S.162/02-03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

Fife Acute Hospitals NHS Trust[1]

The complaint

1. The complaint I have investigated was made by the parents of a young man who received treatment for a condition affecting his left ear at a local hospital (the hospital) which was managed by the Trust[1]. In this report I refer to the parents as Mr and Mrs C and to their son as Mr C Junior. I also refer to Fife Acute Hospitals NHS Trust[1] as the Trust and to Fife Health Board[1] as the Board.

2. Mr C Junior had two consultations at the hospital in 1998 and was given an appointment for review in 1999 because it had not been possible to diagnose his ear condition. The Trust told Mrs C that Mr C Junior cancelled that appointment by telephone and that the receptionist remembered that he said he did not want a further appointment. Mrs C disputed this account of events. I have not investigated this aspect because there is no robust documentary evidence to show which account is correct. I also note that the Trust said they had changed their procedures so that if a patient in the ear, nose and throat department of the hospital indicated they did not want further appointments, an

[1] Fife Acute Hospitals National Health Service Trust was established by The Fife Acute Hospitals National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The Fife National Health Service Trusts (Dissolution) Order 2003 which came into force on 1 October 2003. On the same date an Order transferring the liabilities of the Trust to Fife Health Board came into effect.

appropriate consultant would review the matter. I welcome this improvement in procedures.

3. Mr C Junior attended the hospital again on 3 August 2000, by which time he was 17 years old. As diagnosis of his condition was still not possible, he was put on a waiting list for an exploratory operation to try and reach a diagnosis. However, he was not seen again until 20 February 2001. That delay has never been explained by the Trust in their responses to the letters of complaint from Mr and Mrs C, who, understandably, were very worried about their son's condition and its possible long term effect on his hearing. At the February consultation a diagnosis was made (which meant the exploratory operation was no longer needed) of chronic suppurative otitis media with cholesteatoma. Essentially, cholesteatoma is the development of a pouch of skin within the middle ear which becomes filled with a putty-like material. As a result of its presence, there can be erosion of the ossicles of the middle ear. These are the three small bones within the ear, through which sound is conducted. If, in addition to cholesteatoma, an infection develops, damage to the ossicles can be accelerated. To remove the cholesteatoma, Mr C Junior underwent a surgical procedure called a modified radical mastoidectomy on 19 April 2001.

4. The matter investigated was that there was delay in Mr C Junior's treatment between 3 August 2000 and 20 February 2001, which may have exacerbated his hearing loss.

Investigation

5. The statement of complaint for the investigation was issued to the complainants and the Trust on 3 June 2003. Comments were obtained from the Trust and the Board, and relevant documents including Mr C Junior's clinical records were examined. Oral and written evidence was taken from Mrs C and from staff of the Board. Two professional assessors – who are both consultant otolaryngologists - were appointed to advise on the case. Their report is reproduced in its entirety at paragraph 22 below. I have not included in my report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Oral and written evidence of Mr and Mrs C

6. Mr C Junior attended the hospital twice in 1998 with a several-month history of left ear problems – lack of hearing, discomfort, inflammation, odour and discharge. As it was not possible to diagnose his condition he was given a review appointment for April 1999. The Trust told Mrs C that Mr C Junior cancelled that appointment and that he specifically said he did not want a further one. Mrs C disputed this. Thinking that Mr C Junior had slipped through the review net, and as Mr C Junior's problems persisted, the family's general practitioner (GP) asked the hospital for another appointment in June 2000. This was arranged for 3 August 2000.

7. Mrs C and her son attended the August 2000 appointment, where Mr C Junior was seen by an associate specialist (the associate). The associate confirmed the presence of infection, but diagnosis was still not possible, and examination of the ear was difficult – for example, because of the particularly narrow ear canal. He, therefore, decided that Mr C Junior should have an ear clean and exploratory examination under general anaesthetic (EUA) to try and see more clearly the ear condition. At interview with my Complaints Investigator, Mrs C said that she was given no information about the likely waiting time for the EUA but that she had not expected to have to wait a further six months, given the previous delay between April 1999 and August 2000. She considered that this delay allowed the infection to spread unchecked, requiring surgery.

8. In January 2001 Mr C Junior received an appointment for 20 February. As no indication to the contrary was given, Mrs C and Mr C Junior believed it to be an appointment for the EUA and were most surprised to learn, on arrival, that this was not the case. In fact, the associate did not know why they were there. However, he and a consultant (the first consultant) examined Mr C Junior's ear. The two doctors held a private discussion, after which the associate said that Mr C Junior would be put on the waiting list for a mastoid operation as it had now become possible to make the diagnosis, which meant that the EUA was not required. Mrs C said that the associate told her that her son would need early treatment.

9. The operation was performed on 19 April 2001 by another consultant (the second consultant). Mrs C said her son's ear was so badly diseased by then that one, and most of another, of his three ossicles had to be removed, resulting in further hearing loss.

10. Mr and Mrs C said that the Trust had never explained the delay between the consultations of 3 August 2000 and 20 February 2001 and had merely referred to it in their correspondence with the family as regrettable.

Evidence of the Trust and the Board

Evidence of the Chief Executive

11. The letter and documentation which the Chief Executive of the Trust sent in his response to my statement of complaint included the following:

> 'On 3 August 2000 [Mr C Junior] was seen by [the associate]. The picture of infection was not clear and subsequently [Mr C Junior] was placed on [the daybed waiting list of a consultant otolaryngologist (the first consultant)] for examination under anaesthetic.
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> 'This situation occurred because the patient was seen and listed by a non-consultant member of staff. At the time this situation arose there was a recent history in the department of locum doctors inappropriately placing patients on the waiting list for examination of ear problems under general anaesthetic. All such cases on the Day Bed waiting list were therefore reviewed in the Out-Patient Department prior to admission for surgery. We agree that this delay in arranging the review appointment was not acceptable. We have been unable to find the exact cause for the delay in relation to this appointment; however, we have not had a similar occurrence of this nature.
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> 'When [Mr C Junior] was seen … on 20 February 2001 by [the associate] he found a great deal of debris in the left ear. It had also been discharging a foul smelling discharge for over a year at

that time. His audiogram and tympanogram confirmed a mixed hearing loss of the left ear with good hearing in the right. [The second[2] consultant] also examined [Mr C Junior] that day and having explained the situation to [Mrs C] it was agreed that [he] would place [Mr C Junior] on his waiting list to perform an exploration of the left mastoid. Whilst there was a long waiting list of this operation he was given a fairly quick appointment and his operation was performed on [19] April 2001.

'There is no written policy on prioritisation of patients listed for surgery between August 2000 and February 2001. Patients are listed as urgent, soon or routine appointments and this is determined by the clinician based on clinical need.

'During the period between August 2000 and February 2001 the waiting time target for … daycases was 12 months ….'

Other evidence of the Trust and the Board

12. My Complaints Investigator obtained evidence from the documents and other information provided by the Trust and the Board and from interviews with Board staff, ie: the clinical director (the director); the first consultant; the associate; the patient records and information manager (the manager); and one of the secretaries in the ear, nose and throat (ENT) department (the secretary).

13. The secretary explained that, when the associate decided on surgery, he would make up a waiting list card and dictate a letter for the patient's GP and pass both to the secretaries, who would put the patient on the waiting list. The secretary recalled doing so for Mr C Junior. She said that patients were categorised on the list as 'urgent', 'soon' or 'routine'. The Trust's response to my statement of complaint had also explained that in mid-2000 there was no written policy on prioritisation of patients on the waiting list: the categories were determined by the clinician,

[2] Although in its letter to me and in earlier correspondence with Mr and Mrs C the Trust said that the second consultant examined Mr C Junior on 20 February 2001, this investigation has established that it was the first consultant who did so (see paragraph 21).

based on clinical need. The first consultant also said that 'urgent' and 'soon' patients would be categorised as such, and all other patients were by default 'routine'.

14. Waiting list cards were destroyed when a patient had been seen and the computer system that had then been in place was no longer used. This meant that no evidence remained to show what category Mr C Junior was given in August 2000.

15. The manager and secretary said that at that time the ENT average daybed waiting time for 'routine' patients was six months, with a maximum target of 12 months. The secretary thought that 'soon' patients would probably have been seen in around two months and 'urgent' patients within two to three weeks. When a patient came to the top of the list, the secretaries would pass their name to a consultant. If a patient had not been seen within 11 months, the computer would produce a reminder to help ensure that the 12-month target was met. The manager and secretary felt that there had been no mistake in Mr C Junior's case: he had simply been on a long waiting list and would have been seen in due course.

16. The first consultant said at interview that there was nothing that would have indicated Mr C Junior's needs as 'urgent' or 'soon' and that he had presumably therefore been 'routine'. He would have expected a 'routine' daybed patient to wait around three months, ie until around November 2000. He could not explain why Mr C Junior had not been seen then. He added that he felt the delay probably did not affect the clinical outcome, even taking into account the previous delay between April 1999 and August 2000.

17. The associate said at interview that the ENT daybed list in August 2000 was quite short and so he would have expected Mr C Junior to have the EUA within a few weeks.

18. The Board provided the statistics of the hospital's ENT daybed waiting lists for the five months up to and including August 2000. These showed that the vast majority of patients waited less than three months but that

a very significant number waited up to three further months, with a small number waiting up to three months more.

19. The associate put Mr C Junior on the first consultant's daybed waiting list for the EUA in August 2000 because it was very difficult to examine Mr C Junior's ear. At that time the first consultant had just rejoined the Trust as a locum consultant, having worked away for some time. (He became a substantive consultant in March 2001.) Part of the ENT department's staffing had been provided by a different locum consultant (the locum), and no consultant had overall responsibility for the daybed waiting list as it was a pooled list at that time.

20. On his return to the Trust, the first consultant took responsibility for the clinics of the locum, whose waiting lists, he discovered, were very full, with a lack of clinical decisions having been taken and a significant number of patients listed for procedures which the first consultant considered might be unnecessary. As well as other measures which he carried out to improve the ENT department's performance, he therefore decided to scrutinise fully those specific daybed cases, including some cases listed by the associate, and to recall relevant patients for review at an outpatients clinic, where a decision on appropriate treatment would be taken. This was why Mr C Junior received an appointment for the February 2001 consultation, which he and his mother had expected to be the EUA. When the first consultant decided that a patient be reviewed, the patient's name was removed from the waiting list pending the review appointment in outpatients. In a letter of 6 August 2002 to Mrs C, the Trust said that the first consultant accepted that there had been a delay between Mr C Junior's removal from the list and his outpatients review.

21. When Mrs C and Mr C Junior arrived for the February 2001 appointment, they were seen by the same associate as had seen them in August (that is, the associate). The associate said at interview that he was surprised to see them because he would have expected Mr C Junior to have had the EUA by then. He asked them why they were there but, because they had been expecting the EUA to take place that day, which was clearly now not the case, they could not answer. Nevertheless, the associate examined Mr C Junior's ear and, as he could now see

cholesteatoma, he discussed the matter with the first consultant, who then examined Mr C Junior. Both the first consultant and the associate acknowledged at interview that it was the first, not the second, consultant, who was involved – despite the Trust's earlier statements to the contrary. The first consultant and the associate decided that a modified radical mastoidectomy operation to remove the cholesteatoma should be performed. Because the first consultant was by now focusing on nose, rather than ear, conditions, he asked the associate to arrange for the second consultant, who was also a consultant otolaryngologist, to carry out the operation. This was performed on 19 April 2001. At interview the first consultant said that he would have expected Mr C Junior to have been categorised as 'urgent' for that operation and that he was surprised to be told at interview that in fact the category given to Mr C Junior had been 'routine'.

Report of my professional assessors

22. I now set out the assessors' report:

Basis of report

i) This report is based upon a review of the correspondence and clinical notes and the record of the Complaints Investigator's interviews with Mrs C and the director and also upon the interviews which the Complaints Investigator and one of us attended with the first consultant, the associate, the manager and the secretary.

History and comment

ii) Mr C Junior was seen at the hospital on 3 August 2000 with partial deafness and discharge from his left ear. He had been there before in 1998 but was not reviewed as planned in 1999. He was seen in August 2000 by the associate, who was an associate specialist of 20 years' experience and who, noting the deterioration in hearing and the foul discharge, attempted to clean out the ear and thus identify the problem. This procedure was unsuccessful, largely because of the narrowness of the ear canal and the patient's discomfort. A hearing loss was identified. The associate placed Mr C Junior on a daybed waiting list for a detailed examination and cleaning of the ear under anaesthetic. He did not prioritise this case as his perception was that the waiting time for all

patients on this list was only a few weeks. The associate, although working independently, did not have his own patient lists, and Mr C Junior was therefore listed under the first consultant, who had just rejoined the Trust as a locum consultant and who had overall responsibility for all patients on this pooled day case list.

iii) Examination of an ear under anaesthetic is an appropriate approach, particularly in younger patients with narrow ear canals, as was the case with Mr C Junior. The pooling of patients into a common waiting list as in this case can, however, jeopardise a clear line of clinical responsibility. The associate thought that there was not any requirement to categorise patients on this list as 'urgent', 'soon' or 'routine' as he thought the waiting time was only a few weeks. We consider that a categorisation leading to a waiting time of no longer than eight weeks would have been appropriate, given the possibility of cholesteatoma. We also feel it to be good practice that where cholesteatoma is suspected the examination and assessment under anaesthetic should be done, or at least supervised, by the surgeon who would have proceeded to perform the definitive surgery at a later date. We understand that the Board no longer operate a pooled daybed list and welcome this.

iv) Mr C Junior received a letter from the medical records manager dated 9 January 2001 inviting him to attend the first consultant's outpatient department on 20 February 2001. Mr C Junior attended with his mother, expecting to have the planned examination and suction clearance under anaesthetic at that visit. This visit was, however, a further appointment in the clinic, which had been requested by the first consultant following his review of cases on the daybed list. At that visit he was initially seen again by the associate, who found the left ear problem was now identifiable as cholesteatoma and who arranged for Mr C Junior's placement on the inpatient waiting list for a mastoidectomy at the recommendation of the first consultant, who had been asked to see Mr C Junior by the associate. Mr C Junior was then listed for surgery with the second consultant. Mrs C said she was told that this would be treated as an early or prompt admission.

v) The letter calling Mr C Junior to this review appointment gave no indication that this was not for the awaited examination under anaesthetic. That was poor communication. The first consultant's policy of patient review should have been explained in this letter and it should have been made clear that an operation would not occur at that visit. According to waiting list data the routine waiting time for daybed surgery in summer 2000 was around six to seven months. This was not known to either of the doctors involved, who thought that the wait for a routine patient was no more than three months. The first consultant moved from a locum position at the hospital to a permanent post there on 1 March 2001. He had noted that as a result of a previous locum working in the department, around 20% of patients on the daybed waiting list did not have a management plan that he endorsed. Mr C Junior was selected to be reviewed in the clinic. This was to assess whether the examination under anaesthetic was still the optimum treatment. In doing so, Mr C Junior's name was removed from the waiting list. The review also removed the need for Mr C Junior to have an exploratory operation before the major mastoid operation. However, its purpose and nature were not communicated reasonably by the medical records manager. It is not known what category Mr C Junior was placed in following the August 2000 visit but the waiting time suggests this was a routine listing. The associate said at interview that priority was not given because a routine case would wait only a few weeks. The first consultant thought that this waiting time was around three months. The true length of the waiting time was thus not known to either doctor: the waiting list statistics provided by the Board indicate that in fact the waiting time was around six months and could be much longer. This was also the perception of the manager and the secretary who were interviewed. In our opinion Mr C Junior should have been listed in a priority category to gain admission within two months. This should have been appreciated when the case was listed.

vi) Mr C Junior was admitted for surgery, which was performed by the second consultant on 19 April 2001, when a cholesteatoma was removed during a left modified radical mastoidectomy. This was the first occasion that Mr C Junior met his surgeon. Although an information sheet was provided on admission it is not clear that the family were fully aware of

the implications of this surgery, both in terms of potential complications and the likely post-operative course and long-term effect on his hearing.

vii) The waiting list card shows the priority marking for Mr C Junior's mastoid operation as 'R' for 'routine', although at interview the first consultant expressed surprise at this and said that he would have expected Mr C Junior to have been treated urgently. Mr C Junior was given a date of 21 May 2001 for the operation; however, he was able to accept a cancellation for 19 April as a result of his mother's proactive measures in seeking an early date. This highlights the need for care in listing categories and undertaking a regular review of what patients are on the list. Despite statements by the Trust, including statements by the second consultant, that the second consultant saw Mr C Junior in February 2001, they did not in fact meet until April 2001. In such instances it has to be questioned whether this is appropriate for the doctor/patient relationship in diseases of this nature, which have significant potential for both a poor outcome and a long follow-up period. It is our recommendation that for such patients there should be a clinic visit with the surgeon to fully discuss these issues at a reasonable time in advance of the procedure. We consider that the erroneous statements by the second consultant (for example, in his letter of 23 September 2003 to the Trust's then patient liaison manager) which claimed that he saw Mr C Junior in February 2001 should be taken up by the Board.

<u>Conclusions</u>

viii) The delay in getting appropriate surgery was unreasonable. That delay was due, firstly, to a failure to prioritise urgency correctly and, secondly, to a failure to prioritise Mr C Junior's outpatients review at the time he was removed from the waiting list for the EUA. Two months is the longest reasonable delay that we believe should occur from outpatient consultation until a proposed ear examination under anaesthetic. The additional wait meant further time suffering from a foul smelling ear discharge but is unlikely to have contributed to the final hearing loss.

ix) Key reasons for the delay were lack of clarity in clinical responsibility, in part due to a pooled waiting list. Relevant medical staff were ignorant of true waiting times and consequently lacked awareness of the

importance of prioritisation ratings. Finally, there has been careless documentation of waiting list categorisation as evidenced by the failure to register the mastoid operation as urgent after Mr C Junior was seen in February 2001.

x) Avoidance of pooled lists for complex patients, up to date information to staff on waiting times, coupled to an appropriate prioritisation system and regular list review would reduce the risks of similar events occurring again. We note the Chief Executive's statement in his response to the statement of complaint (paragraph 11 above) that there have been no similar occurrences of this type.

Findings

23. In reaching my findings I have been guided by my professional assessors' advice, which I accept. Mr C Junior was placed on the ENT waiting list for an exploratory operation under anaesthetic (the EUA) to try and diagnose his ear condition. My assessors consider that the EUA should have been done within eight weeks, given the possibility of cholesteatoma. The associate said at interview that he thought the waiting list was only several weeks in length. However, the ENT waiting list statistics show that – although the vast majority of patients waited less than three months – a very significant number waited up to three further months, with a small number waiting up to three months more. Indeed, the waiting time target for daycases was 12 months. The first consultant started his review of the waiting list around August 2000, taking part of the list at a time. When he decided that any particular patient should be reviewed, the patient's name was removed from the waiting list pending the review appointment in outpatients. The first consultant has suggested (paragraph 20) that the delay occurred between the removal from the list and the invitation of 9 January 2001 to the outpatients review. It has not been possible to establish when, during that five-month period from August to January, Mr C Junior's name was removed. Such poor record keeping cannot be considered to be good practice.

24. It is not possible to know when Mr C Junior's name would have come to the top of the list for the EUA if his name had not been removed for the

first consultant's review. However, to be sure of having the EUA within the two months recommended by my assessors and within the several weeks in which the associate thought it would be done, Mr C Junior's name would have needed an 'urgent' or 'soon' marker on the list.

25. The Trust said (paragraph 11) that they did not have written procedures in place for the prioritisation of patients on the waiting list. With the above events in mind, I must conclude that this was poor practice. The Trust should have had procedures in place to ensure that a patient was not put on a waiting list without an appropriate priority marker and to ensure that a patient's removal from a list was followed by timely and appropriate action. I uphold the complaint that there was delay in Mr C Junior's treatment between 3 August 2000 and 20 February 2001.

26. Mr C Junior's hearing must have been a great worry to him and his parents. I am unable to determine with certainty whether his final hearing loss was any worse than it would have been if the mastoid operation had been done earlier. My assessors feel that it was unlikely to have been (paragraph 22 viii)). In these circumstances I accept that view and I do not uphold the complaint that the delay exacerbated his hearing loss. However, I consider that the delay added to the pain and discomfort suffered by Mr C Junior.

27. I note that, beyond saying that it was regrettable, the Trust have not apologised to Mr and Mrs C for the delay. I consider this to be poor practice, particularly given the unsatisfactory inability to explain that delay and the trauma which the delay must have caused the family.

Recommendations

28. I am of the view that the complainants and their son have suffered injustice as a result of the delay in Mr C Junior's treatment between 3 August 2000 and 20 February 2001. In order to redress this injustice, I recommend:

i) that the Board apologise to Mr and Mrs C for the Trust's delay; and

ii) that the Board review the Trust's policies and practices to ensure, as far as is reasonably possible, that the shortcomings identified in my findings cannot recur.

29. In paragraph 2 above I welcomed the improvement that had been made to procedures in the ear, nose and throat department of the hospital in cases where a patient indicates that they do not want further appointments. In response to another recent complaint that I investigated, the Board accepted my recommendations and detailed the actions they will be taking when a patient wishes no further clinic appointments. I urge the Board to extend this good practice to all relevant departments within the Board.

Other points

30. My assessors' report (paragraph 22) raises a number of other concerns (for example, that Mr C Junior and his surgeon did not meet before the April 2001 operation [paragraph 22 vii]). These matters are outside the scope of the investigation and so the Board have not had an opportunity to respond to them. Nevertheless, I urge the Board to consider what actions it should take to address the concerns raised.

Professor Alice Brown
Scottish Public Services Ombudsman

30 August 2004