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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: 202200361

Contents	Page

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 Mrs B.

Summary

Mrs B said that she had waited a long time for orthopaedic surgery and that her understanding of how she 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.

Mrs B was referred in 2018 for right hip pain and again in 2021 for left hip pain. The referral for her left hip was closed in error, but in 2023 her left hip was treated (instead of her right hip as it was clinically worse) and she was removed from the waiting list for her right hip, even though this still required treatment. She continues to experience severe pain in her right hip 5 years after initial referral and is still waiting for it to be operated on.

Mrs B was also put through the stress and pain of a pre-operative assessment, which raised her hopes that surgery would happen soon. This was due to an administrative error.

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 waiting time issues identified, she has asked the Health Board to review the decisions it made in respect of Mrs B and her position on the waiting list. 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. Mrs B complained about the orthopaedic care (treatment relating to bones, joints, muscles and ligament) she received from Swansea Bay University Health Board ("the Health Board"), and in particular that:

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

b) Her expectations were mismanaged by the NHS regarding the pre-operative assessments ("POA" - assessment of general health and fitness before surgery) she attended in March 2020, November 2020 and September 2021.

c) She was advised by a nurse at the March 2020 POA to stop taking Hormone Replacement Therapy ("HRT") and has suffered menopause symptoms and anxiety over the detrimental effect on her bones because this was not monitored.

d) She had not been reviewed by an orthopaedic surgeon since November 2018 and should have been re-examined so any deterioration in her condition could have been taken into account in determining her priority for surgery.

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 Mrs B.

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 Mrs B 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 ("RTT") 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 112 sets out that planned care relates to elective admissions planned to occur in the future where, for medical reasons, there must be a delay before a particular intervention can be carried out. For example, the second part of a bilateral procedure and sequential treatments.

- Paragraph 113 outlines that when a patient clinically requires bilateral or sequential procedures, a new RTT period will begin when the patient is deemed fit and ready for the second or subsequent procedure. The clock will start on the day of the decision to admit and stop on the date of admission for the second or subsequent procedure.

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 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:

- 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.

9. 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.

10. 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 re-start 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

11. 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.

12. 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").

13. During the latter part of **2019**, elective orthopaedic surgery could not be performed at the First Hospital for a period of about 6 months to manage emergency admissions.

14. 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.

15. At the outset of the COVID-19 pandemic in Spring **2020**, the First Hospital lost the capacity to treat complex patients again.

16. 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.

17. On 10 June **2022** the GiRFT team met with the Health Board's Chief Executive Officer ("CEO"). 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.

18. 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.

19. 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.

20. 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".

21. 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.

22. 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.

23. 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 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.

24. 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 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 health 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.

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

What happened regarding Mrs B?

26. Mrs B attended an outpatient clinic on 22 April **2016** where she met with a consultant orthopaedic hip and knee surgeon ("the Consultant"). The letter from the Consultant to Mrs B's GP said she had reported pain in her right hip area and had received a steroid injection and some local anaesthetic. The Consultant organised an MR arthrogram (a specialist machine used to take images of joints) of her right hip. She was seen again on 8 December by a specialist registrar, who administered a further injection and requested physiotherapy and rehabilitation for Mrs B. Mrs B attended physiotherapy appointments during **2017**.

27. Mrs B was reviewed again by a specialist registrar on 26 October, who said it was unlikely any surgical intervention would make her entirely pain free. He suggested shockwave therapy (non-invasive treatment for pain). On 17 May **2018** it was reported by the Consultant, in a letter to Mrs B's GP, that the shockwave therapy had not been beneficial, and X-rays had revealed some increased wear in Mrs B's right hip joint. The Consultant said she would benefit from examination under anaesthetic with diagnostic and treatment injections into the right hip joint to see whether that alleviated her pain. He also said she should continue with physiotherapy.

28. On 23 May the Consultant said in a letter to the Physiotherapy Department that Mrs B was in her mid-40's, and he did not really want to give her a hip replacement at that point because the wear was not so bad, and her main symptom was bursitis (inflammation of a fluid-filled sac that works as a cushion to reduce friction in joints). He referred Mrs B back for physiotherapy.

29. On 22 November the Consultant reported Mrs B had improved significantly for a few hours following her arthrogram and diagnostic treatment of her right hip. He said her significant symptoms were coming from within the right hip joint. In light of this result, he had offered her a right hip arthroscopy (a procedure to diagnose and treat joint problems),

labral stabilisation (a procedure to tighten and repair the joint) and the removal of a lesion (an area of damaged tissue) and she had agreed to that approach and was added to the waiting list that day. He also referred her for further physiotherapy.

30. On 3 March **2020** Mrs B attended a POA for a right hip arthroscopy. Mrs B had a further POA in November and was deemed fit for the procedure. On 30 June **2021** Mrs B completed a health screening questionnaire in preparation for surgery. She attended a further POA on 7 September.

31. On 17 February **2022** an internal email from the Surgical Specialities Department to the Quality and Safety Department stated Mrs B was listed for surgery on 22 November 2018 as a category 4 patient (a routine wait category). Her waiting time at the time of the email was 167 weeks. The email stated the Health Board was not outsourcing hip arthroscopies.

32. In an internal email dated 22 March between the same departments, it was explained that Mrs B had a series of POAs in 2020 for a right hip arthroscopy. It also said -

> "Another referral was then received on 2 July 2021, this time for her left hip, patient has not been booked on [for a POA] from this referral… However, patient is only on [waiting list pathway] for her right hip. Could you let me know whether her left hip will be operated on the same time as her right? It's not clear from [the system]. I have spoken to [the Service Manager] and she couldn't determine what was going on either."

33. In the response of the same date, the writer said the notes recorded for the POA on 3 March 2020 stated Mrs B was told to stop HRT 6 weeks before surgery. Another email of the same date between the Pre-assessment and Acute Pain Department and the Quality and Safety Department confirmed that the Nurse who carried out Mrs B's POA on that date had retired. The email said that a date for surgery is not provided during a POA as this is allocated by the Waiting-List Department, so therefore nurses would only advise that HRT was stopped 6 weeks beforehand.

34. An internal email dated 23 March between the Patients Pathway Co-ordinator and the Orthopaedic Department requested an appointment "ASAP", the email stated -

> "She was referred in June 2021(New Referral) and it has only just come to light via Complaints that the Referral was closed in error. She was/is already on Waiting List for 1 side but a new referral came in for the other side but the new Referral for some reason was added but then closed a few days later when in fact it should have been treated as a separate Referral."

Mrs B's evidence

35. In April 2022 Mrs B said she was in considerable pain in both her hips, which had affected her health and wellbeing. She said she often had a low mood and was short tempered and tearful. She explained she struggled with activities of daily living such as getting out of bed and driving and experienced disrupted sleep. She said the effect of all this had limited her activities and affected family plans. She was also concerned about the long-term effects of medication she was taking to deal with the pain. She pointed out the Health Board had already breached the RTT prior to the COVID-19 pandemic occurring. She considered the original plan for an arthroscopy would no longer be suitable and may not improve her symptoms.

36. Mrs B also said she had been struggling with her left hip for the previous 12-18 months due to the time she had spent awaiting surgery for her right hip. She said she was seeing an osteopath to realign her pelvis due to the deterioration. She said she was concerned that the Consultant only reviewed 1 of her hips when he reviewed her X-rays in 2022.

37. Mrs B explained that when she met with the Consultant in March 2023, he expressed concern regarding her left hip and further deterioration on the right hip. At this point he said she now needed a total hip replacement on the right hip. However, as the left hip would no longer support her, he needed to do surgery on the left hip first. Then she would go back on the waiting list for her right hip as she could not receive surgery and be on the waiting list at the same time. She felt the error of being

removed from the waiting list was only rectified due to a complaint being made to the Ombudsman. Had she not complained, it was unlikely this error would have been noticed and an apology had been made to this office but not to her.

38. Regarding HRT, Mrs B reported that at her POA on 3 March 2020 she was told she would need to stop taking HRT and that this was required 6 weeks before surgery. She said the Health Board denied that this advice would have been given, but Mrs B emphasised she was very concerned about stopping HRT as it had significantly improved her symptoms and would not have done so without medical advice. She reported that the nurse said the Consultant was "flying through procedures" and so her treatment would not be long. The Nurse could not find a doctor to ask about Mrs B's HRT, but she said the usual advice is to stop using patches before surgery. Mrs B said she was outraged by the Health Board's suggestion that she had done so without advice.

39. Mrs B suggested that additional training about the correct protocol, for stopping HRT in preparation for surgery, should be given to clinical staff, as this can have a significant impact on women's health and wellbeing. She said that at her most recent POA the clinicians had been unable to advise her about this and it was only on the day of surgery she was advised that it was safe to continue using HRT patches.

The Health Board's evidence

40. The Health Board explained that Mrs B attended a POA on 3 March 2020, but her surgery did not proceed due to the COVID-19 pandemic. Consequently, she was invited to attend another in November. The Health Board apologised that Mrs B had been asked to attend a further POA in September 2021 and said this was due to an error by a new member of staff who was unaware patients were only requested to attend for re-assessment when they had been given a date for surgery. The Health Board confirmed the Patient Pathway Team had been made fully aware of the correct process and it apologised sincerely for distress caused to Mrs B.

41. On 18 May 2022 the Health Board confirmed Mrs B was a category 4 patient who was suitable for treatment in the Second Hospital. It said the Consultant had reviewed Mrs B's latest X-rays, undertaken less than a year previous, and was satisfied it showed no bony collapse (death of bone tissue due to a lack of blood supply) or evidence of joint failure. It said the Consultant would be happy to review Mrs B as a routine outpatient when his elective clinics recommenced. The Consultant later confirmed he had reviewed X-rays of both of Mrs B's hips. In its formal letter of response to Mrs B's complaint, dated 24 March, the Health Board confirmed it had received a referral from Mrs B's GP on 2 July 2021 for investigations of her left hip and she had been added to the waiting list for an outpatient appointment.

42. A letter to Mrs B's GP from the Consultant, dated 15 June **2023**, explained Mrs B underwent a left hip replacement 6 weeks earlier on 26 April. The Consultant said:

> "She was originally on the waiting list for a right hip arthroscopy after multiple investigations and injections but, by the time we saw her post-pandemic, significant arthritis had progressed in her left hip so she underwent left hip replacement as it was far more symptomatic for her."
>
> "With regards[sic] to her right hip, because her waiting list entry was used to treat her left hip, she has now been removed off the waiting list and all investigations."

43. The Consultant went on to say he had requested an up-to-date Magnetic Resonance Imaging ("MRI scan" - a scan which uses magnetic fields to produce detailed images of inside the body) for Mrs B so he could consider whether she may benefit from arthroscopic surgery or whether changes were too advanced and therefore a full right hip replacement was required. He said he would see Mrs B again with the results of the MRI scan. However, he had added her to the waiting list that day for a right hip arthroscopy, that could be converted to a full hip replacement if the MRI scan showed significant changes.

44. The Health Board said that Mrs B was listed for bilateral hip replacements. Treatment was commenced on 26 April 2023 when she had the first hip operation undertaken and was then listed for the second hip operation which was a “new clock start” as per paragraphs 112 and 113 of the RTT guidance.

45. Regarding HRT, the Health Board confirmed nursing staff at both hospitals advise that patients are required to stop taking oestrogen-based medicine 6 weeks prior to surgery. It said not all patients have dates for surgery when they attend pre-assessment and patients are not instructed to stop taking their HRT if they do not have a date for surgery.

46. 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.

47. 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

48. The Welsh Government said it is fully 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

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

50. 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 Mrs B. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice. I have taken into account the COVID-19 pandemic context, which created extreme pressure for staff. However, I am aware that Mrs B was initially listed for surgery in November 2018, 16 months before the pandemic, and that she had experienced problems with her right hip for over 2 years prior to that.

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

51. Mrs B was initially referred for investigation into the pain she had experienced in her right hip in April 2016, although at that point she had already received some treatment. Over the next 2 years she received physiotherapy, non-invasive treatment and a diagnostic injection. In November 2018 she was added to the Health Board's waiting list for an arthroscopy and offered further physiotherapy. Under the RTT guidance

applicable at the time ("the first clock"), the target date for her treatment was 19 May 2019 (i.e. within 26 weeks) as she was not deemed to be a complex patient.

52. Expectation for treatment in that time would have been unrealistic; the Audit Wales report identified that RTT targets had not been met across Wales for many years. Even in December 2019, prior to the pandemic, the routine waiting time for orthopaedic surgery at the Health Board averaged 159 weeks. That is more than 6 times the 26 weeks included in the RTT guidance.

53. The Audit Wales report highlighted poor performance by the Health Board compared to other health boards in Wales. This is confirmed by a comment from the GiRFT team that 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. The PCIR team has been working with the Health Board to support improvement.

54. 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).

55. Mrs B, and many other patients on the waiting list, have been directly affected by the Health Board's poor performance. Mrs B did not receive surgery until 26 April 2023, almost 4 years after she joined the list. She was not a complex patient, and so was eligible to be treated at the Second Hospital. Even taking into account the pressure placed on the NHS by the COVID-19 pandemic, this delay is shocking.

56. The Health Board's records show that on 2 July 2021 Mrs B was also referred for investigations into the pain in her left hip. This should have constituted a separate referral for treatment under the RTT Guidance ("the second clock"). However, it is clear from the correspondence between departments within the Health Board that this was closed in error, and she was re-added to the list in March 2022 with a request for an appointment "ASAP". It was clearly intended, at this point, that Mrs B should have 2 clocks running.

57. On 26 April when Mrs B went in for surgery, she did not receive treatment for her right hip, for which she had been on the waiting list for 4 years and 5 months. Instead, the Consultant elected to replace her left hip, for which she had been referred for treatment 1 year and 9 months earlier and which was now clinically worse than the right hip. Therefore, it was the second clock which should have been stopped.

58. The Consultant appears to have taken a decision to treat the left hip issue on that day. This may have been an appropriate clinical decision taken for Mrs B's benefit (this is outside of the scope of this investigation), but the treatment he undertook (on the left hip) did not resolve the problem for which Mrs B had been referred.

59. The Health Board confirmed that this meant Mrs B's first clock (under the RTT rules) was reset for treatment to her right hip, and the Consultant said that he had stopped the clock because Mrs B's waiting list entry for her right hip was used to treat her left hip. Therefore, although I cannot see that swapping treatment pathways is allowed for in the RTT guidance, it would appear to me to follow that as the Consultant deemed it was appropriate to swap one hip for the other, the second clock for her left hip should have remained open to Mrs B and used for her right hip so as not to further disadvantage her.

60. The Health Board said that Mrs B was listed for bilateral hip replacements when she received her treatment on 26 April 2023 when she had the first hip operation undertaken and was then listed for the second hip operation, which was a "new clock start" as per paragraphs 112 and 113 of the RTT guidance. This was clearly not the intention of the Consultant who wrote to Mrs B's doctor explaining that the same treatment,

which was determined appropriate when Mrs B was referred in 2018 (right hip arthroscopy), was still an option and he would consider a second hip replacement only if the new MRI scan suggested this was appropriate. He also confirmed that he had used the right hip pathway for the left hip and had stopped the clock as treatment was finished. The Health Board's suggestion that Mrs B was listed for a bilateral procedure, and therefore a new clock would start, is either further evidence of a lack of clarity between the clinician and the Waiting-List Department or is an attempt to retrospectively apply the guidance to fit the situation. Either way, the response is of concern.

61. In any event, this situation highlights disorder within the Waiting-List Department that, according to the emails I have seen, even the Manager could not unravel. It also seems that in this case the Waiting-List Department did not communicate effectively with the clinicians delivering Mrs B's care. It seems grossly unfair that this mismanagement of Mrs B's pathways has resulted in her being put to the back of the waiting list for treatment to her right hip. I do acknowledge the Health Board's efforts to improve waiting list mismanagement but note that in Mrs B's case this failure occurred as recently as April 2023.

62. To summarise, in April 2022, Mrs B explained the debilitating effect of the pain and stress she has experienced due to her right hip and how it has affected her mental wellbeing, daily activities and life with her family. A further 16-19 months have now passed, and Mrs B continues to experience the same effects in her right hip, despite the replacement of her left hip in the meantime. While I have not considered the Consultant's decision regarding the care delivered in April 2023, because it is outside the scope of the investigation, I am satisfied that the disorder identified within the Waiting-List Department is relevant to this complaint and has had a direct impact on the delays faced by Mrs B. The confusion around the 2 referrals was identified in 2022, but it does not appear to have been rectified and this, combined with the general issues identified relating to the overall management of the waiting lists, has caused an injustice to Mrs B, over and above, others on the waiting list. I therefore **uphold** this complaint.

b) Mrs B's expectations were mismanaged by the NHS regarding the POAs she attended in March 2020, November 2020 and September 2021.

63. The Health Board said that the POA of Mrs B for surgery in March 2020 was superseded by the COVID-19 pandemic. I also note that another assessment was carried out in November 2020 in order to establish whether she was suitable for surgery at the Second Hospital. Her suitability was confirmed, but she was not given a date for surgery.

64. The Health Board has confirmed that the POA in September 2021 occurred in error. In my view, this amounts to a service failure. As a result, Mrs B was unnecessarily put through a painful and stressful experience that raised her hopes but resulted in disappointment when her POA expired after a year, and she had not received surgery. This service failure was an injustice to Mrs B, and **I uphold** this complaint.

65. Although I uphold this point, I do not intend to make any recommendations for service improvement. This is because the Health Board has explained it has already reminded the whole Patient Pathway Team of the correct process and I note it has already apologised sincerely for the distress this caused to Mrs B. This is in-line with the recommendations I would have made had action not already been taken.

c) Mrs B was advised by a nurse at the March 2020 POA to stop taking HRT and has suffered menopause symptoms and anxiety over the detrimental effect on her bones because this was not monitored.

66. Mrs B has set out her recollection of her conversation with the Nurse at her POA on 3 March 2020 regarding ceasing her HRT and I do not doubt her sincerity. This is particularly the case because Mrs B has explained that the HRT patches significantly relieved her menopause symptoms. I understand she would not relinquish that relief lightly.

67. The Health Board has explained that nursing staff advise patients that they are required to stop taking oestrogen-based medicine 6 weeks prior to surgery. Furthermore, the nursing staff are not generally privy to anticipated dates for surgery. It is therefore likely that there may have been

a misunderstanding between Mrs B and the Nurse regarding ceasing HRT. Mrs B may have understood that she should stop straightaway, whereas the Nurse may have intended to communicate that this should be done before her surgery (whenever that might be).

68. While I do not doubt that Mrs B left the conversation believing that she should stop her HRT straight away, the information provided to me suggests that it is unlikely that this is what the Nurse intended to communicate, and so on a fine balance, I **do not uphold** this aspect of Mrs B's complaint.

69. As this complaint has not been upheld, I am unable to make any recommendations relating to it. However, the Health Board may wish to remind staff to ensure that information regarding other ongoing treatments, and its potential impact on orthopaedic care, is carefully discussed and that nurses should check the patient's understanding, particularly if any discussions relate to stopping those treatments.

d) At the time of complaint, Mrs B had not been reviewed by an orthopaedic surgeon since November 2018 and should have been re-examined so any deterioration in her condition could have been taken into account in determining her priority for surgery.

70. At the time of making the complaint in April 2022 Mrs B had not been seen by the Consultant since she was referred for treatment of her right hip in 2018.

71. In respect of the referral for her right hip, I am unable to agree that Mrs B should have been reviewed again after her appointments in 2018 as there does not appear to have been any attempt by Mrs B's GP to seek to expedite treatment because of deterioration of the right hip. She was already on the routine waiting list for treatment. However, in July 2021 the GP did make a referral for Mrs B's left hip and this should have triggered being added to the list for a further appointment with the Orthopaedic Department to be assessed.

72. In March 2022 when responding to the complaint Mrs B made to the Health Board, it was identified that Mrs B had been removed from the waiting list for her left hip, in error, immediately after the referral was added to the waiting list. On realising the error, the Health Board re-added her to the list and an appointment was requested immediately. This information was not shared with Mrs B as part of the complaint response. This shows a lack of candour by the Health Board, and may have contributed to the confusion for Mrs B, because she was expecting to be reviewed after the GP made a second referral to treatment, which is an injustice to her.

73. It is not possible to know with certainty that Mrs B would have been seen by a clinician for her referral in July 2021 before the error was noticed in March 2022 (some 8 months later); given the significant delays it would seem unlikely. That said, I note that the member of staff in the Waiting-List Department requested an immediate appointment. This suggests that it was recognised that there had been an unnecessary delay caused by the waiting list error. Therefore, due to the uncertainty caused, I **uphold** this complaint to a limited extent.

74. I note that Mrs B's condition was reviewed, by way of an X-ray of both hips in 2022, following her complaint being made and before treatment was given. While I note this was not an in-person review, and this was of concern to Mrs B, this post-dates the complaint to this office and falls outside of the scope of this investigation.

Related investigations

75. 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

[1] Case references: 202200764; 202200425 and 202201496.

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.

76. 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.

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

78. I do acknowledge the Health Board's actions to improve waiting list mismanagement, but due to failings in this case occurring as recently as April 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.

79. 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 Mrs B's complaint

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

a) Write to Mrs B to apologise for the failures identified in this report specific to her case.

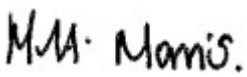
b) Apologise to Mrs B for the failure of the Health Board to explore solutions to the waiting list position sooner which has affected Mrs B and all others on the list.

c) The 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 Mrs B redress of £500 in recognition of the maladministration and service failure identified in this report, (the unnecessary stress caused by the waiting list error, the failure to be open about this in the complaint response and the unnecessary POA in September 2021) and for her time and trouble in pursuing this complaint.

d) Review its decision to place Mrs B at the back of the waiting list for the same treatment to her right hip that caused her to be originally added to the waiting list in 2018 and consider whether it is appropriate to apply the time clock that should have started for her left hip in July 2021. Once the decision has been reviewed, her 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.

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



11 January 2024

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