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The investigation of a complaint against Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202201496

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Introduction

This report is issued under s23 of the Public Services Ombudsman (Wales) Act 2019 (“the Act”).

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr D.

Summary

Mr D complained that he had waited a long time for orthopaedic surgery and that his understanding of how he would be treated was not managed well regarding the pre-operative assessments.

The waiting time for orthopaedic surgery at the Health Board is more than 4 years. The Health Board had issues including not enough staff, not enough suitable places to operate, unclear management arrangements, and unclear processes for these operations.

The Ombudsman identified that in this and 2 other cases, in addition to the long delays experienced by all patients awaiting orthopaedic surgery, the complainants had been treated unfairly because of errors in the way the waiting lists were managed. These issues raised the Ombudsman's concerns about how the waiting list has been managed.

Mr D was removed from the waiting list when he missed surgical appointments because he was in hospital for another illness. Despite provision in the guidance for this type of situation, Mr D was removed from the list and is waiting to be "treated in turn" which appears to be outside of the process. 65 months (5 and a half years) after being added to the list for surgery, he is still waiting for treatment. He is in a lot of pain, and this has affected his wellbeing significantly.

Mr D was also put through the stress and pain of pre-operative assessments, which had raised his hopes that surgery would happen soon when the Health Board would have been aware that it was unable to provide surgery before the pre-operative assessment expired. It failed to take this into account or tell the patients.

The Ombudsman noted that the Health Board has taken action to address the length of its waiting lists so made no recommendations about that. However, because of the issues identified she has asked the Health Board to review the decisions it made in respect of Mr D. The Health Board was also asked to audit the whole of its waiting list to establish whether errors had been made on the waiting list times or improper removal from the list for other patients and if so, it should apologise to those patients and correct the errors.

The Complaint

1. Mr D complained about the orthopaedic care (treatment relating to bones, joints, muscles and ligaments) he received from Swansea Bay University Health Board ("the Health Board"), and in particular:

a) Mr D had to wait an unacceptably long time for orthopaedic surgery when taking account of his clinical need and the impact his condition is having on his daily life.

b) Mr D's expectations were mismanaged by the NHS regarding the pre-operative assessments ("POA" - assessment of general health and fitness before surgery) he attended.

Investigation

2. My Investigation Officer obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr D.

3. In relation to events which occurred at the height of the COVID-19 pandemic, I carefully considered whether the care delivered was appropriate within this context. I have taken account of the severe pressure on public bodies at the time and the impact on the organisation's ability to balance the demands on its resources, and capacity to provide treatment, when reaching a decision about whether the care and treatment was appropriate. In doing so, I have considered the explanations of the organisation complained about and whether its approach to care and treatment was appropriate at the time.

4. Both Mr D and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued. The Welsh Government was also invited to comment on the facts that related to its involvement.

Relevant legislation, guidance and policies

5. The National Health Service (Wales) Act 2006 includes at section 3(1)(c):

> "The Welsh Ministers must provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements - …medical, dental, ophthalmic, nursing and ambulance services."

The Welsh Government arranges for these services to be delivered by the Health Board in its local area.

6. Rules for managing referral to treatment waiting times ("the RTT guidance") - Version 7 - October 2017:

- In March 2005, the First Minister and Minister for Health and Social Services announced that, by December 2009, no patient in Wales will wait more than 26 weeks from GP referral to treatment, including waiting times for any diagnostic tests or therapies required… The achievement of the 26-week RTT target is the responsibility of health boards.

- A maximum of a 36-week wait would be allowed for clinically complex patients, and different targets apply to certain types of treatment, such as diagnostic tests (e.g. X-rays) and treatment for cancer. The wait time begins on receipt of a referral by a healthcare professional to a consultant and is the start of the waiting time "clock". The clock can start or stop at certain designated points explained within the RTT guidance.

- This guidance is to ensure that the period patients wait for elective (planned) care are measured and reported in a consistent and fair manner.

- Paragraph 66 sets out that a "Could not attend" ("CNA") occurs when a patient notifies the Health Board of their inability to attend an appointment that was previously mutually agreed. Notice must be given prior to the appointment.

- Paragraph 67 states that if a CNA occurs, a patient's clock will be reset, but they will remain on the treatment pathway. A new appointment should be agreed when the patient is available. The clock reset should be communicated to the patient.

- Paragraph 68 says that a second CNA on the same pathway means the patient has broken the agreement to be reasonably available and are at risk of being removed from the waiting list. This is at the discretion of the consultant.

- Paragraph 102 states that if a patient is unavailable due to a short-term medical condition, an adjustment may be made to the RTT period. The patient should remain on the active waiting list and an adjustment of up to 21 days may be applied. Advice may be sought from a qualified healthcare professional on whether a condition is likely to resolve in 21 days. If the professional feels that it will not resolve, the clock is stopped.

7. The Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic, produced by the Federation of Surgical Speciality Association at the start of the COVID-19 pandemic ("the FSSA Guide"). The FSSA Guide sets out that categories 1a, to be performed in less than 24 hours, and 1b, to be performed in less than 72 hours, comprise emergency procedures such as fractures, infections, and dislocated joints. Regarding elective patients, the Guide also states that category 2 patients should be treated within a month and category 3 patients should be treated within 3 months.

8. The British Orthopaedic Association Elective Standard - "Providing a Continuous Safe Elective Orthopaedic Environment"- February 2021 ("the BOA Standard"). The relevant sections of the Standard are:

- All surgical providers should have a defined facility that exclusively accepts appropriate orthopaedic patients. This should be distinct from other clinical areas either within an acute site or at a separate geographic location.

- If the ring-fenced capability is breached, all planned cases must be cancelled until the integrity of the facility is re-established, whilst supporting the safe management of patients.

9. The Welsh Orthopaedic Board National Clinical Strategy for Orthopaedics - “The National Blueprint for Orthopaedic Surgical Delivery in Wales” (“the National Blueprint report”) 2022. This report described elective orthopaedic and trauma services in Wales as being in a “state of near collapse” and set out a long-term strategy for orthopaedic surgery. It produced a series of recommendations and actions that included:

- An acknowledgement of the challenge of ring-fencing beds specifically for orthopaedic surgery at Morriston Hospital.

- The development of 3 orthopaedic hubs throughout Wales, with 1 situated in South West Wales on a site that encompasses all of the interdependent services such as anaesthetists and an Intensive Therapy Unit (“ITU”). The report specifically mentioned that Neath Port Talbot Hospital would have an important role, and that its development should continue, but acknowledged the difficulty of providing services to patients with complex needs due to the lack of enhanced recovery facilities.

- Musculoskeletal pathways (for treatment of muscles, bones, joints and connective tissues) should be transformed.

- The development of a day case delivery network by individual health boards.

10. The Getting It Right First Time Project Team report, Orthopaedic National Report Across Wales (“the GiRFT” report) - May 2022. This report aimed to enable the urgent restoration of elective orthopaedic treatment and the adoption of GiRFT principles to ensure best outcomes for patients. The report explained that:

- The GiRFT team identified significant variation between health boards in the way patients are treated and therefore in their outcomes. They stated that plans to re-start elective surgery and to reduce significant waiting lists were not widely known and seemed to be lacking pace. They found that patients on long waiting lists were de-conditioning (declining as a result of physical inactivity) and their conditions worsening; they said this was becoming a duty of candour (health care professionals should be open and transparent with patients) issue.

- The report made a series of 28 recommendations to tackle waiting lists, improve structures and ways of working and enhance quality of care to improve performance, awareness, and governance of orthopaedic surgery delivery across Wales at pace.

11. Audit Wales - Orthopaedic Services in Wales - “Tackling the Waiting List Backlog” (“the Audit Wales report”) - Report of the Auditor General for Wales, March 2023. This report placed the waiting list for orthopaedic services into context, considered what had affected service recovery, looked at what action was being taken and made recommendations for action.

The report includes the following:

- In November 2022, of the 748,271 people on the NHS waiting list in Wales, 101,014 were waiting for orthopaedic services.

- According to national data, RTT targets have not been met since 2011.

- There was a 13% variation in the percentage of people waiting 2 years or more across health boards in Wales. The Health Board had the highest percentage of people in that category, 23%.

- A comparison of the total number of patients within each health board in Wales that had been waiting for over 36 weeks for orthopaedic treatment (per 100,000 population) reveals the Health Board had the largest number, over 300% higher than the health board with the lowest number.

- Orthopaedic and musculoskeletal problems can be debilitating and can significantly affect people’s quality of life. In turn, this can cause wider deterioration in patients’ physical and mental health.

- Factors affecting national service recovery comprised: referral rates that dipped during the COVID-19 pandemic are likely to rise again; demand for linked services such as diagnostic imaging has risen; a

reduction in bed capacity by 12% over 10 years; a slow restart of services following the COVID-19 pandemic; demographic changes will mean greater future demand.

- Action being taken across Wales included: community-based schemes that offer preventative approaches and input from the GiRFT team.

- Recommendations for action consisted of: application of the national strategy developed by the Welsh Orthopaedics Board accompanied by buy-in from local clinical teams; a renewed focus on efficiency; a wider view to be taken of the system supporting the orthopaedic pathway; investment in technology and estate; regional models should be at the core of delivery plans; patient experience and outcomes should shape clinical decision and advice.

The background events

The wider orthopaedic context

12. Patients awaiting orthopaedic surgery are added to a waiting list. They are categorised by a consultant orthopaedic surgeon depending on their degree of urgency. Patients who are on the waiting list are known as elective patients, rather than emergency patients who need immediate treatment, for example, as a result of injury.

13. Patients who are on the waiting list who also have other health conditions may need to have surgery in a hospital where there are critical care facilities (also known as intensive care or ITU), in case of complications following surgery. Other health conditions might include, for example, high body mass index ("BMI" - a method of using height and weight to calculate a medically healthy range) and sleep apnoea. Within the Health Board's area, orthopaedic surgery is carried out at 2 hospitals: Morriston Hospital ("the First Hospital") and Neath Port Talbot Hospital ("the Second Hospital"). The First Hospital has critical care facilities. According to the BOA Standard, some critical care beds should be reserved only for orthopaedic patients (also called ring-fenced beds).

14. During the latter part of **2019**, elective orthopaedic surgery could not be performed at the First Hospital for a period of about 6 months. That was because unscheduled care pressures at the First Hospital meant it was unable to have beds ring-fenced for orthopaedic surgery, in-line with the BOA Standard. It therefore lost elective surgical capacity in order to manage emergency admissions.

15. As of December 2019, the Health Board had introduced the following measures to manage the situation:

- It was outsourcing (a term used to describe attempts to seek help with service provision from other health boards) appropriate patients to allow the First Hospital to focus on patients with more complex needs. Complex patients could not be outsourced as most outsourcing facilities (such as private care) did not have access to critical care facilities.

- It was recruiting and training more orthopaedic theatre staff and backfilling appointments at vacant theatres to cover staff shortages.

- It insourced (a term used to describe services deployed to utilise spare, out-of-hours capacity, typically at the weekend, within a health board) orthopaedic surgery to the Second Hospital for a limited number of appropriate patients.

16. At the outset of the COVID-19 pandemic in Spring **2020**, the First Hospital lost the capacity to treat complex patients again. As the higher risk category of patients could only be treated at the First Hospital, they were therefore not receiving treatment during the period of the pandemic.

17. In November **2021** the Health Board approved development of a major new Orthopaedic Centre at the Second Hospital to expand capacity for orthopaedic surgery. It said the Orthopaedic Centre would be ready to accept patients in early 2023.

18. On 10 June **2022** the GiRFT team met with the Health Board's Chief Executive Officer ("CEO"). The report issued following the meeting concluded that there was no satisfactory solution in place for patients who could only be treated at the First Hospital. The report said "A lack of

ring-fencing in [the First Hospital] remains, this equates to an Infinity waiting list for those patients…" with complex needs. Other challenges identified included a lack of workforce and elective theatre capacity, an ambiguous management structure, and a lack of standard operating procedures including ambulance resource.

19. In July the Health Board reported the routine waiting time for orthopaedic surgery was 259 weeks and the urgent waiting time was 253 weeks. In December 2019 the routine waiting time had been 159 weeks and the urgent waiting time was 139 weeks.

20. The Health Board opened discussions with a neighbouring health board in July to establish if it had the critical care capacity to assist it with outsourcing patients who required an increased level of care. These discussions were not successful.

21. On 10 October a meeting took place between the Health Board's CEO, the GiRFT team and others. A failure in the duty of candour to patients was highlighted, with patients coming to harm on waiting lists with no solution in sight. The Clinical Lead of the GiRFT team said, in response to a comment that 35% of the patients who had been waiting longest for orthopaedic treatment in Wales were under the care of the Health Board, "People have known this for a long time with no solution." The CEO commented, "We have underinvested in orthopaedics for years".

22. On 1 November my Investigation Officer received an email from the Planned Care Improvement and Recovery Team ("the PCIR Team") at the NHS Wales Delivery Unit (this is an all-Wales organisation which supports Welsh health boards to improve safety and quality of patient care). The PCIR Team explained that the Health Board's orthopaedic waiting list had been a focus of discussion and challenge for a number of months. Members of the PCIR Team had met with the Health Board's CEO and others to find a way forward. They acknowledged that whilst all health boards in Wales have long orthopaedic waiting times, the Health Board's capacity was the most restricted with regard to facilities for patients with complex needs. During November the ring-fenced beds were reinstated at the First Hospital, but only for a fortnight before service pressures meant the ring-fencing was removed.

23. On 10 January **2023** the First Minister was asked a question in the Senedd regarding waiting times for orthopaedic surgery within the Health Board's area. The question highlighted that waiting times were in excess of 4 years and said that the Health Board had pointed to historic underfunding of orthopaedic surgery. The First Minister said that the Health Board had a plan to concentrate planned orthopaedic surgery at the Second Hospital, whilst retaining 10 beds at the First Hospital for more complex cases.

24. On 12 January the PCIR Team confirmed that the Orthopaedic Outpatient Department had moved to the Second Hospital and said outpatient capacity had increased, as had the number of patients removed from the waiting list. The team confirmed beds that were ring-fenced for orthopaedic surgery were reinstated briefly at the First Hospital in November 2022. However, recent bed pressures meant that these beds were currently not in use by orthopaedic patients, with general medical patients using them instead. There was no date set for reinstatement of the ring-fencing.

25. The PCIR Team also said that a plan to open additional beds with enhanced recovery facilities at the Second Hospital had been delayed due to clinical concerns about the potential to manage complex patients at this site. This delay meant that fewer complex patients from the "First Hospital only" list were eligible for treatment at the Second Hospital's enhanced recovery unit. To address this, the Health Board was in discussion with the Welsh Ambulance Service NHS Trust ("WAST") about contracting a stand-by ambulance to allow a transfer of any potentially unwell patients from the Second Hospital to the First Hospital's critical care units.

26. On 17 May members of my staff met with a team from the NHS Executive ("the Team") to discuss the orthopaedic waiting list at the Health Board. The Team clarified that it was likely the anaesthetists at the Second Hospital had been "risk averse" when it came to surgery for patients with additional health concerns. They explained that the Health Board had been liaising with a centre of excellence for orthopaedic patients in England regarding potential approaches for treating patients with additional heath concerns at the Second Hospital, to allay its anaesthetists' concerns. The Team said they were hopeful a high

proportion of patients who had been regarded as suitable for treatment at the First Hospital only might be able to receive surgery at the Second Hospital from September.

27. The new orthopaedic theatres at the Second Hospital were opened by the Health Minister on 15 June.

What happened regarding Mr D?

28. Mr D was referred for an outpatient review following an injury to his right shoulder. He saw a consultant orthopaedic surgeon ("the First Consultant") on 4 July **2018**. He noted Mr D was in severe pain and was being treated with morphine (a strong painkiller). The First Consultant said Mr D needed an urgent arthroscopy (a procedure for diagnosing and treating joint problems) and capsular release (surgery to the capsular tissues surrounding the shoulder to allow the joint to move more freely), so he would ask an anaesthetist to assess him, and they would identify a date for Mr D to undergo surgery.

29. On 1 August Mr D attended a POA for a right arthroscopic capsular release and was confirmed as suitable to undergo surgery at the First Hospital only, due to his complex health needs.

30. A referral from Mr D's GP dated 12 February **2019** noted that Mr D had liver damage caused by a significant paracetamol overdose many years prior.

31. Mr D attended an orthopaedic shoulder clinic on 25 July and was assessed by an advanced physiotherapy practitioner. The letter to update Mr D's GP recorded that Mr D had been waiting for a while for surgery, but the waiting list manager had confirmed it was not possible to expedite (speed up) his surgery due to pressure on the service.

32. Mr D attended another POA on 11 February **2020**.

33. On 4 June Mr D was reassessed by another consultant orthopaedic surgeon ("the Second Consultant") and was identified as a category 3 patient under the FSSA Guide. The letter to Mr D's GP recorded that Mr D

told the Consultant he wanted to stay on the waiting list but would prefer the COVID-19 pandemic to resolve before he would feel safe to undertake surgery due to the risks involved.

34. The Second Consultant wrote to Mr D on 4 November to acknowledge that Mr D felt his pain had increased. The Consultant explained that the only option was surgery. He asked Mr D to let him know if he would like to undergo surgery and said he would be admitted for surgery as soon as possible. The Consultant cautioned theatre availability was reduced due to the COVID-19 pandemic.

35. Mr D was reviewed by the Second Consultant on 6 July **2021**, who recorded that Mr D was angry at having to wait so long for surgery. The Consultant noted that Mr D had expressed worries about the effects of morphine on his system and asked questions that the Consultant was not able to answer. He arranged an ultrasound (a diagnosis tool that uses sound waves to produce images of structures within the body) guided injection of Mr D's subacromial bursa (a sac of tissue present in the shoulder). He informed Mr D he could not offer any information on when his surgery might occur but said he would need a further anaesthetic review prior to surgery.

36. An internal email between the Outpatients and the Quality and Safety Departments dated 21 January **2022** said Mr D was initially referred on 4 July 2018 and his waiting date had not been reset. At the time of the email his waiting time was 184 weeks, and he was listed as a category 3 patient. The longest wait was noted to be 263 weeks. He was recorded as being suitable to be treated at the First Hospital only due to a high BMI and no date could be estimated for surgery. An email dated 16 February between the Specialist Surgical Services and Quality and Safety Departments noted that Mr D was category 3, and the Health Board was only able to undertake category 2 surgery at the First Hospital at the time.

37. On 20 April an internal email between the Quality and Safety and Specialist Surgical Services Departments confirmed that the longest waiting patient for Mr D's Consultant was noted to be 247 weeks. On 13 May an internal email within the Quality and Safety Department mentioned Mr D was to be reviewed by an anaesthetist ("the Anaesthetist") to establish if he could undergo surgery at the Second Hospital due to

extraordinary and persistent pressures. On 17 May the Anaesthetist explained Mr D's BMI was 46 and the cut off for the Second Hospital was 45. In addition, he was using a continuous positive airway pressure ("CPAP") machine (used to keep breathing airways open during sleep) and therefore did not meet the criteria for the Second Hospital at that time (as he was classed as a complex patient according to the criteria listed in paragraph 13).

38. Mr D attended a clinic on 24 May and was reviewed by the Second Consultant, who noted that he had not received a therapeutic injection during his recent ultrasound scan. The Consultant recorded that Mr D was in ongoing pain and desperate for intervention. The Second Consultant said he was supportive of Mr D's attempts to gain an answer as to when he could have surgery. He said he explained to Mr D again that he did not have a specific diagnosis so there was no guarantee surgery would benefit him, but noted he was desperate to try anyway.

39. Mr D attended a further pre-operative assessment on 20 April **2023** and an anaesthetic review of his notes on 16 May.

40. Mr D was booked for surgery on 26 July but was admitted to the First Hospital with tonsilitis on 11 July. He was discharged on 13 July but was provided with a course of oral antibiotics to complete. He informed the Health Board of his admittance, and they cancelled his pre-surgical MRSA screening (a test for the presence of a type of bacteria) that was booked for 14 July, his "meet and greet" with his Surgeon that was booked for 20 July, and his surgery was also cancelled. He spoke to the Waiting-List Department to ask about re-arranging a date and was told he had been sent to the back of the waiting list due to the cancellation of those appointments.

41. On 26 July 2023 the Health Board said its waiting list manager explained that if a patient cancels an agreed appointment their waiting time is automatically reset by the system. It said this was in accordance with its usual process and the RTT guidance. As Mr D cancelled 3 appointments (his screening, his meet and greet and his surgery) he would be contacted when the Health Board was in the position to offer him another date. It quoted paragraphs 66-68 of the RTT guidance (see paragraph 6 of this

report). The Health Board later clarified that in circumstances like those experienced by Mr D, it will treat patients out of turn.

Mr D's evidence

42. Mr D said that following his initial referral in July 2018, he was informed by a doctor he would undergo surgery within 5 weeks. That doctor has since left, and Mr D felt misled by the doctor's assurance that he would be treated urgently.

43. He further said that he has not been kept informed of the situation and, when telephoning to chase, has been told to seek private care. He was frustrated by the lack of realistic information regarding when he would be treated.

44. Mr D said he has been taking strong morphine for his pain for the past 4 years and has had to adapt his life. He said that he is receiving care assistance twice a day at a cost of £29 per week. He explained the carers assist him to take the morphine and assist him with personal care if he needs it on the day. He stated he is very concerned about the challenge of weaning himself off the morphine, given his existing mental health issues. Mr D emphasised that the Health Board is aware of his mental health issues, and he is distressed that he has had to take morphine for so long, as this would not have been necessary if he had received surgery sooner.

45. Mr D further explained he has been diagnosed with a variety of mental health conditions. He said he is receiving care from a psychiatrist and has received disability benefits for many years.

The Health Board's evidence

46. In November **2018** the Health Board said a consultant orthopaedic surgeon's waiting list was 113 weeks. It said this was due to a general increase in demand and high volumes of cancellations of scheduled operations due to urgent category 1a and 1b trauma cases, resulting in a lack of beds. The RTT target at that time was 26 weeks (or 36 weeks for complex patients).

47. In March **2019** the Health Board said there were 1,000 patients who had waited for over 36 weeks for orthopaedic surgery, and it was therefore in breach of the RTT guidelines that were in place at the time. It explained that the First Hospital was a centre for many complex surgical specialities and acted as the major Accident and Emergency service for a significant proportion of the surrounding area. This caused demand for beds and services to be unpredictable.

48. The Health Board said in May **2022** that due to the COVID-19 pandemic and ongoing emergency pressures, it was only able to carry out a very limited amount of planned orthopaedic surgery at the First Hospital. It said it was continuing with planned orthopaedic surgery at the Second Hospital, but some patients (including Mr D) with complex needs were unsuitable for surgery there. It was unable to provide a date when normal service would resume at the First Hospital. The Health Board said waiting times for orthopaedic surgery were in excess of 4 years for some patients.

49. The Health Board acknowledged that the first POA attended by Mr D did not lead to a date for surgery and apologised for any disappointment or distress he experienced as a result. It explained that unfortunately, the second anticipated date was superseded by the COVID-19 pandemic, which meant elective surgery was cancelled due to unprecedented pressures.

50. The Health Board explained that patients are assessed and categorised on a clinical basis in line with symptoms. It said it sympathised with patients who have other holistic issues including mental health concerns; however, due to the current waiting list, patients are categorised on specific criteria.

51. Commenting on a draft of this report the Health Board said that in 2022, it recognised there was an issue with consistency of approach to waiting list management. It submitted a proposal to fund a Patient Access Service, which would see the centralisation of waiting list management for both outpatient and inpatient services within a single team, co-located with a centralised outpatient function. The Health Board said it also funded a specific Referral to Treatment “RTT” Management Team to develop

Health Board-wide policies for all waiting list management and standardised training packages to ensure consistency of approach across all its services.

52. The Health Board stated that it could not guarantee individual staff would not make errors in administering waiting lists. However, it was confident that this additional focus and resource would put all reasonable measures in place to minimise errors and identify them at the earliest opportunity. This would ensure any delay or distress to patients would be addressed immediately.

Comments made by the Welsh Government

53. The Welsh Government said it is aware of the challenges associated with the delivery of orthopaedic waiting times across Wales, particularly within the Swansea Bay Health Board, over a period of years. It said it has taken the following actions to support health boards. These include:

- Additional resources and investments for new theatres.
- Engagement of the GiRFT team to support and help health boards increase efficiency and productivity.
- Engaging the orthopaedic clinical network to develop a comprehensive strategy and detailed demand and capacity analysis to support all health boards to effectively plan.
- A clear mandate to all health boards to prioritise (after urgent patients) their long waiting patients.
- A clear escalation of the Health Board to Enhanced Monitoring for poor performance.

Analysis and conclusions

54. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

55. In reaching my conclusions, I must consider whether there were failings on the part of the Health Board and if so, whether those failings caused an injustice to Mr D. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice. I have also taken into account the COVID-19 context which created extreme pressure for staff. However, I am aware that Mr D was initially listed for surgery in 2018, 16 months before the pandemic.

a) Mr D has had to wait an unacceptably long time for orthopaedic surgery when taking account of his clinical need and the impact his condition is having on his daily life.

56. Mr D was added to the Health Board's waiting list for shoulder surgery in July 2018. He was re-assessed in June 2020 and classified as category 3 under the FSSA Guide (see paragraph 7 of this report), which meant that he should have received treatment within 3 months. However, Mr D said he would prefer the COVID-19 pandemic to subside before he would feel safer undertaking surgery.

57. I have noted this but consider this decision did not substantially alter Mr D's situation, as elective orthopaedic surgery was not being undertaken at the First Hospital during this period and Mr D's waiting date was not reset. The evidence shows he contacted the Surgeon later in 2020, who said in November that he would attempt to admit Mr D for surgery as soon as possible, although theatre availability was significantly less than usual.

58. Mr D continued to wait and in May 2022 he was re-assessed by the Anaesthetist to establish if he could be treated at the Second Hospital. The Anaesthetist said Mr D did not meet the criteria at the time. I note the view of the NHS Executive that anaesthetists at the Second Hospital may have been risk averse when it came to surgery for patients with additional health concerns (see paragraph 26 of this report).

59. More recently, Mr D reports he was given a date for surgery but was unable to undergo the treatment and the ancillary appointments because he was admitted to the First Hospital with tonsilitis, then prescribed a course of oral antibiotics. The Health Board has confirmed that Mr D's waiting time was automatically reset by its system, in accordance with its usual process and the RTT guidance, and quoted paragraphs 66-68 of it

(see paragraph 6 of this report). It did, however, clarify that patients in these circumstances are treated out of turn when an appointment becomes available.

60. I have considered the RTT guidance and noted the contents of the paragraphs quoted by the Health Board. I have seen that when a previously agreed appointment is cancelled by the patient, the waiting time clock is reset. However, it is my view that paragraph 102 of the Guide also applies here, as it sets out what should happen if a patient is unavailable due to a short-term medical condition, defined as lasting for 21 days or fewer. Paragraph 102 says that in this event, an adjustment may be made to the RTT period, rather than the waiting time being reset. As Mr D suffered from tonsilitis, even if admitted to hospital as a result, it seems likely to me that this condition may have resolved within 21 days. If the Health Board felt this was unlikely to be the case, I would expect to see that advice had been sought from a qualified healthcare professional and recorded, in-line with paragraph 102 of the RTT guidance.

61. Although I understand the Health Board's explanation that the system had automatically reset Mr D's waiting time, I consider it is reasonable to expect its systems to be robust enough to reflect the requirements of the RTT guidance, published 6 years ago. I do not consider it is satisfactory for the Health Board to rely on "treating out of turn" as a method of ensuring Mr D receives the care he needs, with no known date. It is my view that this is a failure that amounts to maladministration and that Mr D suffered an injustice as a result of the additional stress he experienced, as outlined above. I acknowledge the Health Board's efforts to improve waiting list mismanagement but note that in Mr D's case an e issue occurred as recently as July 2023.

62. The waiting list for orthopaedic surgery at the Health Board has been in excess of 4 years. Efforts have been made by the Health Board to improve this issue, especially for patients with complex needs. For example:

- The development of a new Orthopaedic Centre at the Second Hospital, which was approved in November 2021 and opened on 15 June 2023 (albeit with a limited ability to support the needs of complex patients).

- Insourcing of appropriate patients without complex needs to the Second Hospital from September 2021 onwards.

- Discussions in July 2022 with a neighbouring health board to establish if it had the critical care capacity to assist the Health Board with patients who require an increased level of care.

- The NHS Executive considered it likely that anaesthetists at the Second Hospital may have been risk averse when it came to surgery for patients with additional health concerns and steps have been put in place to consider their approach.

63. I acknowledge that there is a resource issue within the NHS more widely and within orthopaedic surgery specifically. Efforts have been made to improve the service provided to orthopaedic patients. This included the development of a new Orthopaedic Centre at the Second Hospital. However, the Health Board said it was experiencing difficulty meeting demand for orthopaedic care as far back as 2018 (well before the pandemic), when it was already exceeding targets set by the "RTT guidelines applicable at the time by over 200%" (the Audit Wales report explained targets have not been met nationally since 2011).

64. Also, whilst all health boards in Wales have long waiting times, the Health Board's capacity is the most restricted with regard to facilities for orthopaedic patients with complex needs. This is demonstrated by the GiRFT report, which identified significant variation between health boards in the way patients are treated and therefore in their outcomes. The GiRFT team also said more than a third of the patients who had been waiting longest for orthopaedic treatment in Wales were under the care of the Health Board.

65. There has been a period of several years when very little provision has been made for patients with complex requirements to access orthopaedic surgery. I would expect to see that the Health Board had taken more action from the outset to improve its level of service to these complex patients, which includes Mr D. Although the Health Board did make the efforts noted above to improve its service, it did not begin to do so until 2021, despite problems being recognised much earlier. It is my

view that the Health Board could have sought to identify interim solutions sooner than it did. I regard this failure to do so as maladministration.

66. Mr D, and many other patients on the waiting list, have been directly affected by the Health Board's poor performance, and in particular the issues surrounding the treatment of more complex patients. This is particularly important in Mr D's case, as he has explained that he already experienced poor mental health prior to joining the waiting list for surgery, which was exacerbated by the frustration and uncertainty of his waiting period. Mr D has provided a full explanation of the impact he has experienced whilst awaiting surgery, and the detrimental effect that had on his wellbeing and life. In my view this represents a further injustice to Mr D.

67. For the reasons set out above, relating to both the overall waiting list failure and the clock reset issue specific to Mr D, I **uphold** this complaint.

b) Mr D's expectations were mismanaged by the NHS regarding the POAs he attended.

68. Mr D attended 3 POAs, the first on 1 August 2018, the second on 11 February 2020 and the third on 20 April 2023. I am satisfied that the second and third were reasonably arranged, as the second was disrupted by the COVID-19 pandemic, which was unforeseen, and the third did lead to surgery being booked for Mr D, even though it was then cancelled, as considered above. I understand Mr D has complex health needs and was considered to be suitable for surgery at the First Hospital only due to the critical care facilities available there. The first assessment occurred a year before the loss of elective orthopaedic procedures at the First Hospital in the latter part of 2019. Under the RTT guidelines in place then, he should have undergone surgery within 6 months. However, the Audit Wales report states that RTT timelines had not been met for some time prior to that, and the Health Board said its RTT targets were being exceeded by 200% in 2018, meaning it was unlikely Mr D would have undergone surgery before the POA deadline expired. I accept it is likely that Mr D was told the assessment did not mean his surgery was imminent, but it was reasonable for him to expect it would take place before the assessment's expiry date. I consider the Health Board ought to have been aware of this, and should have taken this into account when making arrangements for a POA which was likely to expire before surgery could be offered.

69. As a result, Mr D was unnecessarily put through a painful and stressful experience that raised his hopes and legitimate expectation but resulted in disappointment. I therefore consider an injustice occurred as a result of the service failure and I **uphold** this complaint.

Related investigations

70. I have been simultaneously investigating 3 other complaints about orthopaedic waiting lists at the Health Board.[1] While those complainants have different individual circumstances, each has been significantly negatively impacted by the time the patients have been waiting for treatment. For each I have made a finding of maladministration and injustice relevant to their specific circumstances. It is plain to see that the Health Board has not provided the expected levels of care and service to a number of people on the waiting lists and that in addition to that there are also individual failings which need to be considered alongside improvements to the service.

71. Part of my role is to recommend improvements where I have identified failings. I find myself in the unusual situation where I am unable to make recommendations for systemic improvement of management of the length of the waiting lists. This is because a national strategy developed by the Welsh Orthopaedics Board is in place and the Health Board is being assisted by the PCIR Team to adopt the GiRFT report's recommendations and the National Blueprint report's strategy. They are better placed to assess available resources and how they might be used to improve waiting times. I have no role in decisions about the allocation of resources.

72. That said, while patients are waiting for surgery on the list, they should be treated fairly in relation to the management of their place on that list, how they are communicated with about the time it is likely to take to receive treatment and to have their expectations fairly managed. The maladministration identified, in the cases I have investigated, demonstrates that patients have also been treated unfairly because of the way the list has

[1] Case references: 202200764; 202200361 and 202200425

been managed. The recommendations below therefore seek to address the failings which have been specifically identified in Mr D's patient journey while waiting on the list.

73. I do acknowledge the Health Board's actions to improve waiting list mismanagement, but due to failings in this case occurring as recently as July 2023, I also remain concerned that there may be an existing systemic issue relating to the way that waiting lists have been managed. I have therefore made an additional recommendation to audit the waiting list and identify whether similar failings are still occurring.

74. I am sharing this report directly with the Minister for Health and Health Inspectorate Wales. I urge the Minister for Health, the Health Board, and the associated health organisations to expedite plans to find ways to deliver care to those patients who have been waiting an inordinate amount of time.

Recommendations in respect of Mr D's complaint

75. I **recommend** that within **1 month** of the date of the final report being issued the Health Board should:

a) Write to Mr D to apologise for the failures identified in this report.

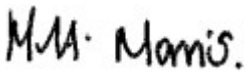
b) Apologise to Mr D for the failure of the Health Board to explore solutions to the waiting list position sooner which has affected Mr D and all others on the list.

c) This main purpose of this office is to bring about service improvement rather than award compensation for service failure. However, I consider it is appropriate for the Health Board to offer Mr D redress of £500 in recognition of the injustice and time and trouble and distress caused to Mr D because of having to undergo an unproductive POA, the distress caused by the mismanagement of his waiting time when he suffered with tonsillitis and his time and trouble in pursuing this complaint.

d) Review the decision to reset the waiting list clock for Mr D due to cancelling his 3 appointments as a consequence of his tonsilitis. Once the decision has been reviewed, his position on the list should be amended in-line with the outcome of that review, and an explanation of how the amended position was calculated should be provided.

e) Undertake an audit of the waiting list to establish whether any other errors have been made relating to the re-setting of waiting list times or improper removal from the list. If any are identified. Apologise to those patients and correct the waiting list date accordingly.

76. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.



Michelle Morris 11 January 2024
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