Investigation Report

Investigation of a complaint against

3FiveTwo Healthcare

NIPSO Reference: 22298

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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, and 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.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

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.

TABLE OF CONTENTS

Page

Case Reference: 22298

Listed Authority: 3FiveTwo Healthcare

SUMMARY

This complaint is about care and treatment 3FiveTwo Healthcare (3FiveTwo) provided to the patient between 2013 and 2016. The patient raised concerns regarding its failure to diagnose her hip osteoarthritis[1]. She also said 3FiveTwo mistakenly discharged her, and failed to action a letter from a Consultant within the Belfast Health and Social Care Trust (the Trust). The patient said the failures led to a delay in her treatment.

The investigation examined the details of the complaint, 3FiveTwo's response, information obtained from the Trust, and internal and GMC Guidance. I also sought independent professional advice from an Orthopaedic Surgeon. The investigation found that 3FiveTwo did not diagnose the patient's hip osteoarthritis; however its care and treatment of her, based on her symptoms, from January 2013 to February 2016 was appropriate and in accordance with GMC Guidance. However, it identified that 3FiveTwo failed to appropriately action a letter it received from the Trust regarding the patient's care and treatment after July 2016. It identified that this failure caused a delay in the patient's clinical pathway. The investigation found that 3FiveTwo discharged the patient in February 2016. I accepted that administrative staff appropriately followed the Orthopaedic Consultant's instruction to discharge the patient. However, the investigation established that an error occurred at some point in the process that led to either the patient's discharge, or the failure to notify her of her discharge. I consider this led to 3FiveTwo's failure to provide an effective service for the patient.

I recommended that 3FiveTwo apologise to the patient for the injustice she experienced. I also recommended that it undertake an audit following its implementation of a new system.

[1] A degenerative disease in which the surface cartilage of the hip joint wears away eventually leaving just bone beneath it exposed.

THE COMPLAINT

1. I received a complaint about the care and treatment 3FiveTwo Healthcare (3FiveTwo) provided to the patient between 2013 and 2016. It was established that 3FiveTwo provided care and treatment to the patient as part of its arrangement with the Belfast Health and Social Care Trust (the Trust). Therefore, by virtue of this arrangement, it is considered to be a body in jurisdiction. It was also established that the patient did not complain to 3FiveTwo about the care and treatment she received. However, the 2016 Act permits the exercise of discretion to investigate a complaint in the absence of a complaint to the body. It was determined that it was appropriate to investigate the actions of 3FiveTwo given the complaint concerned its care and treatment of the patient.

2. The patient raised concerns regarding 3FiveTwo's failure to diagnose her hip osteoarthritis between January 2013 and February 2016. She also said it mistakenly discharged her, and failed to action a letter from a Consultant within the Trust. She said the failures caused a delay in her treatment.

Background

3. The patient was referred to the Trust's orthopaedic service in August 2012. The form documented that the patient suffered with lower back pain associated with right sided sciatica[2]. The Trust referred her to 3FiveTwo in December 2012 under a waiting list initiative. The patient remained under the care of an Orthopaedic Consultant in 3FiveTwo from 2013 to 2016. The Orthopaedic Consultant referred her to the neurology and neurosurgery departments in the Trust in early 2016, and she was subsequently discharged from 3FiveTwo. A Neurologist reviewed her in May 2016. The patient also attended a Neurosurgeon (Neurosurgeon A) in July 2016. Neurosurgeon A referred the patient back to 3FiveTwo on 14 July 2016, and included as one of his recommendations '*a proper assessment for her hip'*.

4. The patient said she did not receive any communication from 3FiveTwo after her appointment with the Trust in July 2016. She said she contacted 3FiveTwo

[2] Where the sciatic nerve, which runs from the lower back to the feet, is irritated or compressed.

around November 2016[3] and was informed she was discharged. Her general practitioner (GP) again referred her to Orthopaedics on 30 January 2017 listing '*hip pain'* as the reason. The referral also requested a hip x-ray, which was undertaken in February 2017. The report noted '*significant degenerative changes affecting the right hip joint with nearly complete loss of joint space'* in comparison to a previous examination from 22 April 2010. The patient also attended a Neurosurgeon in 3FiveTwo (Neurosurgeon B) on 20 February 2017 and underwent further tests and scans. Neurosurgeon B wrote to the patient's GP on 14 August 2017 documenting that her pain was more likely to be from her hip than her spine. An Orthopaedic Surgeon within the Trust reviewed the patient on 11 September 2017 and she was added to the waiting list for a total hip replacement. The surgery was undertaken in July 2018.

Issues of complaint

5. The issues of complaint accepted for investigation were:

Issue 1: Whether the care and treatment 3FiveTwo Healthcare provided to the patient was appropriate and in line with good medical practice.

Issue 2: Whether the discharge process was appropriate and in accordance with relevant standards.

Issue 3: Whether 3FiveTwo Healthcare handled a letter from the Trust, dated 14 July 2016, appropriately and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from 3FiveTwo all relevant documentation together with its comments on the issues the patient and her MLA raised. This documentation included information relating to 3FiveTwo's involvement in the handling of the complaint. The Investigating Officer also interviewed the patient (accompanied by her MLA) to obtain further information on the issues of her complaint.

[3] Records document that the patient contacted 3FiveTwo in early January 2017.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - [redacted] MB ChB, FRCS, FRCS (Tr/Ortho); a Consultant Orthopaedic Surgeon for over 25 years (O IPA).

    The clinical advice received is enclosed at Appendix two to this report.

8. The information and advice that informed the findings and conclusions are included within the body of this report and its appendices. The O IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

9. 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. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[4]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

10. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, April 2013 (the GMC Guidance);
    - 3FiveTwo Healthcare's Guidance for Sending Results to the Consultant, not dated (3FiveTwo's Guidance for Sending Results to

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

the Consultant); and

- 3FiveTwo Healthcare's Discharge Process, not dated (3FiveTwo's Discharge Process).

11. I did not include all of the information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. A draft copy of this report was shared with the patient and 3FiveTwo for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment 3FiveTwo Healthcare provided to the patient was appropriate and in line with good medical practice.

Detail of Complaint

13. This issue of complaint is about the diagnosis of the patient's hip osteoarthritis. The patient said 3FiveTwo failed to diagnose the condition when she was under its care between January 2013 and February 2016.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies and guidance:

    - The GMC Guidance.

    Relevant extracts of the policies and guidance referred to are enclosed at Appendix three to this report.

3FiveTwo's response to investigation enquiries

15. In response to enquiries, 3FiveTwo explained the patient was referred '*for a new patient assessment with a Spinal Orthopaedic Consultant. The referral received by 3fivetwo healthcare had been triaged and graded by Musgrave Park Hospital Orthopaedic team as a routine Spinal assessment'*. It further explained it is '*content that the appropriate clinical management was*

undertaken for this patient within an appropriate time frame'. In relation to medical tests undertaken for the patient, 3FiveTwo explained it believes the '*clinical pathway for this patient was appropriate throughout her care with 3fivetwo healthcare'*.

16. 3FiveTwo provided information regarding the parameters for treating patients in accordance with its orthopaedic contract with the Trust. These were '*an assessment by [an] appropriate consultant in relation to the referral received, in this case a Spinal Consultant; each referral was pre-approved for: one consultation, any diagnostics required, up to two reviews, one surgical procedure, two post-operative reviews, if any additional reviews or procedures were required in addition to the above an individual authorisation request was required to be submitted to the [Trust] and approved by their clinical team'*. It further explained that '*3fivetwo healthcare could only assess the patient within the scope of the referral, in this case Orthopaedic Spinal. In the event referral was required for input from/or onward referral to another speciality these referrals were to be directed to appropriate referral office within the [Trust]'.*

17. The Orthopaedic Consultant who treated the patient in 3FiveTwo also provided a statement to my office. He detailed the care and treatment he provided to the patient between 2013 and 2016. He also outlined the referrals made and the investigations undertaken during this time. Further details are enclosed at Appendix four to this report.

18. The Orthopaedic Consultant explained that '*when I first saw her…she has had an assessment by the physiotherapist who has reported symptoms more suggestive of lower back pain and radicular symptoms…Throughout the time she was seen her history was very typically that of radicular pain with lower back pain and pain going down into her right leg down to her ankle. She also complained of numbness at various stages. I thoroughly assessed her symptoms at all stages and in fact I got a second opinion initially from [the]…Orthopaedic Spinal Surgeon, and we also got some nerve conduction studies…[which] reported initially some nerve root changes. His examination also pointed to a neurological cause'*.

19. The Orthopaedic Consultant said the *'diagnosis could have been made earlier but I think delay was at least in part related to the description of symptoms recorded in the records. There were several opinions sought and, initially at least, none considered the diagnosis [the patient] saw [Neurosurgeon B] it was 2017 and clearly four years after I first saw this patient and that is a long time and her symptoms had evolved. I last saw this patient in 2015[5] myself'*. He further explained that '*the MRI scan report of the hip is that suggestive of avascular necrosis[6] and secondary degenerative changes[7]. Eventually she did have arthritis of the hip. The fact that avascular necrosis has been described would mean that there has been a sudden deterioration of the hip joint which is the only reason to explain her sudden change in symptoms. Clearly by the time she was seeing [Neurosurgeon B] she had some stiffness in the hip which clearly was not detected by any of the attending personnel before that including myself…Hence it is incorrect to say that I did not detect the hip arthritis'*.

20. The Orthopaedic Consultant explained that '*any patient of her age would have minor changes, but it is a question of whether these changes are responsible for the symptoms that the patient has presented with and has been referred for'*. He said the patient's '*presenting history was of lower back pain and radicular pain which is going down to the ankle which would not fit in with hip pathology. Hip pathology seldom causes pain beyond the knee. The main feature of hip pathology is groin pain and stiffness, neither of which she complained of in the periods when I was seeing her. At no stage before her presentation to [Neurosurgeon B] was hip stiffness and abnormal gait a clinical feature. She had femoral stretch tests and straight leg raise tests done on several occasions and these would have concentrated attention to the hip if she complained of stiffness and pain on these examinations which was not the case. I do not agree that the hip pathology was missed by myself. However, over the long period of time that she has been under investigation her hip has probably deteriorated and the contributing factors in her case would have been*

[5] It was established from records that the Orthopaedic Consultant last reviewed the patient in February 2016.
[6] Death of bone tissue due to a lack of blood supply.
[7] Damage caused by another disease or medical condition.

the hyperlipidaemia[8] *that she has had and was being investigated for. This may have triggered her avascular necrosis of the hip and caused her hip symptoms'*.

Relevant records

21. A summary of the records considered is enclosed at Appendix four to this report. 3FiveTwo also provided a report it commissioned following a review of the patient's care and treatment. A Consultant Orthopaedic Spinal Surgeon undertook the review in September 2020. A summary of his findings is enclosed at Appendix four to this report.

Interviews

Interview with the patient and her MLA

22. The patient said her last meeting with the Orthopaedic Consultant in 3FiveTwo was at the beginning of 2016 (February). She explained that she '*kept emphasising [her] right hip, I wasn't happy with it, it was getting worse. I was reduced to a walking stick because I was falling and that was when he said, oh well I arranged for you to be seen by a neurologist'.* The patient further explained that she attended Neurosurgeon A [within the Trust] in July 2016 and he identified she may have a defect in her right hip. She said he informed her he would refer her back to the Orthopaedic Consultant in 3FiveTwo.

23. The patient referred to the x-ray of her hip undertaken in February 2017. She said it showed she '*no longer had a hip, it was bone on bone'*. She also said that her '*cortisol levels were all raised due to stress…it caused other health problems as well. It caused depression as well as raised cortisol levels'*.

Relevant Independent Professional Advice

24. I obtained independent professional advice from a Consultant Orthopaedic Surgeon (O IPA). In relation to the patient's first attendance at 3FiveTwo in January 2013, the O IPA advised that she presented with '*Low back pain and right leg pain…for 12 to 18 months. However, the original referral letter from 19/09/12 does refer to "she is stiff, slight reduction of internal rotation of the right hip". In addition, there is an x-ray report from 2010, which does not refer to*

[8] The presence of elevated plasma concentrations of lipids including cholesterol, triglycerides and lipoproteins.

any hip pathology, especially on the right side'. He advised that the Orthopaedic Consultant undertook an assessment of the patient's '*lumbar spine and lower limb neurology'*. The O IPA considered this action appropriate. He was asked if the Orthopaedic Consultant ought to have undertaken any other assessments at that time. He advised '*Not directly on the basis of the presenting symptoms. I believe that it was not unreasonable to clarify the source of what appeared to be her "primary symptoms". However, an examination of the pelvis and hips would have been desirable'*. The O IPA advised that the care and treatment provided to the patient during this attendance was appropriate.

25. The O IPA advised that in April 2013, the Orthopaedic Consultant reviewed the results of the MRI of the patient's cervical spine. He further advised that the Orthopaedic Consultant '*reaffirmed [his] recommendation of right L5 nerve root block'*. The O IPA considered the care and treatment provided at this time appropriate and in accordance with relevant standards.

26. The O IPA advised that in September 2013, the Orthopaedic Consultant requested a '*repeat MRI lumbar spine in view of length of time since original scan'*. He considered this action appropriate and in accordance with relevant standards. The Orthopaedic Consultant reviewed the results of this MRI with the patient in December 2013. The O IPA advised that the Orthopaedic Consultant '*not unreasonably, requested a second opinion (spinal) as unable to confirm a specific spinal diagnosis'*. He considered this action appropriate and in accordance with relevant standards.

27. The O IPA advised that the patient attended 3FiveTwo again in July 2014. He also advised that '*separately, this lady had been reviewed for a second opinion in March 2014 as requested. In this letter there is a reference to "trochanteric bursitis[9]" in the right hip. An injection was performed but I have no documentation of follow up on this or indeed assessment of the right hip. Nerve conduction studies had also been requested previously'*. In relation to action taken following this attendance, the O IPA advised that '*in view of the nerve*

[9] Swelling of the fluid-filled sac near a joint (bursa) at the outside point of the hip. When the bursa becomes irritated or inflamed, it causes pain in the hip.

conduction study results a neurological opinion was requested quite reasonably'. He considered this action appropriate and in accordance with relevant standards.

28. The O IPA advised that the patient attended 3FiveTwo on 27 February 2016. He also advised that during this attendance, the Orthopaedic Consultant reviewed '*all of the previous scans and nerve conductions and previous alternative opinions'*. In relation to action taken following this appointment, the O IPA advised that 3FiveTwo requested a '*neurosurgical opinion'*. He considered this action appropriate and in accordance with relevant standards.

29. In relation to 3FiveTwo's overall care and treatment of the patient, the O IPA advised that '*the main learning point here is that referral to a hip specialist earlier may have clarified the diagnosis sooner'.* He added that he considered the '*delay was at least in part related to the description of symptoms recorded in the records. There were several opinions sought and, initially at least, none considered the diagnosis'*. The O IPA advised that *'However, I could not fault the clinicians involved to any degree as several further opinions were sought to help with the diagnosis'*.

30. The O IPA further advised that '*there is nothing to suggest that the initial and subsequent assessment of this lady's potential spinal issues were not addressed and managed accordingly. The diagnosis may have been made earlier and possibly confirmed with a diagnostic and therapeutic injection to the right hip but clearly the hip disease seems to have progressed over some years rather than weeks or months. Even when the diagnosis of hip osteoarthritis was made it was not initially considered severe enough to proceed to a hip replacement at that time although the records would suggest that it did progress fairly quickly thereafter. The final management has been carried out in a timely manner once the diagnosis was confirmed*.'

Analysis and Findings

31. This issue of complaint is about the care and treatment 3FiveTwo provided to the patient from January 2013 to February 2016. The patient said 3FiveTwo failed to diagnose her hip osteoarthritis during this time. I note that following

assessments undertaken within that three year period, the Orthopaedic Consultant in 3FiveTwo referred the patient to the Trust in February 2016 for a neurosurgical opinion. It was during this neurosurgical assessment in July 2016 that the patient's hip osteoarthritis was first considered. Based on the records available, I am satisfied that in the time he assessed and treated the patient, the Orthopaedic Consultant did not document a suspicion that she suffered from hip osteoarthritis.

32. I considered whether the actions the Orthopaedic Consultant took between January 2013 and February 2016 were appropriate and in accordance with relevant standards. I note the patient's referral to the Trust in September 2012 documented that she experienced '*ongoing low back pain associated with right sided sciatica'*. I also note that when she attended the Orthopaedic Consultant in 3FiveTwo in January 2013, he undertook an assessment of the patient's '*lumbar spine and lower limb neurology'*. I note the O IPA's advice that while an assessment of the patient's hip and pelvis would have been '*desirable*', given the patient's presenting symptoms, the care and treatment provided to her during her first appointment was appropriate.

33. I note that over the course of the next three years, the Orthopaedic Consultant undertook numerous tests for the patient, and referred her to other specialists to establish the source of her pain. I accept the O IPA's advice that given the patient's symptoms, and results of the tests undertaken, the Orthopaedic Consultant's actions during this period were appropriate.

34. Standard 15 of GMC Guidance states that medical professionals ought to *'adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values'.* Standard 16 of the guidance states that doctors also ought to '*provide effective treatments based on the best available evidence'*.

35. I note the O IPA's advice that while '*referral to a hip specialist earlier may have clarified the diagnosis sooner… delay was at least in part related to the description of symptoms recorded in the records'*. He also advised that '*there is*

nothing to suggest that the initial and subsequent assessment of this lady's potential spinal issues were not addressed and managed accordingly'. I accept the O IPA's advice that he could '*not fault the clinicians involved to any degree as several further opinions were sought to help with the diagnosis'*. I consider that in assessing and treating the patient, the Orthopaedic Consultant considered her presenting symptoms and took action based on the evidence available to him at the time. I consider that in doing so, his actions were in accordance with the GMC Guidance. I did not identify any failure in 3FiveTwo's care and treatment of the patient between January 2013 and February 2016. I do not uphold this issue of complaint.

36. I note that while the patient's hip osteoarthritis was identified in February 2017, the Trust's Orthopaedic Surgeon did not consider at that time she required immediate treatment, and she was not placed on the waiting list for a hip replacement until September 2017. As the Trust's Orthopaedic Surgeon did not consider the patient required surgical treatment immediately, I consider it unlikely that an earlier diagnosis [by 3FiveTwo] would have changed her clinical pathway. I am pleased to note the patient underwent her surgery in July 2018.

Issue 2: Whether 3FiveTwo Healthcare handled a letter from the Trust, dated 14 July 2016, appropriately and in accordance with relevant standards.

Detail of Complaint

37. This issue of complaint is about 3FiveTwo's management of a letter the Trust sent to it in July 2016. The letter re-referred the patient to 3FiveTwo for an assessment of her hip. The patient said that although the letter was addressed incorrectly, 3FiveTwo received it and ought to have actioned it appropriately. The patient said 3FiveTwo's failure to do so caused a delay in her ongoing care and treatment.

Evidence Considered

Legislation/Policies/Guidance

38. I considered the following policies and guidance:

- 3FiveTwo's Guidance for Sending Results to the Consultant.

Relevant extracts of the guidance referred to are enclosed at Appendix three to this report.

3FiveTwo's response to investigation enquiries

39. In response to enquiries, 3FiveTwo explained *'The patient attended an appointment with [Neurosurgeon A], Neurosurgery department on the 7.7.16. [Neurosurgeon A] assessed the patient and referred her back to 3fivetwo Healthcare for a further review. This letter was received by 3fivetwo Healthcare on the 30.8.2016 and was attached to the electronic record of the patient's discharged episode of care'*.

40. 3FiveTwo further explained that '*in normal circumstances this letter should have been sent to [the Orthopaedic Consultant] for review and authorisation would have been sought from the Belfast Health and Social Care Trust to reinstate the patient for a review. Regrettably this action was not carried out at the time and this is attributed to individual human error. This resulted in a delay between the 30.8.2016 and 10.1.2017 until the patient contacted to enquire about a follow-up appointment. Authorisation to reinstate the patient was immediately sought from the Belfast Trust on 10.1.2017. Authorisation was received from the Belfast [Trust] on the 9.2.2017 and the patient was reviewed by [Neurosurgeon B] on the 20.2.2017'*.

41. 3FiveTwo explained its Guidance for Sending Results to Consultants is '*specifically related to diagnostic results but does detail the actions around sending notification emails to consultant upon receipt correspondence. 3fivetwo have since introduced a portal system for stakeholders that helps to automate this process and helps to mitigate the opportunity for human error'*.

Relevant records

42. A summary of the records considered is enclosed at Appendix four to this report.

Other information considered

43. The Trust explained that '*3FiveTwo Healthcare have confirmed that they do not have a member of staff called Mr Benicar and that this was a spelling error on*

[Neurosurgeon A's] letter...[the Trust] contacted 3FiveTwo Healthcare to determine why there was a delay in follow up by 3FiveTwo Healthcare following receipt [of Neurosurgeon A's letter]…It was explained that due to the letter having been incorrectly addressed…there was an oversight by 3FiveTwo Healthcare as there was no consultant by this name, which meant that the letter was not acted upon'.

44. The Trust further explained that '*3FiveTwo Healthcare at the time apologised for this error and [the Trust] provided assurance that processes had been updated to ensure that patients would be followed up in a timely manner. He also advised that the Trust would also be reminding staff of the importance of accuracy when it comes to the administrative processes to ensure letters are sent to the correct staff. On behalf of the Trust I would like to offer my sincere apologies to [the patient] for this oversight, which resulted in a delayed return to Trust for follow up'*.

Relevant Independent Professional Advice

45. In relation to the letter from Neurosurgeon A, the O IPA advised that it '*very specifically refers to concerns about the right hip, which it was felt merited separate evaluation'*. In relation to the potential impact of 3FiveTwo failing to action the letter, the O IPA advised that the letter documents '"*I will leave her further management in the hands of her Consultants in 352 to manage this further". It does not suggest that she was discharged to the care of her GP at that time'.*

46. The O IPA further advised that '*In view of the advice of [the surgeon] at that time [February 2017], I do not believe that there was any significant impact on her care and treatment. However, we are aware that…she was listed for a right THR [total hip replacement] in September 2017, the surgery being carried out in July 2018'*.

Analysis and Findings

47. The patient raised concerns with 3FiveTwo's failure to action a letter the Trust sent to it in July 2016. 3FiveTwo said it received the letter in August 2016. The patient said its failure to appropriately action the letter led to a delay in her

receiving treatment. I note the letter was addressed to 'Mr Benicar' in error, which the Trust acknowledged.

48. I note 3FiveTwo's Guidance for Sending Results to Consultants states that outcomes will be '*sent to the consultant via email'*. I note that while the Trust's letter was attached to the patient's record, 3FiveTwo explained it was not emailed to the Orthopaedic Consultant to progress. I acknowledge the letter was addressed incorrectly. However, as 3FiveTwo staff were able to identify the patient to attach it to her record, I am satisfied the Trust's error would not prevent 3FiveTwo from identifying the appropriate consultant and processing the letter in accordance with its guidance.

49. I note the patient contacted 3FiveTwo in January 2017 and after being told that she was discharged, the patient's GP re-referred her to the Trust on 30 January 2017. I am pleased to note that following the referral, the process was expedited and the Trust assessed the patient's hip in February 2017.

50. I consider that 3FiveTwo's failure to action the Trust's letter caused at least a five month delay in the patient receiving her assessment. I also consider that had the patient not contacted 3FiveTwo for an update in January 2017, this delay may have been further protracted. I am satisfied this represents a failure in 3FiveTwo's care and treatment of the patient.

51. I considered the impact this failure had on the patient. While I am satisfied that the failure caused a delay in the patient receiving an assessment, I note that when she was assessed, in February 2017, the Trust's Orthopaedic Surgeon did not consider that she required immediate treatment. I also note it was approximately a further six months [September 2017] before the Trust assessed the patient and placed her on the waiting list for a hip replacement. Therefore, I do not consider that 3FiveTwo's failure to action the letter caused a delay in the patient receiving the surgery required to treat her condition. However, I am satisfied that the failure identified caused the patient to experience the injustice of the loss of opportunity to undergo an earlier assessment of her hip, and uncertainty and frustration.

Issue 3: Whether the discharge process was appropriate and in accordance with relevant standards.

Detail of Complaint

52. This issue of complaint is about 3FiveTwo's discharge of the patient in 2016. The patient said she should not have been discharged at that time. She also raised concerns with 3FiveTwo's failure to inform her that she was discharged from its care.

Evidence Considered

Legislation/Policies/Guidance

53. I considered the following policies and guidance:

    - 3FiveTwo's Discharge Process.

3FiveTwo's response to investigation enquiries

54. 3FiveTwo explained that *'the outcome from the patient's review with [the Orthopaedic Consultant] on the 27.2.16 was a discharge from [his] care and tertiary referral was made to the Belfast Health and Social Care Trust's Neurosurgery Service at the Royal Victoria Hospital'*. It further explained that the Orthopaedic Consultant '*discharged the patient and referred her onto the neurosurgery department at RVH for further assessment'*.

55. 3Five Two said that '*the discharge outcome of this appointment had been entered directly by [the Orthopaedic Consultant] using our electronic system, this was entered at the time of the appointment…it should be noted that…[the Orthopaedic Consultant] was happy to reassess the patient following their neurosurgery assessment. He may not have intended to enter an outcome of discharged from this appointment. This discrepancy did not contribute to any delay in the patient's pathway as an authorisation process between 3fivetwo and BHSCT was in place to request a reinstatement if further follow-up was required'*.

56. 3FiveTwo referred to the patient's telephone call, it said it received on 7 January 2017. It explained that '*we have been unable to retrieve the call recording. From the note left by the administrator that took the call it is unclear*

as whether the patient was advised of her discharge at the time of the call. The administrator sent an email to our outcomes and typing team to say that the patient was scheduled as discharged but the patient had indicated she should be having a further review and asked if they could investigate this'.

57. 3FiveTwo's discharge process states that it sends an email to the Trust to advise if the patient is to remain active. 3FiveTwo explained that it was '*unable to provide confirmation as to whether this email was sent to the Trust in 2016, as a large majority of the staff who may have sent this email have since left the company. However, we can confidently confirm the relevant referral reached its destination, as we know that the patient was assessed within the Neurosurgery dept of RVH. Please note, that whether this email was sent or not, it would not have had any bearing or potential negative impact on the patient's pathway and would not have prevented the human error already outlined'*.

58. 3FiveTwo was asked if the patient's record was deactivated from its system. It explained that '*this is an internal administrative process…that deactivates discharged patients from the system and archives their record. This would have had no impact on the patient's pathway. The patient would have been discharged and deactivated from the system following the processing of her appointment with [the orthopaedic consultant] in 2016'*. It further explained that the patient was reactivated on its system in 2017.

59. In relation to informing the patient of her discharge, 3FiveTwo explained that '*this scenario is considered a clinical discharge by the Consultant…the outcome entered by the consultant at the time of this appointment, in February 2016, was that the patient had been discharged'*. It further explained that '*in this instance, the dictated clinic letter by the consultant acts as the discharge letter'*. 3FiveTwo said that a proforma discharge letter is only sent to the patient and their GP in the case of an '*administrative discharge for repeated cancellation, DNA [did not attend] or at the patient's request'*.

60. In his response to enquiries, the Orthopaedic Consultant explained that '*at that stage when I referred her to the Neurology Department, I had not discharged her from 3FiveTwo. The understanding was that if nothing were found in the*

neurology or the neurosurgery assessments, we would continue to manage her pain'.

Relevant records

61. A summary of the records considered is enclosed at Appendix four to this report.

Interviews

Interview with the patient and her MLA

62. The patient explained that she contacted 3FiveTwo in November 2016 and a staff member informed her, '*I'm sorry but you have been discharged…I can only apologise on behalf of 3FiveTwo…but I am sorry the only thing I'm going to have to do is to re-refer you again to another consultant'*. She further explained that she wished to know '*why a consultant discharged me without even contacting me to tell me he was discharging me. To discharge me without even going by the notes that he had got from the neurosurgeon and the neurologist and doing something about it'*.

Relevant Independent Professional Advice

63. The IPA was asked if the records provide evidence that the patient was informed of her discharge from 3FiveTwo in February 2016. The O IPA advised that '*the consultant did not refer to discharge on that date in the letter provided'*. He further advised that '*this lady would appear to have been inadvertently discharged sometime between July 2016 and January 2017 presumably by default. Although I do not believe that this had any bearing on her subsequent care, the mechanism of this should be more carefully looked at to prevent this happening again'*.

The patient's response to a draft copy of this report

64. The patient said she was concerned she was discharged from 3FiveTwo and that it failed to notify her of her discharge. She explained that she '*sees this as being of great weakness and is very concerned that that could affect other members of the community'.*

3FiveTwo's response to a draft copy of this report

65. In its response, 3FiveTwo explained it did not consider it '*wrongly or inadvertently'* discharged the patient as she was '*administrated in line with the consultant's clear instructions'*. It further explained that '*the patient was clinically discharged based on the outcome information entered by the consultant at the time of the appointment, this clearly stated that the patient had been discharged'*. 3FiveTwo said it contested any finding of maladministration relating to the discharge process.

66. Following receipt of the response, the Investigating Officer obtained further information from 3FiveTwo about the patient's discharge. It explained that while the patient was tertiary referred to the Trust, she was also discharged from its clinical pathway; there was no expectation that the patient would return to 3FiveTwo following the outcome of her assessment within the Trust.

67. 3FiveTwo was referred to the Orthopaedic Consultant's statement, which documented that he did not discharge the patient. The statement also documented that dependent on the outcome of her assessment with the Trust (in July 2016), he expected the patient to return to his care. 3FiveTwo explained that this statement contradicted the instruction from the Orthopaedic Consultant staff received in February 2016. It said this was new information that it was only made aware of following commencement of the investigation.

68. 3FiveTwo was asked how a patient is notified of their discharge in this situation. It explained that it relies on the consultant to inform patients of their discharge during their face to face consultation. It further explained that the clinic letter acts as written notification of the discharge. 3FiveTwo said that in the patient's case, this letter was issued to the Trust and her GP. 3FiveTwo explained that it did not notify the patient in writing of her discharge.

Analysis and Findings

69. The patient raised concerns that 3FiveTwo discharged her from its care in 2016. She was also concerned that 3FiveTwo failed to notify her of her discharge. I note that 3FiveTwo explained that the patient was tertiary

referred[10] to the Trust's neurosurgery department on 27 February 2016. It also explained that she was discharged from its clinical pathway on this date. However, I note that in his statement, the Orthopaedic Consultant explained he did not discharge the patient from his care, and he expected to continue treating the patient dependent on the outcome of her assessment with the Trust.

70. In order to establish whether 3FiveTwo's action to discharge the patient was appropriate, I considered its discharge records and its responses to my enquiries. I note the screenshot of the patient's online record for 27 February 2016 documents, '*Title created by clinician…Next step = discharge'*. I consider this a clear instruction for staff to discharge the patient. I also note the screenshot documents, '*Treatment complete'*. Therefore, I consider there was no indication on the patient's record that the Orthopaedic Consultant expected her to return to his care dependent on the outcome of the Trust assessment.

71. I am unable to determine why the discharge instruction on the system differs from the Orthopaedic Consultant's expectation that the patient would return to his care (depending on the outcome of the Trust's assessment). While it is possible the instruction to discharge was entered on the system in error, I cannot definitively conclude that this occurred. However, I am satisfied it was this action that led to the patient being discharged.

72. I note 3FiveTwo explained that a consultant normally informs the patient of their discharge during their face to face consultation. I acknowledge that most, if not all, healthcare providers follow the same process, and only notify the patient's GP (rather than the patient) in writing. However, in this case, it is clear the patient was not aware she was discharged until she contacted 3FiveTwo in January 2017. I consider it likely this is because the Orthopaedic Consultant did not expect to discharge the patient at the time of their consultation. Therefore, he did not inform her of the proposed action during their consultation. Regardless of whether the patient was discharged due to the Orthopaedic

[10] The patient is referred to a different speciality.

Consultant's error, or whether he failed to notify her of the decision to discharge, it remains the detriment was on the patient.

73. I considered the impact the error likely had on the patient. I note she did not receive her hip assessment until February 2017. However, I already established this was because 3FiveTwo failed to action Neurosurgeon A's referral letter. I cannot conclude that had she not been discharged, or had 3FiveTwo notified her of her discharge earlier, she would have received an earlier assessment. I also note the O IPA did not consider the discharge of the patient '*had any bearing on her subsequent care'*. Therefore, I am satisfied the discharge did not affect the patient's ongoing treatment.

74. I note 3FiveTwo explained it does not consider it '*wrongly or inadvertently'* discharged the patient. I accept its administrative staff appropriately processed the patient's discharge on the Orthopaedic Consultant's instruction. However, it remains that an error occurred at some point in the process that led to either the patient's discharge, or the failure to notify her of her discharge. I accept the responsibility for this error may lie with the Orthopaedic Consultant and not the administrative staff who processed the discharge. However, I am satisfied the Orthopaedic Consultant was acting on behalf of 3FiveTwo. Therefore, I do not accept that 3FiveTwo can absolve itself of its responsibility for the error that occurred.

75. The First Principle of Good Administration requires bodies to provide effective services. While I consider it likely this was an isolated error, it remains that the error occurred and it impacted the service 3FiveTwo provided to the patient. I am satisfied this constitutes maladministration and I partly uphold this element of the complaint. I am satisfied 3FiveTwo's failure to provide an effective service caused the patient to experience the injustice of uncertainty and frustration. I acknowledge the patient's concern that this situation may reoccur and impact another patient. However, as I already established, I consider this was an isolated error and given the systems 3FiveTwo now have in place, I am confident that a similar situation would not reoccur.

76. In relation to 3FiveTwo's records of its discharge of the patient, I note its Discharge Process states that when undertaking a tertiary referral, administrators should '*Deactivate the patient on CRM and be sure to add a note explaining that the patient has been tertiary referred and where to'.* I am satisfied that the clinical letter attached to the record acted as this notification. The process also states, '*Confirm that an email has been sent to the trust'*, which ought to document if *'The patient remains active'* or *'The patient is no longer active with 3fivetwo'.* However, the records do not provide evidence that an email confirming the patient's status was sent to the Trust, and 3FiveTwo was unable to confirm if it did so. As the Trust arranged the patient's neurosurgical appointment (that occurred in July 2016), I am satisfied that some form of correspondence was sent to the Trust. However, retaining a copy of the email may have provided some clarity on the matter of the patient's discharge. I would ask 3FiveTwo to ensure it retains all relevant correspondence regarding the discharge process, in accordance with appropriate standards.

CONCLUSION

77. I received a complaint about 3FiveTwo's care and treatment of the patient between 2013 and 2016. The patient raised concerns about 3FiveTwo's failure to diagnose her hip osteoarthritis. She also said it mistakenly discharged her, and failed to action a letter from a Consultant within the Trust. She said the failures led to a delay in her treatment.

78. The investigation established that while the Orthopaedic Consultant did not diagnose the patient's hip osteoarthritis, his care and treatment of her from January 2013 to February 2016, based on her presenting symptoms, was appropriate and in accordance with GMC Guidance. It found that 3FiveTwo failed to appropriately action a letter it received from the Trust regarding the patient's ongoing care and treatment. It identified that this failure caused a delay in the patient's clinical pathway. The investigation found that 3FiveTwo discharged the patient in February 2016. I accept that administrative staff appropriately followed the Orthopaedic Consultant's instruction to discharge the patient. However, the investigation established that an error occurred at some

point in the process that led to either the patient's discharge, or the failure to notify her of her discharge. I consider this led to 3FiveTwo's failure to provide an effective service for the patient.

79. I consider the failures identified caused the patient to experience the injustice of the loss of opportunity of an earlier assessment of her hip, and frustration and uncertainty.

Recommendations

80. I recommend that 3FiveTwo provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016) within **one month** of the date of this report, for the injustice she experienced.

81. I note 3FiveTwo explained it introduced a system to automate the process for sending correspondence to consultants. It said it expects this system to minimise the risk of staff failing to appropriately action incoming correspondence. I welcome this learning. However, I recommend that 3FiveTwo undertake an audit of a random sample of such correspondence it received after it introduced this system, and report if each piece of correspondence was actioned appropriately. 3FiveTwo ought to include any recommendations identified from this process in its update to my office.

MARGARET KELLY
Ombudsman **March 2021**

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.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.