# Investigation Report

## Investigation of a complaint against the Southern Health and Social Care Trust

**NIPSO Reference: 18475**

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## The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities. She may also investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

## Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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# EXECUTIVE SUMMARY

I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust) in relation to the care and treatment of the complainant's husband (the patient) at Craigavon Area Hospital in 2017.

**Issue of Complaint**

I accepted the following issues of complaint for investigation:

1. **Whether the care and treatment provided to the patient in the Emergency Department of the hospital was appropriate and reasonable?**
2. **Whether the care and treatment provided to the patient by two consultant orthopaedic surgeons at the hospital was appropriate and reasonable?**

I carefully considered the detail of the complaint, the responses from the Trust, the clinical records provided by the Trust and the independent professional advisor (IPA).

In relation to issue one, I found that the care and treatment provided to the patient on 27 and 30 March 2017 was appropriate and in line with GMC Guidance. I did not therefore uphold this issue of complaint

In relation to issue two, I held that the care and treatment provided by the consultant orthopaedic surgeons was appropriate and reasonable. Therefore I did not uphold this issue of complaint.

However, I found there was maladministration in relation to the availability of the patient's history to one of the surgeons because of a clerical error. I found that no injustice was caused to the patient in consequence of this.

The Trust accepted my findings.

**General Comment**: This case highlights a systemic issue relating to the sharing of patient information between NHS funded and privately funded care. I have written to the Department of Health raising my concerns generally on this issue.

# THE COMPLAINT

1. The patient's wife complained to the Southern Health and Social Care Trust (the Trust) in April 2017 about the care and treatment provided by the Craigavon Area Hospital in 2017. She remained dissatisfied and complained to this Office on 3 January 2018. The patient provided express consent for his wife to act for him in relation to this complaint.

2. The issues of complaint which I accepted for investigation were:

   i. **Whether the care and treatment provided to the patient in the Emergency Department of the hospital was appropriate and reasonable?**

   ii. **Whether the care and treatment provided to the patient by the consultant orthopaedic surgeons was appropriate and reasonable?**

# INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised.

4. After further consideration of the issues, I obtained independent professional advice from two IPAs. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice'. However, how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

**The relevant standards**

5. In order to investigate complaints I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

6. The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration
- The Principles of Good Complaint's Handling
- The Public Services Ombudsman's Principles for Remedy

7. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Trust staff whose actions are the subject of this complaint.

8. The specific standards relevant to this complaint are:

(i) The General Medical Council (GMC)'s guidance 'Good Medical Practice' April 2013 (The Good Medical Practice guidance)

(ii) The GMC Confidentiality: Good practice in handling patient information 2017.

9. I have not included all of the information obtained in the course of the investigation in this report. I am satisfied, however, that everything that I consider to be relevant and important has been taken into account in reaching my findings.

10. A copy of this draft investigation report has been provided to the complainant, the Trust and the relevant Trust staff for comment on factual accuracy and the reasonableness of the findings.

# THE INVESTIGATION

(i) **Whether the care and treatment provided to the patient in the Emergency Department of Craigavon Area Hospital was appropriate and reasonable?**

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

11. The patient attended the Emergency Department on 27 March 2017 due to pain in his right shoulder and loss of power in his right arm. The notes record that he had been walking his dog two weeks earlier and the dog had pulled on the lead. The patient provided a history of back problems and told the doctor he had previously suffered from a blood clot in the affected arm. The doctor diagnosed a supraspinatus muscle tear and a trapezius muscle tear. He made an appointment for the patient to attend physiotherapy on 8 April 2017, and discharged him to his home with pain medication. The complainant alleged that no blood tests, X-rays or scans were performed on her husband on 27 March 2017 in the Emergency Department.

12. On 30 March 2017, the patient attended his GP complaining of a reduced range of movement and increased pain. His GP referred him back to the Emergency Department for tests with a query about 'upper limb venous thromboembolism[2]'. He was advised the likely diagnosis was frozen shoulder and rotator cuff injury. An X-ray was taken of his right shoulder area and it was noted that physiotherapy had already been arranged for 8 April 2017. The complainant alleged that her husband would not have had to attend the Emergency Department for a second time had these investigations been carried out at his first attendance on 27 March 2017.

13. I note that on 3 April 2017 the patient had had physiotherapy privately. The patient subsequently attended his Emergency Department physiotherapy appointment on 8 April 2017. The physiotherapist looked at a private MRI scan provided by the patient which was performed on 4 April 2017. He was referred by the Emergency Department registrar to the fracture clinic for a surgical opinion. It is recorded that the family was very worried about the patient's loss of earnings and were demanding to know the waiting list for surgery.

14. In deciding whether care and treatment is appropriate and reasonable, I consider the applicable clinical standards and guidelines. I then assess whether the relevant care and treatment provided meets those standards. In this case I

[2] the blocking of a blood vessel by a particle that has broken away from a blood clot at its site of formation

refer to the GMC Good Medical Practice Guidance which outlines the duties of a doctor.

15. In relation to the key issues of communication, partnership and teamwork, the GMC guidance states that doctors should:
    - 'Treat patients as individuals and respect their dignity.
    - Treat patients politely and considerately.
    - Respect patients' right to confidentiality.
    - Work in partnership with patients.
    - Listen to, and respond to, their concerns and preferences.
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care.
    - Support patients in caring for themselves to improve and maintain their health.
    - Work with colleagues in the ways that best serve patients' interests.'

16. The Investigating Officer obtained the patient's medical notes and records, documenting his care and treatment at the hospital in 2017. A copy of his GP records were also obtained. These were referred to a Consultant in Emergency Medicine (EM) IPA.

17. The Investigating Officer asked the EM IPA to comment on the care and treatment provided to the patient on 27 March 2017. The EM IPA notes that the patient was complaining of neck and lower back pain, and pain and stiffness in his right shoulder with a reduced range of movement. The IPA advised: *'The patient underwent an assessment of his neck, right shoulder and the veins of his right upper arm to ensure he hadn't redeveloped a deep venous thrombosis (DVT). In addition, he also underwent a neurological examination to make sure there was no objective numbness or weakness and this was said to be normal.'* The IPA also advised that pulse rate and blood pressure were raised but *'other clinical observations were within normal limits'.*

18. The IPA described the assessments as '*appropriate for the presenting complaint'* and that *'no other tests were mandated'.* He advised that*:*
    - *It would not be routine nor standard practice to request an MRI scan in the Emergency Department when dealing with musculoskeletal problems'.*
    - *The medication provided* [Naproxen] *was an anti-inflammatory which was appropriate for the musculoskeletal nature of his pain'.*
    - *The diagnosis* [of a supraspinatus muscle tear and an injury to his trapezius muscle] *would be in keeping with the mechanism of the injury.*
    - *The referral to physiotherapy was entirely appropriate and the twelve day gap between the 27.03.17 and the 08.04.17 was in keeping with a standard wait for physiotherapy in 2017.*
    - *No other referrals were necessary.'*

19. The Investigating Officer asked the EM IPA to comment on the care and treatment provided to the patient on 30 March 2017. The IPA noted that he had been referred by his GP who had observed some distended veins in his right shoulder and queried whether there may have been a recurrence of his right upper limb DVT. The GP requested a D-dimer which, the IPA explained, is *'a blood test looking for the breakdown products of clots'.* The IPA advised that '*the D-dimer was only marginally raised'* and the clinical decision that a DVT was unlikely, was appropriate. He advised that the tests and examination were appropriate and indicated that '*the injury was confined to the soft tissues'*. He advised that there was '*no indication for a surgical opinion'* or any other referral to be made at that time.

20. The patient attended his Emergency Department physiotherapy appointment on 8 April 2017 as arranged. The Investigating Officer asked the EM IPA if it was appropriate for the Emergency Department registrar to refer the patient to the fracture clinic for a surgical opinion on 8 April 2017. The IPA advised that this referral was made following a review of the findings of the MRI scan which the patient had obtained privately. The IPA advised '*when new information came to light, i.e. the MRI scan, he was referred appropriately for specialist care'.*

21. The Trust received a copy of the EM IPA advice and did not offer any comment.

## Analysis and Findings

### Issue 1 - Whether the care and treatment provided to the patient in the Emergency Department was appropriate and reasonable?

22. The complainant alleged that no blood tests, x-rays or scans were performed on 27 March 2017. I have read the relevant medical notes and records. I have read the advice of the Consultant in Emergency Medicine. I accept the advice of the EM IPA that it would not be routine or standard practice to request an MRI scan in the Emergency Department when dealing with musculoskeletal problems. I also accept the EM IPA advice that the assessment carried out, the anti-inflammatory medication provided and the referral for physiotherapy was appropriate and sufficient for the presenting complaint.

23. I note that an x-ray was requested and performed on 30 March 2017. This indicated no significant abnormality. A D-Dimer test was also performed. I accept the advice of the IPA that the D-Dimer blood test result was only slightly elevated and on clinical grounds there was no indication of a recurrence of a DVT. This is likely to have been the case on 27 March 2017, three days earlier. I therefore consider that the lack of an x-ray or D-Dimer blood test on 27 March 2017 was not detrimental to the patient's diagnosis and treatment. I accept the advice of the IPA that the referral to the fracture clinic for a surgical opinion on 8 April 2017, once the MRI results were available, was appropriate. The referral was also and in line with the GMC guidance '*Work with colleagues in the ways that best serve patients' interests.'*

24. Based on the available evidence and the expert advice, I find that the care and treatment provided to the patient in the Emergency Department of Craigavon Area Hospital on 27 and 30 March 2017 was appropriate and in line with GMC Good Medical Practice Guidance. **I do not therefore uphold this issue of complaint.**

**Issue 2 - Whether the care and treatment provided to the patient by the consultant orthopaedic surgeons was appropriate and reasonable?**

25. The complainant stated that her husband '*was referred to multiple surgeons and nobody would help him or offer him any treatment in due time'.* She states that the patient's GP was so unhappy with his treatment following the consultation (with consultant A) on 13 July 2017 that he made a referral to a neurosurgeon in Belfast for a second opinion. This took place on 16 August 2017. The complainant alleged that her husband had physically suffered unnecessarily due his care and treatment in hospital and had suffered from depression due to the medication and his ongoing pain.

26. The complainant alleged that her husband ought not to have had to wait seven months for treatment or pay for his own care. She also complained that he should not have been discharged from the Trauma and Orthopaedic Department of Craigavon Area Hospital on 24 November 2017.

27. As part of my investigation I considered the relevant GMC guidance including guidance on sharing information for direct care as follows:
'*Appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who provide their care do not have access to relevant, accurate and up to date information about them. Multidisciplinary and multi-agency teamwork is also placing increasing emphasis on integrated care and partnership working, and information sharing is central to this, but information must be shared within the framework provided by law and ethics.'* The GMC Guidance also states that doctors should 'w*ork with colleagues in the ways that best serve patients' interests'.*

28. I considered the medical notes and records provided by the Trust. I note that, following the referral by the Emergency Department registrar on 8 April 2017, the patient attended the fracture clinic on 24 April 2017 as arranged. He was seen initially by consultant B's specialist registrar who wrote to the patient's GP on 26 April 2017. He referred to the results of the private MRI performed on 4

April 2017 '*which shows AC joint arthropathy[3] as to be expected with his previous injury. He also has severe tendinosis around the shoulder although no rotator cuff tear'.* An MRI of the cervical spine was arranged by the doctor who informed the patient's GP '*with his intermittent weakness and paraesthesia I think it would be prudent to investigate his cervical spine by the way of an MRI scan to assure there is no nerve root irritation'.*

29. The patient was also seen again by the Emergency Department's physiotherapist at that time. Further physiotherapy was arranged, with a plan to review the patient in six weeks. It is recorded that he attended the fracture clinic physiotherapist on 8 May 2017 and 18 May 2017. Physiotherapy was discontinued at this time.

30. I note that on 22 May 2017 the patient had his cervical spine MRI scan as arranged. On 6 June 2017 he attended a further fracture clinic appointment, this time with consultant B, a general orthopaedic surgeon. He was informed of the outcome of the scan which showed evidence of spinal stenosis. The shoulder MRI was also considered and evidence of tendinosis[4] and acromioclavicular joint arthropathy[5] was noted. He was referred to consultant A, a surgeon specialising in shoulder problems. He was also referred to spinal surgeons at Musgrave Park Hospital with regard to neck problems evidenced on a private MRI of the shoulder performed on 4 April 2017.

31. The Investigating Officer asked the Trust to explain why the patient was initially referred to the general orthopaedic surgeon. The Trust explained :
'*The patients are referred into the hospital system from the ICATS[6] to be seen by General Orthopaedic surgeons, not necessarily the sub-speciality. This covers all of the Orthopaedic Consultants. The patient had his initial orthopaedic appointment […] and subsequently transferred […] for his specialist input. Not all patients require to be seen by the sub-specialties.'*

[3] The cartilage cushioning the Acromioclavicular joint in the shoulder begins to wear out or becomes inflamed. This may cause severe degeneration, disabling the shoulder joint or deforming it
[4] A condition that is characterised by swelling and pain of a tendon
[5] Stress produces wear and tear on the cartilage, the cartilage becomes worn over time, and eventually arthritis of the joint may occur.
[6] Integrated Clinical Assessment and Treatment Services. This service provides specialist assessment and appropriate management of patients with orthopaedic conditions, following a GP referral

32. On 13 July 2017 the patient attended an appointment with consultant A in the Trauma and Orthopaedic Department. The surgeon's record of the clinic states '*he attended today with no records and only a copy of his last couple of attendances was available to me'*. The complainant complains that she had provided the hospital with copies of the private shoulder MRI scan of 4 April 2017 but that these were not available at this consultation because they had been mislaid. Therefore a further appointment had to be arranged through the surgeon's secretary for 17 August 2017. The Trust has however confirmed that '*the images from [the patient's] private MRI were uploaded to the Trust's Radiology Information System on 6 June 2017'* and had not therefore been mislaid.

33. I note that consultant A wrote to the patient's GP on 13 July 2017, referring to the shoulder scan performed privately on 4 April, stating '*I am concerned that his scan has been reported as normal but I do not have any evidence of this as they do not have the report with them. I have asked him to come back to my clinic in 4 weeks' time when I am here'.* I note that he also wrote *'if he does not have a cuff tear, this is a neurogenic*[7] *shoulder and I would consider referring him to my spinal colleagues to investigate his neck as a source of his trouble'.* I note that the patient had already been referred to the spinal surgeons on 20 June 2017.

34. In the meantime, the patient sought a second opinion and saw a consultant neurosurgeon privately at the Royal Victoria Hospital on 16 August 2017 who suggested that '*his predominant problems relate to his right shoulder'.*

35. He attended the further appointment with consultant A on 17 August 2017 as arranged. The patient brought with him the report of the shoulder MRI from 4 April 2017 as requested. The surgeon stated the MRI scan '*has not been reported as showing a rotator cuff tear'*. He made a routine referral for physiotherapy for a *'dedicated rehabilitation programme to strengthen his cuff'* and also for an ultrasound guided injection. He intended to review the patient 2-3 months after the ultrasound guided injection.

[7] **Neurogenic** pain originates in the nerves, as opposed to muscle pain, bone pain, etc.

36. The patient attended privately to have this ultrasound guided injection because he was in pain and was losing wages because of his inability to work. When he informed Craigavon Area Hospital Radiology Department that he had received his injection privately, consultant A discharged him back to the care of his GP.

37. The Trust explained that it outsourced this procedure to an independent clinic '*as there was no NHS capacity to see him'*. The Trust further stated '*if [the patient] initiated a private injection, it is up to [him] to initiate review thereafter'.* The Trust explained that this would have been a new GP referral with a waiting time of 54 weeks for urgent patients and 84 weeks for routine patients.

38. The Investigating Officer obtained the patient's medical notes and records, documenting his care and treatment at the fracture clinic and consultant orthopaedic and trauma clinic and obtained IPA advice.

39. The consultant orthopaedic and trauma consultant IPA advised that the doctor's assessment on 8 April 2017 '*was not only entirely appropriate, but perceptive of the diagnostic dilemma of this patient's presentation, where there was uncertainty over the primary anatomical aetiology of the patient's symptoms, that is, were they due to an intrinsic shoulder problem or intrinsic neck problem, or perhaps both, but with one anatomical site more so than the other'.*

40. The IPA also advised that requesting an MRI and referring to more specialist colleagues for further investigation of the shoulder and cervical spine was appropriate. The IPA advised that referral to the fracture clinic was '*less than ideal'* and '*it would have been more appropriate for the referral to be made to a surgeon with a special interest in either shoulder or neck pathology'*. However, he added '*despite my reservations about the appropriateness of the referral to the fracture clinic, it is my opinion that [the doctor] demonstrated an entirely appropriate level of assessment, investigation and follow-up of this patient'.*

41. I note that the patient attended for review with consultant B on 6 June 2017. He reviewed the reports of the MRIs of the shoulder and the cervical spine which had been performed respectively on 4 April 2017 and 22 May 2017. The

surgeon made referrals to more specialist colleagues in relation to the neck and shoulder findings. The IPA advised '*it was entirely appropriate to explore both anatomical sites for additional opinions'.*

42. The patient subsequently attended an appointment with consultant A on 13 July 2017. It has been established that this surgeon wished to see the report of the shoulder MRI scan that the patient had obtained privately on 4 April 2017, and therefore asked the patient to arrange a further appointment and to bring the report with him. This took place on 17 August 2017. The IPA advised that '*the patient was appropriately assessed, given the diagnostic dilemma as to just where the anatomical primary pathology existed, that is between the cervical spine and the intrinsic problem in the right shoulder'*.

43. I note that consultant A made a routine referral for physiotherapy on 17 August 2017. The Investigating Officer asked the IPA if the terms of this referral were appropriate and sufficient. He advised '*I consider it was sufficient from a shoulder point of view for the physiotherapy to be marked routine, given the chronic nature of the pathology in the patient's right shoulder joint and the length of time since onset of the increased symptoms in early March 2017'.*

44. At the clinic on 17 August 2017, consultant A referred the patient for the ultrasound guided injection and planned to review him two to three months later. The independent clinic, where the ultrasound guided injection was due to be administered, contacted the hospital's radiology department to inform them that the patient had had his injection privately and did not require the injection on the NHS. The Investigating Officer asked the IPA if there was clinical justification for discharging the patient from his clinic to the care of his GP on 24 November 2017 as a result of this. The IPA advised '*From a clinical point of view, the follow up after the private ultrasound guided injection is something which ought to have been done in primary care by the general practitioner. This would also have enabled the general practitioner to decide whether a referral back to secondary care was appropriate'.*

45. The complainant has complained about her husband's discharge from the Orthopaedic and Trauma Clinic at that time, stating that he did not require the

injection. However it was not the case that he had asked the Orthopaedic and Trauma Clinic not to send out any further appointments. In response to the Investigating Officer's query about whether a misunderstanding may have occurred, the IPA advised '*The potential for failures of communication and misunderstanding are significantly increased as [the patient] moved between the NHS orthopaedic clinic, the NHS funded outsourced clinic and private treatment'.*

**Analysis and Findings**

**Issue 2 - Whether the care and treatment provided by the consultant orthopaedic surgeons at Craigavon Area Hospital was appropriate and reasonable?**

46. The GMC Guidance states that doctors should 'w*ork with colleagues in the ways that best serve patients' interests'.* GMC Guidance also states that *'Appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who provide their care do not have access to relevant, accurate and up to date information about them.* I therefore considered as part of my investigation whether this guidance was observed appropriately in this case.

47. The Trust has explained that patients are referred into the hospital system from ICATs to be seen by general orthopaedic surgeons. In this case the patient was seen firstly by consultant B's specialist registrar at the fracture clinic and then by consultant B himself, a general orthopaedic surgeon specialising in lower limb arthroplasty.

48. I consider that it was in accordance with the Trust's ICATs procedure that the patient was seen initially by the speciality doctor. The IPA has advised that referral to the fracture clinic was not ideal as the patient did not have a fracture. It would have been more appropriate for the referral to be made to a surgeon. However, despite the IPA's reservations about the referral to the fracture clinic, he has advised that the speciality doctor '*demonstrated an entirely appropriate*

*level of assessment, investigation and follow-up'.* Based on this advice, I conclude that the patient did not suffer any detriment as a result of the initial referral to the Fracture Clinic.

49. The speciality doctor arranged for a spinal MRI which was performed on 22 April 2017. The patient was reviewed promptly on 6 June by consultant B whose further investigations included referral to spinal surgeons at Musgrave Park Hospital and a referral to consultant A, the consultant surgeon in the Trauma and Orthopaedic department. I accept the advice of the IPA that it was appropriate to investigate both the cervical spine and the shoulder before making a diagnosis therefore these referrals by consultant B were appropriate.

50. The patient attended with consultant A on 13 July 2017. The complainant alleged that the consultant did not have his file and it was therefore necessary to make another appointment for four weeks hence to review the scans. The Trust has explained that the primary reason for the further review, which took place on 17 August 2018 was for the consultant to consider the report of the private MRI shoulder scan performed on 4 April 2017. I note the challenge of sharing clinical information between private providers and the NHS which the IPA has referenced in his advice to me.

51. I note that the complainant and her husband were dissatisfied by the experience at the consultation on 13 July 2017. They left with the impression that the NHS records had been mislaid and as a result had lost confidence in the process. Further, the lack of progress in the patient's care led his GP to seek a second opinion from a neurosurgeon. However, I do not believe that the absence of the private report of the private MRI resulted in a failing in the patient's care and treatment. It was not the fault of the Trust that the report of the MRI carried out privately was not available to consultant A. This highlights the significant systemic issue which is the sharing of patient data between private and publicly funded healthcare providers.

52. I consider that requesting the further review on 17 August 2017 in order to consider the privately funded MRI was appropriate because the report of the

MRI shoulder scan was an important factor in consultant A's determining what further investigations were required. I accept the opinion of the IPA that this case is an example of the lack of integration between private practice and NHS practice. I conclude therefore that it was appropriate for the consultant to seek a further review with the patient in a month's time. **I do therefore not uphold this element of complaint.**

53. I note that consultant A wrote to the patient's GP on 7 August 2017. In that letter, he stated that the patient attended today *'with no records'* therefore the only record available to him was '*a copy of his last couple of attendances'.* He also stated that he would consider a referral to his spinal colleagues at next review. The patient's most recent previous attendance had been on 6 June 2017 with consultant B. It is surprising therefore that consultant A was not aware that a referral to the spinal surgeons had already been made on 6 June 2017. However, as the referral had been made two months earlier, I am satisfied that the patient suffered no injustice as a result of this error. In response to the draft report consultant A asked for it to be noted that he was not aware that this referral had been made, because of a clerical error. The Trust stated that '*The clerical staff have been made aware of this error and learning has been discussed at the staff meetings'*

54. I believe that it was the patient's intention to cancel the NHS US guided injection. However he did not realise that the consequences would be discharge from the Trauma and Orthopaedic department. I accept the advice of the IPA that any follow up to the US guided injection obtained privately ought to have been organised in a primary care setting by the patient's GP. It was therefore appropriate that the patient was discharged from the Trauma and Orthopaedic department at that time. I am not aware that a further referral back to the Trauma and Orthopaedic department was made by the patient's GP. **I do not therefore uphold this element of the complaint.**

# CONCLUSION

55. The issues of complaint which I accepted for investigation were:

i. Whether the care and treatment provided to the patient in the Emergency Department of Craigavon Area Hospital was appropriate and reasonable?

ii. Whether the care and treatment provided to the patient by two consultant orthopaedic surgeons at the hospital was appropriate and reasonable?

56. I carefully considered the detail of the complaint, the responses from the Trust, the clinical records provided by the Trust and the IPA advice.

57. In relation to issue (i), I find that the care and treatment provided to the patient was appropriate and in line with GMC Guidance. I do not therefore uphold this issue of complaint

58. In relation to issue (ii), I held that the care and treatment provided to the patient by the Consultant orthopaedic surgeons was appropriate and reasonable. I do not uphold this issue of complaint.

59. However, I find there was maladministration in relation to the availability of the patient's patient history to consultant A because of a clerical error. I find that no injustice was caused to the patient in consequence of this.

**General Comment**: This case highlights a systemic issue relating to the sharing of patient information between NHS funded and privately funded care. I have written to the Department of Health raising my concerns generally on this issue.A

Marie Anderson

**MARIE ANDERSON**
**Ombudsman** **August 2019**

**APPENDIX ONE**

# PRINCIPLES OF GOOD ADMINISTRATION

**Good administration by public service providers means:**

**1. Getting it right**

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

**2. Being customer focused**

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

**3. Being open and accountable**

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

**4. Acting fairly and proportionately**

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

**5. Putting things right**

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

**6. Seeking continuous improvement**

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.