IPA advised *‘it was entirely appropriate that no further medication was prescribed’*. I accept this advice. I also accept the P IPA’s advice regarding the patient’s symptoms and other treatments: *‘the only realistic option was to offer him psychological support and this was done as [the patient] was referred to a Pain Management Programme’*. Therefore, I do not consider the decision not to prescribe steroid injections for the patient a failure in his care and treatment.

46. The patient was also concerned the Clinician decided on his treatment without viewing his records. The Trust stated the Clinician experienced technical difficulties during the patient’s consultation on 13 January 2021 and could not access his records. I note the patient was under the care of a surgeon within another Trust area at that time. The P IPA advised this surgeon previously viewed the patient’s imaging. He also advised a pain consultant would not be trained in the interpretation of imaging. Therefore, *‘it was not necessary for the Pain Consultant at that stage to review the imaging’*. I accept this advice.

47. The P PA advised it is *‘good practice’* for clinicians to have access to relevant records during a consultation. However, I accept the P IPA’s advice in this instance, it was not mandatory for the Clinician to review the records. I also accept his advice that not doing so had *‘no impact’* on the patient. Therefore, I have not identified a failure in care and treatment in this respect.

48. While I note the complainant’s concern, I accept the P IPA’s advice that the Clinician’s assessment, and care and treatment of the patient, on 13 January 2021 *‘was entirely clinically appropriate’*. I do not uphold this element of the complaint.

Detail of Complaint

Discharge from ED April 2021

49. The patient said during his ED attendance on 23 April 2021, the ED Doctor accused him of taking cocaine. The patient is dissatisfied that medical staff discharged him from ED on the same day with no medical follow up or support. The patient also said he suffered heart complications as a result of his self-inflicted overdose.

Evidence Considered

Legislation/Policies/Guidance

50. I considered the following policies/guidance:
    - GMC Guidance;
    - NICE Drug Misuse Guidance; and
    - NICE Overdose Guidance.

The Trust's response to investigation enquiries

51. The Trust stated the ED Doctor reviewed the patient's heart tracings and blood tests from that time and found *'no evidence of heart damage'*.

52. The Trust stated *'it is normal practice to ask about illicit drug use in overdose presentations as their presence can complicate the clinical presentation'*. It wished to assure the patient it was not an accusation.

53. The Trust stated the patient's medical records document *'he had been challenging and uncooperative to the Emergency Department staff and refused an assessment from MHLS [Mental Health Liaison Service[12]]'*. The MHLS initiated contact with the patient. He did not refer to having suicidal ideation nor was he *'observed to be in a state of acute mental distress'*. MHLS discharged the patient on 23 April 2021 *'due to non-engagement'.* It also contacted the patient's GP on 26 April 2021.

54. The Trust stated Dalriada Urgent Care[13] (DUC) referred the patient to the Crisis Resolution Home Treatment Team[14] (CRHTT) on 24 April 2021. During the CRHTT's assessment, the patient *'denied any ongoing thoughts of self-harm, or of life not worth living and identified constant pain as a cause affecting his mood'*. Following this assessment the patient agreed for CRHTT to refer him back to the care of his GP.

Relevant Trust records

55. The Trust provided this Office with the clinical records for the patient's ED attendance on 23 April 2021.

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[12] Works with ED staff to provide specialist mental health assessment to patients presenting having self-harmed, used alcohol and drugs in a harmful hazardous way or who have mental health difficulties associated with old age.
[13] DUC provides out of hours GP services to the population of the Northern sector of the Health and Social Care Board.
[14] Provides intensive home treatment and high level support to adults experiencing severe mental health problems who would otherwise have no option but to be admitted to hospital.

Relevant Independent Professional Advice

56. The ED IPA advised the patient's heart tracing had some non-specific abnormalities. However, *'these are unlikely to be of significance if the patient had no cardiac symptoms and would not be related to the recent overdose'*. Neither the medical nor nursing notes *'suggest any cardiac problems'*.

57. In relation to the patient's concern that he suffered heart complications following his ED attendance, the ED IPA considered both the Trust's records and the patient's GP records. He advised the patient told his GP in June 2021 (by email) that staff in the ED said he had a '*minor heart attack'*. However, '*there is nothing corresponding with this in the ED notes, the discharge letter or the GP notes'*. In the absence of any symptoms or signs of a heart problem, '*there would be no actions for the ED staff to complete to prevent the onset of heart complications'*.

58. The ED IPA advised the NICE Drug Misuse guidance instructs ED staff to *'ask patients questions about drug use if they present with symptoms of mood disorders'*.

59. The ED IPA referred to the NICE Drug Misuse Guidance which states staff should offer those patients who attend ED following a suicide attempt a referral to liaison psychiatry services. The ED IPA advised the ED Doctor *'assessed [the patient] appropriately'*. The ED Doctor referred the patient to the MHLT, which was *'appropriate and consistent with national guidance'*. The MHLT later discharged the patient from its care.

Analysis and Findings

60. The medical records document the patient attended Causeway Hospital ED Department at 22:31 on 23 April 2021 following an overdose.

61. The patient raised concern that he suffered with heart complications following his ED attendance. The medical records document the patient's heart tracing taken during his attendance had some non-specific abnormalities. The Trust stated the ED Doctor reviewed the patient's heart tracings and blood tests from 23 April 2021, and found *'no evidence of heart damage'*. I note in his advice, the ED IPA agreed *'there was no suggestion of any cardiac problems during the patient's attendance'*.

62. I considered if the treatment provided to the patient during his ED attendance led to him developing heart complications. The ED IPA advised that he did not find any evidence in the relevant records to support this concern. He also advised there was no additional care and treatment ED staff could have provided to prevent the onset of heart complications. Based on the records available, I accept this advice.

63. The medical records do not document that the ED Doctor asked the patient if he had taken cocaine before attending ED. However, the patient stated the ED Doctor accused him of taking cocaine. I have no reason to doubt the patient's account. However, I am unable to determine whether the ED Doctor meant it as an accusation or a question. I note in response to this Office's enquiries the Trust stated it wished to assure the patient *'this was not an accusation'*. I refer to the NICE Drug Misuse Guidance which states ED staff should consider asking a patient about illicit drug use when they present with symptoms of mood disorders. I accept the advice of the ED IPA that *'this would be usual practice'* and consider the ED Doctor's action was in accordance with this guidance.

64. I note the patient's medical records document during the patient's ED attendance the ED Doctor assessed the patient's physical condition. The medical records document the nursing staff monitored the patient. At 08.10 on 24 April 2021, the records document the patient was medically fit for discharge. The ED Consultant referred the patient to the care of the MHLT prior to discharge. I refer to the NICE Overdose Guidance which states if a patient is presented with self-inflicted poisoning the patient should receive *'preliminary psychosocial assessments'* to determine the patient's mental capacity. I also note the NICE Drug Misuse Guidance states staff should offer patients who attend ED following a suicide attempt a referral to liaison psychiatry services. I accept the ED IPA's advice that the Consultant's referral to MHLT *'was appropriate and consistent with national guidance'*.

65. I have not identified any evidence to suggest the Trust failed in its care and treatment of the patient during his attendance to the ED on 23 April 2021. I refer to the GMC Guidance which requires clinicians to *'provide effective treatments based on the best available evidence'.* It also requires clinicians to '*refer a patient to another practitioner when this serves the patient's needs*'. I accept the ED IPA's

advice, *'the patient was assessed appropriately and referred on to the mental health team'*. I do not uphold this element of the complaint.

Issue 2: Whether the Trust addressed all issues of the complaint in its written responses issued on 14 July 2021 in accordance with its policy and relevant standards.

Detail of Complaint

66. The patient said the response he received from the Trust in relation to his complaint on 14 July 2021 apologised for the distress caused. However, it did not refer to *'the abuse carried out by the Trust staff'* involved in the patient's care during his ED attendance in April 2021.

Evidence Considered

Legislation/Policies/Guidance

67. I considered the following policies/guidance:
    - DoH Complaints Guidance.

Trust's response to investigation enquiries

68. The Trust stated *'there has been no evidence that [the patient] was abused by staff in Emergency Department; this appears to be [the patient's] perception of his treatment'*.

Relevant Trust records

69. The Trust provided this Office with the complaint file.

Analysis and Findings

70. The DoH Complaints Guidance states the Trust's response to a complaint should *'address the concerns expressed by the complainant and show that each element has been fully and fairly investigated'*. This guidance also requires the Trust to address all issues of complaint in its response to a complainant.

71. I acknowledge upon my review of the complaint file it is difficult to distinguish the issues the patient raised in his complaint. This is because during the period December 2020 to July 2021, the patient submitted several emails of complaint to

the Trust. I note the patient did not specifically use the word 'abuse' in his emails. However, in his email dated 14 June 2021, the patient stated the ED Doctor's actions caused him to feel degraded. Upon my review of the Trust's response dated 14 July 2021, I consider the Trust failed to address the patient's specific concern that the ED Doctor caused him to feel degraded. Therefore, I do not consider the Trust's response addressed all issues of complaint raised in the patient's email dated 14 June 2021.

72. As there is no evidence to suggest the Trust considered this aspect of the complaint, I do not consider it demonstrated it fully investigated all issues the patient raised. By failing to do so, I consider the Trust failed to act in accordance with this element of the DoH Complaints Guidance.

73. I refer to the First Principle of Good Complaint Handling 'Getting it right' which requires the Trust to follow its own guidance. I also refer to the Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' which requires the Trust to ensure it investigates complaints '*thoroughly and fairly'*. I consider the Trust failed to act in accordance with these principles in its handling of this complaint. I consider this maladministration. I uphold this element of the complaint.

74. I consider the identified maladministration caused the patient to sustain the injustice of frustration, uncertainty, and loss of confidence in the Trust's complaints procedure.

CONCLUSION

75. I received a complaint about care and treatment the Northern Health and Social Care Trust provided to the patient between April 2019 to April 2021. The investigation established the Trust failed to provide the patient with a diagnostic MRI scan within the CPD targeted time of 26 weeks. However, I did not consider this a failure in care and treatment when set in the context of lengthy waiting times across the NHS for so many patients.

76. The investigation established the Radiologist appropriately interpreted the patient's scan results in December 2020. It also found the Pain Clinician appropriately assessed the patient's pain and provided appropriate care and treatment during his

consultation on 13 January 2021. Furthermore, the investigation found the Trust provided appropriate care and treatment to the patient during his ED attendance on 23 and 24 April 2021.

77. The patient also raised concerns about how the Trust handled the subsequent complaint. The investigation established the Trust failed to address all issues of the patient's complaint in its response on 14 July 2021. By not doing so, I cannot be satisfied the Trust conducted a full investigation of all issues raised. I consider this constitutes maladministration.

78. I appreciate how difficult this time has been for the patient, especially as he continues to manage his pain. I hope this report provides him reassurance that the care and treatment he received was appropriate.

Recommendations

79. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified, within **one month** of the date of this report.

80. I further recommend within **one month** of the date of this report the Trust:
    i. Discusses the findings of this report with relevant staff and asks them to reflect on the failures identified;
    ii. The Trust reminds staff charged with the responsibility of investigating complaints of the requirement to undertake a thorough investigation and to consider all elements of the complaint;

Margaret Kelly
Ombudsman **2023**

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.