Scottish Parliament Region: North East Scotland

Case 200700903: Tayside NHS Board

Summary of Investigation

Category

Health: Appointments/admissions (delay, cancellation, waiting lists)

Overview

The complainant (Mr C) was referred to an orthopaedic consultant (Consultant 1) at Ninewells Hospital for treatment to his knee and foot. Before a date for surgery could be arranged, personal circumstances meant that Consultant 1 had to take an extended period of absence from work, at short notice. Mr C complained that his surgery was unacceptably delayed, as Tayside NHS Board (the Board) did not make adequate arrangements to progress the treatment of Consultant 1's patients during his absence.

Specific complaint and conclusion

The complaint which has been investigated is that Mr C was subjected to an unacceptably long wait for operations on his foot and knee *(not upheld)*.

Redress and recommendation

The Ombudsman recommends that the Board considers Mr C's overall treatment plan, and the time taken up by administration, when reviewing their procedures in line with the Scottish Government's revised waiting time targets.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. The complainant (Mr C) had previously undergone two unsuccessful surgical procedures on his left big toe. In March 2006, he injured his right knee cartilage in a fall. Mr C was referred by his GP for further investigations in July 2006 and was examined privately by an orthopaedic consultant (Consultant 1) that August. Consultant 1 agreed to see Mr C as an NHS patient and examined him further in September 2006. Consultant 1 decided to treat Mr C's knee himself and to refer him to a different orthopaedic consultant (Consultant 2) for treatment of his toe.

2. Shortly after seeing Mr C, personal circumstances meant that Consultant 1 had to take an immediate, long-term leave of absence from work. Mr C complained to Tayside NHS Board (the Board) that, whilst Consultant 1's absence was understandable, no action was taken to ensure that his work was covered until his return. Mr C did not hear back from the Board with an appointment for surgery and he told me that it was only once he asked his GP to chase the Board in January 2007 that appointments were made for the two operations that he required. Mr C was dissatisfied with the explanation that the Board gave him for the delays to his operation. He, therefore, brought the matter to this office in June 2007.

3. The complaint from Mr C which I have investigated is that Mr C was subjected to an unacceptably long wait for operations on his foot and knee.

Investigation

4. In order to investigate this complaint, I have reviewed all of the complaint correspondence between Mr C and the Board. I have also sought professional medical advice from the Ombudsman's clinical adviser (the Adviser) and reviewed the Board's clinical records for Mr C.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Mr C was subjected to an unacceptably long wait for operations on his foot and knee

6. Mr C had a bunion on his left big toe and required surgery to remove it and realign the bones of that toe. In September 2005, he underwent an operation to fuse the bones of his big toe. This failed and a Keller's Arthroplasty (an operation involving the removal of part of the toe joint) was subsequently carried out in February 2006. Following this second operation, his toe became extremely painful. Additionally, Mr C fell at home in March 2006 and injured his right knee. He visited his GP who sent a referral for him to be seen at Ninewells Hospital (Hospital 1). Mr C went on holiday in August 2006. He said that, while he was away, the pain in his knee became unbearable. Mr C's wife, therefore, wrote to his GP to request an urgent referral to Fernbrae Hospital, where a private consultation was arranged for 26 August 2006.

7. At the consultation on 26 August 2006, Mr C was seen by Consultant 1, who agreed to see him again as an NHS patient at Stracathro Hospital (Hospital 2). Consultant 1 wrote to Mr C's GP following the consultation of 26 August 2006 noting that Mr C's big toe was 'very short and floppy'. It was also noted that he had been experiencing problems with the other toes on his left foot. Consultant 1 commented that this is often the case following a Keller's Arthroplasty.

8. An NHS appointment was arranged for 13 September 2006 at Hospital 1. Consultant 1 organised x-rays of Mr C's pelvis, right knee and left foot. The x-rays showed no obvious signs of arthritis. Consultant 1 commented in the clinical note for this consultation that Mr C's left big toe seemed to have avascular necrosis (death of the bone cells caused by an interruption of blood supply to the bone). It was noted that Mr C was due to see an Orthotist the following day. In the meantime, Consultant 1 arranged for an MRI scan of Mr C's right knee.

9. The clinical records do not contain details of Mr C's MRI scan, however, Consultant 1 wrote a letter to Mr C's GP following a clinic on 25 October 2006. The letter was dated 16 November 2006 (marked as referring to the clinic of 25 October 2006) with the comment 'Dictated but not read' above Consultant 1's name. The letter explained that the MRI scan results had been received and showed that Mr C had an extensive complex tear of the posterior horn of medial meniscus (a section of cartilage to the rear of the knee) and a

small vertical tear in the anterior horn of the meniscus (a section of cartilage to the front of the knee).

10. The letter of 16 November 2006 noted that Mr C's main priority was to address the problems with his left big toe. Consultant 1 commented that he would refer Mr C to Consultant 2 for the toe problem, after which he would return to Consultant 1 for treatment on his knee.

11. In his complaint to this office, Mr C indicated that he was happy with the way that his treatment progressed up to this point. However, he said that in late September 2006, personal circumstances meant that Consultant 1 had to take an extended leave of absence at short notice. Mr C said that Consultant 1 was off work between late September 2006 and early February 2007. I asked the Board for confirmation of this and they told me that Consultant 1 was absent between 30 October 2006 and 1 February 2007. I did not seek details of the incident that led to Consultant 1's absence as part of my investigation, however, it is evident that Mr C's treatment progressed normally until the clinic of 25 October 2006, shortly after which Consultant 1 had to take time off work.

12. Mr C said that no action was taken by the Board in Consultant 1's absence and it was only once he had contacted three separate GPs at his local practice, in early January 2007, that his case was remembered. He complained that he did not hear from the Board between early September 2006 and late January 2007, a period of five months during which he was in severe pain. He believed that the progression of his treatment was overlooked due to the Board not making arrangements for another consultant to take over Consultant 1's patient list during his absence. In his complaint, Mr C recounted a telephone conversation with a secretary at Hospital 2. He reported being advised that the Board did not re-distribute Consultant 1's patient list, as they were unsure of the length of his absence.

13. Although I acknowledge Mr C's general description of events, the evidence that I have seen does not match exactly the timeline that he provided. The clinical records show that Mr C was seen by Consultant 1 on 25 October 2006 and then by Consultant 2 on 28 December 2006. I have, therefore, tried to establish what action was taken during this period to progress Mr C's treatment.

14. When investigating this complaint, I asked the Board what action they took to cover Consultant 1's patients' treatment during his absence. The Board told me that, as soon as it was identified that his period of absence was to be long-term, Consultant 1's patients were assigned to other consultants, unless, upon being contacted, they requested to remain on Consultant 1's waiting list.

15. Following the consultation on 25 October 2006, Consultant 1 wrote two letters. One, as described in paragraph 7, to Mr C's GP and the other, a referral letter to Consultant 2, asking that he see Mr C about his left big toe. As with the letter to Mr C's GP, the referral letter was marked 'dictated but not read'. The Board provided me with two copies of the letter referring Mr C to Consultant 2. Both were identical except one was dated 16 November 2006 and the other 5 December 2006. The letter dated 5 December had a handwritten note on it confirming Mr C's appointment for 28 December 2006 with Consultant 2. I asked the Board to confirm which of the two letters had been sent to Consultant 2, and when. The Board explained that, following the consultation of 25 October 2006, administrative staff typed up the letter which had been dictated by Consultant 1 prior to his absence. The letter was dated 16 November 2006 and was sent in the Hospital 1's internal post on that day. Consultant 2 did not receive the letter and a second copy was, therefore, printed and sent to him by fax on 5 December 2006. Hospital 1's computer system automatically updates the date on letters when they are printed. The Board further advised that the letter was seen by Consultant 2 and then forwarded to Medical Records, who received it on 7 December 2006. Medical Records would have entered the referral onto their computer system before sending it back to Consultant 2 for an appointment to be arranged. The appointment was arranged for 28 December 2006.

16. The clinic letter written by Consultant 2, dated 12 January 2007, following the consultation on 28 December 2006, noted that Mr C had three possible problems with his left big toe: it was short and floppy; he was experiencing neuralgic discomfort (nerve pain); and soft tissue swelling. It was recorded that Mr C was quite concerned about the neuralgic discomfort. Consultant 2 noted that this could be related to an interdigital neuroma (a growth in the forefoot). He considered it necessary to arrange an ultrasound scan of Mr C's foot to see the status of Mr C's digital nerve.

17. In his clinic letter, Consultant 2 surmised that little could be done about Mr C's toe being short and floppy. Although surgery was an option, the procedure was technically difficult with no guarantee of success. Consultant 2 explained his conclusions to Mr C and noted that they would meet again once the ultrasound results had been confirmed.

18. Mr C was seen at Hospital 1 on 8 February 2007 by Consultant 2 and another orthopaedic consultant (Consultant 3). The clinic letter referring to this appointment does not mention the results of Mr C's ultrasound scan, however these were detailed in a separate letter from Consultant 3 to Mr C's GP, dated 9 February 2007. The ultrasound showed no neuroma. A soft tissue swelling was highlighted on one of Mr C's joints and Consultant 3 reflected that a nerve may have been trapped during previous surgery.

19. The clinic letter for the 8 February 2007 consultation notes that an extensive examination was carried out to determine the source of Mr C's pain. This was considered to be concentrated around the soft tissue swelling on his big toe, at the second MTP joint and at the first MTP joint, where he had had his previous two operations. An excision arthroplasty (creation of a new, mobile joint by separating the bones in the toe and padding the gap) was arranged for the second MTP joint. Consultant 2 also discussed with Mr C the option of using a bone graft to extend his big toe. It was noted, however, that if this was unsuccessful, the toe may have to be amputated. In a letter to Consultant 2, dated 9 February 2007, Mr C's wife confirmed that she and her husband had discussed this and did not wish to proceed with the toe extension.

20. The clinic letter, which was dated 15 February 2007, requested that Mr C be put on the waiting list for excision arthroplasty surgery. In the meantime, an orthopaedic support was ordered to support Mr C's foot and toes.

21. On 10 February 2007, Mr C wrote to the Board, via his MSP, to complain about the length of time that he had been waiting for his surgery. The Board responded to his MSP on 19 April 2007, explaining that Mr C's foot surgery had to take place prior to his knee surgery. An appointment had been made for the foot surgery on 18 May 2007, with a further appointment on 30 May 2007 for the knee surgery. Prior to this letter, Mr C was contacted directly by Hospital 2 and was told that the surgeon that would be operating on his knee wished to postpone the operation, as a minimum of six weeks should be left between operations due to the anaesthetic used.

22. Mr C's foot surgery was carried out on 18 May 2007. He visited Consultant 2 on 14 May 2007 and it was explained to him that the purpose of the surgery was to remove the soft tissue swelling in his left big toe. No other procedures were to be carried out. There are no notes in the clinical records to explain why the excision arthroplasty (mentioned in paragraph 19) was not to be attempted, however, it is noted on more than one occasion that the soft tissue swelling appeared to be the main cause of Mr C's pain.

23. Mr C's knee surgery was rescheduled for 11 July 2007. He was advised of this on 13 June 2007. Prior to this, Mr C wrote a further complaint letter to the Board, dated 11 May 2007, stating that he had waited 67 weeks for his foot surgery and would be required to wait 85 weeks for his knee surgery. He sought an admission and apology from the Board that they had failed to progress his treatment in line with national waiting time targets.

24. I asked the Adviser for her comments with regard to the time taken by the Board to arrange Mr C's operations. She noted that Mr C's foot surgery was complex and required the referral from Consultant 1 to Consultant 2. This caused some initial delay, but was necessary, given the specialist treatment required. Additional appointments were required to assess Mr C's foot prior to him being formally added to the waiting list for surgery. The Adviser noted that Mr C's case was not considered to be urgent. As such, she considered the time taken between consultations to be reasonable and in line with standard procedures.

25. The Scottish Government set waiting time targets for operations. At the time of Mr C's surgery, the targeted national waiting time standard was for patients to receive treatment within 18 weeks of being placed on the waiting list for surgery. Mr C was added to the waiting list on 15 February 2007. His foot surgery was carried out on 18 May 2007.

Conclusion

26. Mr C complained that it took 67 weeks for his foot surgery to be carried out. Counting back from the operation date, I understand that he calculated this timeline from the date of his first, failed, operation in September 2005. As the first two operations were not part of the treatment process being complained about, I have considered the overall care path from Mr C's GP referral on 10 July 2006 until his foot surgery in May 2007. This constituted a total of

44 weeks. I accept that Mr C's knee surgery had to be delayed by a minimum of six weeks following his foot surgery. I consider the appointment date seven weeks after the first operation to be appropriate.

27. As Mr C stated himself, investigations carried out by Consultant 1 proceeded satisfactorily from the first private consultation on 26 August 2006 to his review as an NHS patient and initial diagnosis on 25 October 2006. On 30 October 2006, Consultant 1 left work on an extended period of absence. Mr C believed that a subsequent lack of provisional arrangements for Consultant 1's patients led to delays to his care.

28. The Board confirmed that Consultant 1's patients were allocated to other consultants. I consider it to be reasonable that this was not done until such time as it was known that Consultant 1 would be absent for an extended period.

29. The evidence that I have been provided with shows that, following the consultation of 25 October 2006, Consultant 1 felt it necessary to refer Mr C to Consultant 2. Although Consultant 1 was absent by this time, his dictated referral was acted upon and typed up on 16 November 2006. For reasons unknown, the referral letter did not reach Consultant 2, and a further copy was re-sent on 5 December 2006. Mr C said that no action was taken to progress his treatment until his GP chased the Board in January 2007. Although the dates do not correspond, and I have seen no evidence to suggest that the referral letter was re-sent following the GP's intervention, I accept that this may have been the case. However, it is clear from the clinical records that Consultant 1's absence did not directly hamper the progression of Mr C's treatment. Consultant 1's referral was passed on and further appointments arranged during the period that he was absent.

30. Although I am satisfied with the arrangements made by the Board to cover Consultant 1's absence, and do not find that his sudden absence directly impacted on Mr C's care, I wished to identify any other factors that could have led to unnecessary delays to his treatment. Given the complex nature of his toe problem, the Adviser advised me that it was reasonable for Mr C to be referred to Consultant 2, and that it was appropriate for him to be seen more than once by him before being put on the waiting list for surgery. She expressed no concern over the clinical aspects of his care and felt that the investigations by Consultant 1 and Consultant 2 followed a reasonable progression. I have already commented that the care under Consultant 1 progressed well until his

final consultation on 25 October 2006. Furthermore, from the point of being added to the waiting list on 15 February 2007, it took only 14 weeks before Mr C received his treatment, well within the targeted 18-week waiting time.

31. There was a period of just over nine weeks between Mr C's consultations with Consultant 1 on 25 October 2006 and Consultant 2 on 28 December 2006. I have identified a clear delay of three weeks within this period due to the non-receipt of Consultant 1's referral letter by Consultant 2. Whilst this was unfortunate, and certainly would have added to the overall time taken to confirm an operation date for Mr C, I am satisfied that the situation was most likely caused by a basic administrative error rather than being indicative of significant organisational issues within the Board.

32. When reviewing the paperwork that accompanied the clinical records for this case, I had some concerns over the Board's general administration. Although no delays were caused as a result, the fact that Mr C was sent a letter confirming that his two operations would take place in May 2007, when he had already been contacted and told that the knee surgery would be delayed by a minimum of six weeks, could only have added to his concerns over the Board's organisational capabilities. Furthermore, I noted that there was a delay of at least one week, following each consultation, before the corresponding clinic letter was typed up. Looking at each consultation independently, this in itself is not a cause for concern and I do not consider the time taken to be unreasonable, particularly in cases that have been deemed to be non-urgent. However, I do recognise that in cases such as Mr C's, where a number of consultations were required before a date for surgery could be arranged, these additional weeks accumulate and contribute to the overall waiting time for treatment. The Scottish Government have recently pledged to ensure that, by December 2011, all patients are treated within 18 weeks of being referred by their GP. The Board may wish to consider their administrative procedures when seeking to achieve this target.

33. Although I have identified an avoidable delay of three weeks within the overall treatment path, I do not consider this to have significantly impacted on Mr C's overall care. I am also satisfied that Consultant 1's absence did not directly impact on the progression of Mr C's care and that the consultations arranged for him with Consultant 2 were done so in a timely manner, given the non-urgent status of his condition. I, therefore, do not uphold this complaint.

Recommendation

34. Although I do not uphold this complaint, I have commented on the accumulative delays related to the Board's procedures for typing up clinical letters.

35. The Ombudsman recommends that the Board considers Mr C's overall treatment plan, and the time taken up by administration, when reviewing their procedures in line with the Scottish Government's revised waiting time targets.

36. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Consultant 1	An orthopaedic consultant at Ninewells Hospital
Consultant 2	An orthopaedic consultant at Ninewells Hospital
The Board	Tayside NHS Board
The Adviser	Clinical adviser to the Ombudsman
Hospital 1	Ninewells Hospital, Dundee
Hospital 2	Stracathro Hospital, Brechin
Consultant 3	An orthopaedic consultant at Ninewells Hospital

Annex 2

Glossary of terms

Avascular necrosis	Death of the cell structure of bones due to an interruption to the blood supply
Excision arthroplasty	Construction of a new joint by separating the existing bones and padding the resultant gap with fibrous tissue or muscle tissue
Interdigital neuroma	A painful growth in the forefoot that results in pain between the toes
Keller's arthroplasty	A form of bunion surgery whereby parts of the bones of the toe are removed so that the toe joint can be realigned
MTP joint	Metatarsophalangeal joint. The joints of the toes

Annex 3

List of legislation and policies considered

Scottish Government national hospital waiting times standards