Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust and Spire Healthcare Ltd

NIPSO Reference: 19231

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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.

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EXECUTIVE SUMMARY

I received a complaint regarding the actions of the Belfast Health and Social Care Trust (the Trust). The complaint concerned the care and treatment the complainant received in relation to carpal tunnel decompression surgery, which was carried out on 2 February 2016. The surgery was undertaken by an Independent Sector Provider (ISP), Spire Healthcare Limited (Spire), under a waiting list initiative operated by the Trust. In consideration of the issues raised by the complainant, I exercised my discretion and opened a complaint against Spire.

I accepted the following issues of complaint for investigation:

- **Issue 1: Whether the care and treatment provided to the complainant by the Trust and Spire, in relation to carpal tunnel decompression surgery, was appropriate and reasonable; and**

- **Issue 2: The Trust's and Spire's handling of the complaint.**

My investigation of the complaint identified failures in the care and treatment provided to her in respect of the following matters:

(i) Failure to communicate to the complainant that she was being discharged on 30 April 2016 (Spire);

(ii) Failure to arrange hand therapy at the review appointment on 30 April 2016 (Spire);

(iii) Failure to appropriately inform the complainant of the risks associated with carpal tunnel decompression surgery during the consent process (Spire), and to have regard to her human rights (Spire);

(iv) Failure to review the complainant's earlier decision to consent to the surgery, prior to her treatment commencing (Spire); and

(v) Failure to record a contemporaneous note of the discharge discussion on 30 April 2016 (Spire).

I did not identify any failure in care and treatment in respect of the following:

(vi) The decision to discharge the complainant on 30 April 2016; and

(vii) The outcome of the surgery.

I am satisfied that the failures in care and treatment I identified caused the complainant to experience the injustice of uncertainty, loss of opportunity to be appropriately informed about the risks associated with her surgery, loss of opportunity to reconsider the consent decision she had made previously, and distress as a result of a potential slowing down of her recovery.

My investigation did not identify and maladministration in respect of the Trust's and Spire's handling of the complaint.

I recommended:

(i) The Chief Executive of Spire issue an apology (which accords with NIPSO guidance on apology) to the complainant for the failings I have identified, within **one month** of the date of my final report;

(ii) Spire make a payment of £500 to the complainant by way of solatium for the injustices identified, within **one month** of the date of my final report; and

(iii) Spire clinicians are reminded of the importance of contemporaneous record keeping.

I also recommended that Spire implement an action plan to incorporate my recommendations and that it provide me with an update within **one** month of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

I was pleased to note that both the Trust and Spire confirmed to me their acceptance of my investigation findings and my recommendations. I was also pleased to note that the Trust has shared the learning from its investigation of this complaint with Spire, and with all other Independent Sector Providers.

Having noted my Independent Professional Adviser's (IPA) recommendation that the complainant ought to have a further opinion from a specialist hand surgeon who has

been made fully cognisant of the complexities of the case, I also recorded my expectation that the Trust considers this recommendation and that it informs her of the outcome of that consideration.

THE COMPLAINT

1. The complainant was referred to the Belfast Health and Social Care Trust (the Trust) for carpal tunnel decompression surgery[1] to her right (dominant) wrist in May 2014. Under a waiting list initiative operated by the Trust, she was assessed for the surgery by an Independent Sector Provider (ISP) on 19 December 2015. On 2 February 2016, the complainant underwent surgery at Spire Healthcare's Flyde Coast Hospital, Blackpool, on behalf of Spire Healthcare Limited (hereinafter referred to as Spire).[2] On 30 April 2016, she was reviewed in Belfast by a clinician from Spire, and was subsequently discharged. She complained to me that she ought not to have been discharged on that date, and that she was not made aware that she had been discharged. She further complained that she was dissatisfied with the outcome of her surgery and that she was discharged without having received any post-surgery therapies. Spire is an Independent Healthcare Provider commissioned in this case by the Trust.

2. As part of my consideration of the complaint, I exercised my discretion to open a complaint about the actions of Spire in relation to her care and treatment, pursuant to section 30 of the 2016 Act. I informed Spire of my decision in a letter dated 8 October 2018. I refer Spire to the legislative requirement for signposting under section 25 of the 2016 Act.

Issues of complaint

3. The issues of the complaint, which were accepted for investigation were:

Issue 1: Whether the care and treatment provided to the complainant by the Trust and Spire, in relation to carpal tunnel decompression surgery, was appropriate and reasonable; and

Issue 2: The Trust's and Spire's handling of the complaint.

[1] Minor surgery, during which the carpal ligament (in the underside of the wrist) is divided to relieve the symptoms of carpal tunnel syndrome caused by pressure on the nerve

[2] the complainant's surgery was carried out under a contractual arrangement in place between the Trust and Classic Hospitals Limited on the basis of a Service Level Agreement (SLA) dated 21 December 2012. I have been informed by Spire that on 1 July 2016, the assets and liabilities of Classic Hospitals Limited were transferred to Spire as part of an internal corporate reorganisation.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust and Spire all relevant documentation, together with the Trust's and Spire's comments on the issues the complainant had raised. This documentation included information relating to the Trust's and Spire's handling of this complaint. As part of the investigation, further information was sought from the complainant during a meeting with the Investigating Officer on 16 May 2018.

5. I have referred to the exercise of my discretion to investigate the actions of Spire as the independent provider of care in this instance. I have determined to issue a composite report of the investigation of the complaint in respect of the complainant's care and treatment, in order to provide a clear and complete explanation to all parties to the complaint of the events complained of, and of how I reached my conclusions. I have informed both the Trust and Spire of my determination to issue a composite report. This report will therefore encompass the issues of complaint against both the Trust and Spire, as set out in paragraph 3.

6. A first draft of this report, which included my provisional findings and conclusions, was shared with the complainant, the Trust and Spire, and the individuals named within it, Dr A, Consultant Orthopaedic Surgeon, and Dr B, Consultant Orthopaedic Surgeon. The complainant, the Trust and Spire provided comments to me in response, and I gave careful consideration to each of the matters they raised. Dr A and Dr B both indicated that they did not wish to comment directly to me on the content of the draft report.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from a Consultant Orthopaedic Surgeon

8. The information and advice that has informed my findings and conclusions is included within the body of my report. The IPA has provided me with 'advice'. However, how I have weighed that 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.

10. The general standards are the Ombudsman's Principles[3]:

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

11. The specific standards are those which applied at the time the events complained of occurred, and which governed the exercise of the administrative functions of the Trust and Spire and the professional judgment of the individuals whose actions are the subject of this complaint.

12. The specific standards relevant to this complaint are:

- The General Medical Council's guidance, 'Good medical practice', which came into effect on 22 April 2013 (hereafter referred to as 'the GMC Guidance 2013')
- The General Medical Council's guidance, 'Consent: patients and doctors making decisions together', which came into effect on 2 June 2008 ('the GMC Consent Guidance 2008')
- Spire's 'Consent to Investigation or treatment' document, issued in January 2016 ('the Spire Consent Document').

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

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

INVESTIGATION

Issue 1: Whether the care and treatment provided to the complainant by the Trust, in relation to carpal tunnel decompression, was appropriate and reasonable.

14. The complainant complained about a number of aspects of the clinical care and treatment she received. She complained that:
(i) she ought not to have been discharged on 30 April 2016, and that she was not made aware that she had been discharged by Spire;
(ii) she ought not to have been discharged without having received any post-surgery therapies; and
(iii) she was dissatisfied with the outcome of the surgery provided by Spire, contending that it had not been performed correctly.

(i) Discharge on 30 April 2016

15. The complainant stated that she ought not to have been discharged on 30 April 2016 and that she was not made aware that she had been discharged.

Evidence Considered

16. The complainant was discharged on 30 April 2016 by Spire's Consultant Orthopaedic Surgeon, Dr A. I have considered the GMC Guidance 2013, in particular standard 32, which states *'you must give patients the information they want or need to know in a way they can understand'.* I have also considered standard 19, which states *'documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'*

17. I have also considered the service level agreement (SLA) between the Trust and Spire in relation to the issues raised in the complainant's complaint. I refer to schedule 4 of the SLA, which outlines the service requirements expected of Spire. I note the following relevant extract:

'5.0 DISCHARGE OBLIGATIONS

5.1 Classic Hospitals Ltd shall avoid discharges of Patients which would not be in accordance with Good Clinical and Good Healthcare Practice…and will use all reasonable endeavours to avoid circumstances and discharges likely to or leading to emergency re-admissions.

5.2 Classic Hospitals Ltd shall adhere to discharge protocols agreed with all external, interested organisations…

5.3 Prior to discharge, each Patient shall be examined by an appropriately qualified member of clinical staff to ensure the Patient meets the discharge criteria. The results of such examination shall be documented and, if considered fit to be discharged, the Patient…shall be discharged.

5.4 Prior to discharge, Classic Hospitals Ltd shall:

5.4.1 Provide a copy of the Patient discharge letter to:

5.4.1.1 the Patient…'

18. I note, from the complainant's clinical notes and records, a letter dated 30 April 2016 on headed paper from Spire Flyde Coast Hospital from Dr A who reviewed the complainant on that date. The letter is addressed to the complainant's GP and copied to Dr B, the Consultant Orthopaedic Surgeon who carried out the complainant's surgery. The letter records that the complainant is disappointed following the results of her surgery for right carpal tunnel release. Dr A sates in his letter, *'…I had a long consultation with her today when it was clearly explained that she is in no better a situation today with regards to her wrist pain and seems to be in significant discomfort with restriction of movements of her wrist and in fact swelling of her fingers of middle and ring finger of her hand. I have had a long discussion with her and she had suggested to me that she would go the legal way trying to find out the reasons behind the complications which have developed which have affected her daily life. I have discharged her from this but will be copying this letter regarding her to Dr B so that he is aware of the situation…'*

19. As part of the investigation enquiries, the Trust provided a copy of letter dated 3 April 2017 that Dr A had sent to Spire's Hospital Director. Dr A had corresponded with the Hospital Director, responding to her enquiries about the circumstances of

the complainant's discharge on 30 April 2016. In his letter to the Hospital Director, Dr A wrote,

*'**Q2) [the complainant] was not copied into the OP clinic letter and was unaware she had been discharged from Spire's care. Was that explained to her during the consultation?***

I recollect [the complainant] mention that having had this bad experience she would be unwilling to attend a hospital that was outside Belfast in future. I discharged her to the care of her GP and copied the letter to Dr B the operating surgeon so that he was aware.'

20. The Trust was also asked to provide a copy of the discharge criteria referred to in section 5.3 of the SLA. The Trust responded, '*the Contracts Department advise that this section of the contract refers to "Prior to discharge each patient shall be examined by an appropriately qualified member of clinical staff to ensure the patient meets the discharge criteria the results of such examination shall be documented and if considered fit to be discharged the patient shall be provided with a signed discharge order and shall be discharged".'*

21. The IPA referred to the record of the review on 30 April 2016, which is the letter of that same date from Dr A to the complainant's GP (as referred to in paragraph 17). The IPA advised, *'The letter indicates that the history was taken and the hand was examined. It records the presence of significant discomfort with restriction of movements and swelling, affecting* [the complainant's] *daily life.'*

22. The IPA further advised, *'The history and clinical examination findings recorded correlate with the subsequent records from Musgrave Park Hospital* [MPH]. *I do consider them to have been appropriate and reasonable…the record is clear, documents the problems and clinical findings. It is appropriate.'*

23. Advice was also sought from the IPA in relation to the clinician who had carried out the review on 30 April 2016. The IPA advised, '*Dr A is…an appropriate person to undertake the review. Within the NHS it is entirely normal for someone other than the operating surgeon to review a patient and consider the need for ongoing*

treatment or discharge.'

24. The IPA was asked to provide advice as to whether it was appropriate for the complainant to have been discharged at the time of the review. The IPA advised *'…there was no evidence of a specific complication that would require further surgical intervention…discharge from the care of the Spire Hospital on that date was therefore reasonable. In my opinion the purpose of a review appointment undertaken following surgery is not only to confirm the successful outcome of the operation, and to deal with any specific complications, but also to consider the possible need for further or ongoing care. It is in this area that the consultation may be considered to be inadequate. It is clear from the letter that [the complainant] was significantly compromised by the pain, swelling and stiffness that occurred after the operation…The correct management for [the complainant] therefore at that stage would have been to arrange for such therapy and ongoing supervision. Clearly the treatment could not be provided in Blackpool, but a recommendation for ongoing treatment in Northern Ireland, either arranged by her General Practitioner or via Musgrave Park Hospital would in my opinion have been appropriate…'*

25. The IPA was also asked about the communication of the discharge to the complainant. The IPA advised *'The letter following the clinic of 30 April 2016 is quite clear that Dr A had "a long consultation with her" and that "I have discharged her"…the letter is quite clear about discharge. Although not explicitly stated that she was told that she was discharged, the implication (reflecting common practice), is clear that [the complainant] was informed on 30 April 2016, at the time of the consultation, that she was discharged and there would be no further follow-up at the hospital.'*

26. In response to investigation enquiries about this issue of complaint, Spire advised that following a meeting between the Trust's Orthopaedic Clinical Director and the complainant, it had been asked a number of questions about the review appointment on 20 April 2016. Spire also responded that the Trust's questions had been passed on to Dr A for his comments, and that he had responded to those questions in his letter of 3 April 2017 to Spire's Hospital Director (as referred to in paragraph 17). .

Analysis and Findings

27. The clinical records evidence that a review appointment with Dr A took place on 30 April 2016. There is no contemporaneous clinical record of the discussions between Dr A and the complainant. The discharge letter records only the outcome of their discussion. The letter, which was sent to the complainant's GP indicates that the consultation was protracted and that the complainant was discharged on that date. However, I consider the record of the consultation to be brief and lacking in detail.

28. The Trust did not provide details of the discharge criteria referred to in its SLA with Spire. I have carefully considered the IPA's advice regarding this issue of complaint and his view on whether the complainant's discharge on 30 April 2016 was reasonable. I have concluded that it was appropriate that the complainant was discharged from the service of Spire on that date[4]. I do not therefore uphold this element of the complainant's complaint. However, the failure to separately record the discharge discussion does not meet the standards required by the GMC Guidance 2013. Consequently, I conclude this is a failure in the care and treatment provided to the complainant.

29. The lack of a contemporaneous clinical record is significant in this case because the complainant is clear in her assertion that she was unaware she had been discharged until she had sight of the letter dated 30 April 2016 that Dr A sent to her GP. The complainant has stated that she did not have sight of this letter until some weeks later, and that she was not provided with a copy of a signed discharge order or the discharge letter, contrary to the requirements of the SLA.

30. Given the lack of contemporaneous records, I am not satisfied, on the basis of the available evidence, that the complainant was informed on 30 April 2016 that she was being discharged. I note the IPA's advice regarding the implication he has drawn from the records. However, in the absence of documentary evidence within the record of the communication of that information to the complainant, I am unable to conclude that she was informed that she was discharged. I refer to Standard 32 of the GMC Guidance 2013, which requires clinicians to communicate information

[4] Whether the complainant ought to have been referred for further therapy will be considered at a later point in this report

patients 'need to know'. I do not consider this standard was met in this case. As communication of the discharge is inherently connected to the care and treatment received, I find that the failure to communicate the decision to discharge to the complainant is a failure in the care and treatment provided to the complainant.

(ii) Lack of post-surgery therapies

31. The complainant also complained that she ought to have been referred for post-surgery therapies following her review appointment on 30 April 2016.

Evidence Considered

32. I have considered the SLA in place between Spire and the Trust. Schedule 1 of the SLA lists the *'Specialties/Procedures involved'* as *'New Orthopaedic Outpatient Appointment and treatment consequences'*. Schedule 2 of the SLA (page 67) outlines the fees payable to the ISP for *'Post-operative rehabilitation / Conservative Management'* and *'Physiotherapy attendance'* is listed. Under the service '*Occupational Therapy Attendance'*, the SLA states, *'Onward referral to local community services'.*

33. I also note that Appendix 4 of the SLA lists the actions that are the responsibility of the Trust and the actions that are the responsibility of the ISP. I note that under the heading, *'Treatment Consequence'*, *'Outpatient physiotherapy'* and *'Home visit occupational therapy'* are listed as being the responsibility of the ISP. Further, under the heading *'Post operative care'*, all actions, including *'Other postoperative arrangements'* are listed as being the responsibility of the ISP.

34. I also considered the GMC Guidance 2013 in relation to this aspect of the complainant's complaint, in particular standard 15, which states,
'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
…
b *Promptly provide or arrange suitable advice, investigations or treatment where necessary*
c *Refer a patient to another practitioner when this serves the patient's needs…'*

35. In response to investigation enquiries, the Trust stated *'[the complainant] was post-operatively reviewed by Spire Healthcare on 30 April 2016 at Musgrave Park Hospital. No post-operative therapies were organised and [the complainant] was discharged.'*

36. The Trust further advised that in response to an MLA enquiry it received on 31 May 2016 about the complainant's dissatisfaction with the care and treatment she had received, it *'arranged an appointment with Dr C at Musgrave Park* [Hospital] *on 27 June 2016'.* The Trust stated, '*The purpose of this appointment was for assessment by Dr C and to see if any further support could be given to [the complainant] to alleviate her symptoms or improve her reported pain. At this appointment Dr C organised hand therapy to compliment ongoing Physiotherapy.'*

37. The letter forwarded by Dr A to the Hospital Director on 3 April 2017 also references this issue of the complainant's complaint:
'Q1) The Clinic letter indicates [the complainant] still had residual pain and discomfort – why were no further treatments prescribed or offered such as referral to physiotherapy?
I recollect seeing [the complainant] on 30th April 2016 at the review clinic about 12 weeks after routine carpal tunnel surgery. [The complainant] stated she had sought the services of an accredited private physiotherapist in view of the delay in NHS Physiotherapy. In view of [the complainant]'s persistent swelling, residual pain and discomfort in her right wrist, options of further management like scar sensitization and revision surgery were discussed. I did suggest any further revision surgery would need to be performed by a dedicated upper limb specialist.'

38. As part of my consideration of the complaint about the lack of post-operative therapies, I reviewed the discharge letter dated 30 April 2016, referred to previously in this report.

39. I also note within the complainant's clinical records, a note of Dr C's assessment of the complainant on 27 June 2016 at MPH. The following extract of the record is relevant to this aspect of the complaint:

'I have explained to [[the complainant]] and her husband that I am unable to comment on the aspects of the surgery as I don't have any clinical notes and wasn't involved however, some of the symptoms she has would be expected as part of the normal post operative course. She has less wrist extension than would normally be expected although I am unsure exactly how much wrist extension she had prior to the surgery…this lady would benefit from hand therapy…'

40. I refer to the IPA's advice on the issue of post-operative therapies. The note of the complainant's appointment with Dr C on 27 June 2016 records that she would benefit from hand therapy. The IPA stated *'hand therapy is treatment provided either by an Occupational Therapist or a Physiotherapist who has specialised in the care of patients with conditions of the hand'*. The IPA also advised *'Hand therapy is not required for the majority of patients who undergo carpal tunnel surgery. If however on review there are problems with pain welling and stiffness hand therapy may well be indicated.'*

41. The IPA reviewed the complainant's clinical records and advised *'[[the complainant]] was referred for hand therapy by Dr C on 27 June 2016 at Musgrave Park Hospital'*. The IPA advised this action was appropriate and reasonable.

42. The IPA was also asked to advise on the effects of not having post-operative hand therapy earlier. The IPA advised, *'The purpose of hand therapy when a patient has a slow recovery following hand surgery is to speed the recovery and ensure an optimum outcome in the long term. It is certain that the hand therapy speeds the recovery, it is less certain that the long term final outcome is always significantly influenced…I consider that arrangements for hand therapy should have been put in place/recommended when [the complainant] was reviewed on 30 April 2016. The arrangements were made on 27 June 2016. This delayed the treatment that she should have received by less than two months. I do not consider that a delay of this nature in arranging appropriate treatment will have any effect on the long-term outcome…it may have resulted in a slowing down of her recovery.'*

43. In response to investigation enquiries, Spire referred to a letter sent by the operating

Consultant Orthopaedic Surgeon, Dr B, to Spire on 6 June 2018, in response to my sharing of the advice I had received from the IPA. I note the following relevant extract of Dr B's letter:

'…rather than reassuring [the complainant] and indeed referring her for therapy he discharged her, which lost the opportunity for [the complainant]'s symptoms to be addressed and potentially improved at an earlier stage…The surgery was undertaken proficiently and to a high standard and follow up was organised but it would appear the opportunities to address her post-operative complaints was not pursued perhaps as well as they could have been.'

Analysis and Findings

44. The IPA's advice on this element of the complainant's complaint was that he considers that arrangements for hand therapy ought to have been put in place when the complainant was reviewed by Dr A on 30 April 2016. I accept this advice from the IPA and I note his view that the purpose of hand therapy is to *'speed recovery and ensure an optimum outcome in the long term'.*

45. The complainant was referred for hand therapy on 27 June 2016, when she was assessed by Dr C. The IPA provided advice as to the effect of the delay in the complainant receiving hand therapy. He advised that he does not consider a delay of this nature will have any effect on the complainant's long term outcome. However, the IPA also advised that the lack of hand therapy '*may have resulted in a slowing down of her recovery'*.

46. I take into account standard 15 of the GMC Guidance 2013, and conclude that the complainant ought to have been referred for hand therapy at the review appointment which took place on 30 April 2016.

47. Having concluded that hand therapy ought to have been offered to the complainant to assist in her recovery, I have considered the matter of which body had responsibility to organise that therapy. I have carefully considered the provisions within the SLA in place between the Trust and the Spire. I conclude that it was the responsibility of the Spire to refer or make arrangements for hand therapy for the

complainant. I consider the failure to do so was contrary to standard 15 of the GMC Guidance 2013. This omission constitutes a failure in care and treatment.

48. I note the IPA's advice that this failure may have resulted in a slowing down of the complainant's recovery. I consider that as a result of the failure outlined above, the complainant sustained the injustice of uncertainty regarding her treatment and upset as a result of a potential slowing down of her recovery.

(iii) Outcome of surgery

49. The complainant remains unhappy with the outcome of the surgery undertaken by Spire.

Evidence Considered

50. I considered the GMC Consent Guidance 2008, noting the following relevant extracts:

*'…**28** Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.*

***29** In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:*
***a** side effects*
***b** complications*
***c** failure of an intervention to achieve the desired aim…'*

*'…**52** Before beginning treatment, you or a member of the healthcare team should check that the patient still wants to go ahead; and you must respond to any new or repeated concerns or questions they raise. This is particularly important if:*
***a** significant time has passed since the initial decision was made*

b *there have been material changes in the patient's condition, or in any aspect of the proposed investigation or treatment*

c *new information has become available, for example about the risks of treatment or about other treatment options…'*

51. The giving of consent to surgical procedures is an important aspect of a patient's right to autonomy and to participate in decision making that affects their quality of life. I also considered the Spire Consent Document, noting the following relevant extracts:

'2.0 The meaning of consent

…valid consent must be obtained before starting treatment…'

'5.0 Provision of information

The provision of information is central to the consent process. Patients should be advised of any material, or significant risks even if small, of the proposed treatment, any alternatives to it and the risks of doing nothing. Health professionals should provide information regarding all possible significant adverse outcomes and document the information provided… as a general rule, to avoid any issues, write down/note everything that was and has been discussed with the patient…

6.2 Two or more stage process

In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion…the consent process will therefore have at least two stages:

1. The provision of information, discussion of options and initial (oral) discussion,

2. Confirmation immediately prior to the treatment that the patient still wants to go ahead.

The consent form should be used as a means of documenting the information stages(s), as well as the confirmation stage…'

52. In response to investigation enquiries, the Trust stated that it *'apologise* [sic] *sincerely that the outcome of [the complainant]'s surgery was not in keeping with her expectations.* [The Trust's Clinical Director of Orthopaedics] *explained to [the*

complainant] at the meeting [on 7 March 2017] *that 5% of all Carpel* [sic.] *Tunnel surgeries are unsuccessful and that her symptoms were surrounding the ulnar nerve, and not the median nerve, which is the nerve operated on during the carpel* [sic] *tunnel procedure*. [The Clinical Director of Orthopaedics] *suggested that the pins and needles she was experiencing in her hand were more likely related to her underlying neuropathy condition as opposed to the surgery. [The complainant] has been reviewed by two further Consultant Orthopaedic Surgeons who specialise in hand surgery at Musgrave Park Hospital. Neither feel further surgery or orthopaedic treatment will be of benefit to [[the complainant]] but are willing to see [her] again.'*

53. I note that the complainant's clinical records contain a form entitled 'Patient agreement to investigation or treatment', which has been signed by the operating Consultant Orthopaedic Surgeon, Dr B, and dated 19 December 2015. I note the complainant signed section 5 of this form. However, her signature is not dated.

54. In response to investigation enquiries to Spire, I was provided with a letter dated 19 December 2015 Dr B sent to the complainant's GP, following his (Dr B's) review of the complainant in clinic that day. I note the following relevant extract of Dr B's letter:
'[The complainant] is unfortunately still troubled with paraesthesia[5] in the median nerve distribution in her right hand…there is no doubt that two separate nerve conduction studies have confirmed right carpal tunnel syndrome. I have explained to [[the complainant]] that decompression of her right carpal tunnel will to some degree ease some of her symptoms but probably not all of her symptoms and this she does accept…'

55. The clinical records contain a record of the complainant's surgery dated 2 February 2016. I have examined these records.

56. The complainant met with Trust staff on 7 March 2017 in relation to her complaint. The following extract of the minutes of the meeting is relevant to this issue of the complaint:

[5] An abnormal sensation, usually tingling or pricking

'[Trust's Clinical Director of Orthopaedics] *referred to the carpal tunnel release procedure. He explained that given what [[the complainant]] had explained about her symptoms following surgery, these symptoms related to the ulnar nerve and not the median nerve which is the nerve operated on during the carpal tunnel procedure…'*

57. I sought independent clinical advice on this issue of the complaint. The IPA was asked about the risks involved in carpal tunnel decompression surgery (CTD). The IPA advised that *'the only significant specific risk of the operation is median nerve injury'*. However, the IPA advised this is '*very rare'*. The IPA further advised that *'all relevant risks associated with the procedure are the general risks applicable to any operation'.*

58. The IPA was asked if there was evidence within the clinical records of the complainant having been informed of the risks of the procedure. The IPA advised that there is a record on 12 May 2014 made by the Trust's Consultant Orthopaedic Surgeon, Dr C, which stated *'I have explained the operation to her today including rest'.* The IPA also pointed out that the consent form dated 19 December 2015 (as referred to in paragraph 53) *'records the risks as "ongoing symptoms" (handwritten) and "DVT, PE, infection, ongoing pain, limited movement, nerve and vessel damage, revision" (typed, clearly a stamp).'* The IPA advised*, 'It is acceptable/normal practice for consent forms to be signed in advance of the date of surgery. The consent was taken two months before the surgery approximately. On the reverse of the consent form there is a section for completion by the surgeon on the day of the operation when the consent has been signed in advance. This section was not completed.'*

59. The IPA also advised that Dr B was *'an appropriate and suitable person to take the consent'.*

60. The IPA referred to the GMC Consent Guidance 2008 and advised *'the consent form does contain written evidence that [the complainant] was advised of the potential adverse consequences of the operation about which she is complaining – "ongoing symptoms…ongoing pain , limited movement"… of note however to my*

mind, is the stamped list of complications which includes "DVT, PE". These risks are also repeated in the complaint response. It is my opinion that there is no risk of DVT (deep vein thrombosis) or PE (pulmonary embolus) as a consequence of carpal tunnel decompression performed under local anaesthetic…she appears to have been told of serious potential complications which might well have caused her to decide not to have the operation, had they actually existed.'

61. The IPA further advised *'in my opinion it is probably that Dr B uses this stamp as part of his standard consenting process. With respect of major orthopaedic surgery, particularly in joint replacements, discussion of the risks of pulmonary embolus and deep venous thrombosis is appropriate and necessary. In upper limb surgery if there are no associated risk factors (as in this case) even under a general anaesthetic, a carpal tunnel operation would not be considered to have a significant risk of such a complication…therefore whilst in principle the consequences of the operation about which she is complaining were recorded preoperatively, it is my opinion on the balance of probabilities that they were not adequately explained to her to make her understand and be fully aware of this potential outcome, contravening the GMC advice.'*

62. The IPA was asked for advice in relation to the clinical record made of the CTD surgery. The IPA advised that there is an operation note and that *'…this appears to me to be a standard, typical operation note of carpal tunnel decompression, in my opinion it is adequate…there is nothing untoward in the medical records indicating that something went wrong at the time of surgery that might specifically have caused the adverse outcome.'*

63. The Trust was given an opportunity to comment on the IPA advice that was obtained for the purpose of the investigation. The Trust shared the IPA advice with its Consultant Neurologist who stated, *'It would appear clear from reading the report from the independent professional advisor to the ombudsman that they have not been made fully familiar with the complexities of this woman's case. From a neurological perspective she is felt to have a paraproteinaemic neuropathy[6] likely*

[6] A disorder of the peripheral nervous system

complicating a small low grade non-Hodgkin's lymphoma with bone marrow infiltration…' The Consultant Neurologist advised that he had first seen the complainant in November 2015 '*when she reported that for the last number of years she had a problem with all four limbs.'* He further advised that *'… neurological testing did not reveal any features in keeping with carpal tunnel syndrome. This has repeatedly been the case on neurological testing. In addition to being seen in Belfast she has been assessed by a colleague… at King's College London who would be considered an international expert…For your information her nerve conduction studies were repeated when she was at King's College London these being done on 31st January 2017.* [The King's College Hospital Consultant Neurologist] *commented that the repeat studies were virtually normal except for findings consistent with right sided carpal tunnel syndrome with in addition dysfunction of the right peroneal*[7] *and right ulnar nerves.'* The Trust's Consultant Neurologist also stated, *'In summary while this woman has been shown to have clear electrophysical evidence for right sided carpal tunnel syndrome her clinical presentation has never really been consistent with this with any neuropathic symptoms that she complains of seeming to fall within a much more widespread disorder…In fact* [The King's College Hospital Consultant Neurologist] *recorded that he was not certain whether or not she had truly ever had a compressive carpal tunnel syndrome or if instead her symptoms were in keeping with a non-compressive median neuropathy. He also commented that it might be worthwhile considering ultra sound scan of her right wrist to see if the nerve had been satisfactorily decompressed.'*

64. As part of the investigation, the Trust's comments in response to the IPA's advice were forwarded to the IPA, and he was asked to provide additional advice in relation to those comments. The IPA referred to a letter dated 7 February 2017 from the King's College Hospital Consultant Neurologist to the complainant's GP. The IPA advised, *'Whilst* [the King's College Hospital Consultant Neurologist] *was uncertain whether the symptoms are arising from carpal tunnel syndrome, the fact that he recommended an ultrasound scan to ensure that the nerve had become decompressed implies that were it to be positive, he would accept that there is*

[7] A branch of sciatic nerve

ongoing median nerve compression. The further implication of this is that he might well then consider repeat treatment for carpal tunnel syndrome worthwhile, despite the uncertainty whether the symptoms that she is, and has been experiencing are due to the underlying neuropathy or secondary to carpal tunnel syndrome.'

65. The IPA referred to guidance in relation to the assessment of carpal tunnel syndrome using ultrasonography, stating, *'… whilst a positive ultrasound would support the diagnosis of ongoing carpal tunnel decompression, a negative study would not rule it out.'* The IPA further advised *'…in my experience of carpal tunnel syndrome, the symptoms can be atypical, and confirmatory clinical signs can be absent. Once again the absence of these features does not rule out the diagnosis. The position consequently is that [the complainant] may have ongoing carpal tunnel compression from which she may be significantly symptomatic…'*

66. As part of the investigation enquiries, Spire was also given an opportunity to comment on the IPA advice I obtained. In response, Spire advised that the IPA's advice had been shared with Dr A and Dr B. Spire further advised that while Dr A had no comments to offer, the operating Consultant Orthopaedic Surgeon Dr B's comments were as set out in his letter dated 6 June 2018 (as referred to in paragraph 42). In his letter, Dr B stated, *'in my letter of 19th December 2015* [to the complainant's GP] *I expressed to [[the complainant]] that decompression of her right carpal tunnel may ease some of her symptoms but probably not all of her symptoms and that she did accept.'*

67. In relation to the specific issue of consent, Dr B stated '[the complainant] *was also warned of the risk of DVT and pulmonary embolis* [sic.] *The* [IPA] *feels, despite there being no official guidelines in the latter regard, that proposing DVT and pulmonary embolus as consequences of carpal tunnel syndrome implies that the consent process and discussion of the risks associated with the operation were not explained to [the complainant]. With this opinion I would disagree. I am aware of upper limb cases which have resulted in the above complication hence my wish to explain those risks to patients. The* [IPA] *states there are no risk* [sic] *of such complications in carpal tunnel surgery and I would respectfully disagree but I accept*

they are rare and I was simply being comprehensive in my informed consent. The reason a stamp is used to list the potential risks is so the type is clearly legible and indeed most of the consent form is also of a typed nature, surely one would not be expected to write out a full consent form by hand.'

68. Dr B also stated in his letter of 6 June 2018, *'I do not think a significant time (8 weeks) had passed since the initial consent was obtained but on reflection, whilst confirmatory verbal consent was again received on the day of surgery, further signed confirmation of the consent by me on the rear of the consent form would not have been unreasonable…When the* [IPA] *carefully reviews the letter of 19th December 2015 and the stamp outlining the possible complications it will be seen that it explains the risks of DVT, pulmonary embolus, infection, ongoing pain, nerve and vessel damage and limited movement but the possibility of non-union has actually been erased. This would suggest to me that I was indeed carefully thinking about the risks that could be associated with the said surgery and in addition the hopeful gains of diminished pain and diminished paraesthesiae[8] are also noted along with the risk of ongoing symptoms. This to me is suggestive the consent form was indeed informed and considered and not cursory.'*

69. The IPA was provided with Dr B's comments and was asked to advise further on the issues raised by them. The IPA stated *'Whilst pulmonary embolus might occasionally occur after major upper limb surgery, I remain of the opinion that pulmonary embolus and deep venous thrombosis are not potential complications of brief upper limb procedures carried out under local anaesthetic. This applies to carpal tunnel surgery. An automatic collar of the risk of having a pulmonary embolus is that there is also a risk of death…if however the burden is on "the balance of probability" then my opinion remains unchanged.'*

70. Subsequently, the Investigating Officer was provided with Dr B's letter of 19 December 2015 to the complainant's GP, and to which he had referred in his comments on the IPA's earlier advice. The IPA was asked to review this correspondence and state whether it changed his previous advice in any way. The

[8] Abnormal sensation in the skin

IPA stated, *'The letter that has been newly provided is indeed a letter from Dr B, to [[the complainant]'s] General Practitioner, written on the day of the consenting – the absence of which letter I comment on as recorded above and which largely lead to the conclusions that I reached. The content of this letter indicates to me that the process was very different from that indicated by the documentation previously available (the consent form). In the letter Dr B clearly records that not only did he take the history, but he examined her, he reviewed the previous notes adequately, was aware of the previous neurological opinion and background, and the presence of neurophysiological studies. There is also a clear statement that "I have explained to [[the complainant]] that decompression of the right carpal tunnel will to some degree ease some of the symptoms but probably not all of the symptoms and this she does accept". In light of this further information about a very much more thorough process of assessment than indicated in the previously available paperwork, I must now revise my opinion regarding the consenting process. Whilst the issue regarding the possibility of a pulmonary embolus remains outstanding, this in itself is not an indicator of a fundamentally flawed process in light of the new evidence provided. The new information clearly indicates that Dr B considered the case carefully, discussed it with [the complainant], and explained that she was likely to have ongoing symptoms after the operation.'* The IPA concluded *'I now conclude that the consenting process was adequate, and that [the complainant] was appropriately counselled regarding the process, and potential benefits and consequences of the operation.'*

71. Finally, advice was sought from the IPA regarding the comments made by the Trust's Clinical Director of Orthopaedics at the meeting with the complainant on 7 March 2017, as part of the Trust's handling of her complaint. The IPA advised *'I cannot find any reference to the ulna nerve symptoms in the clinical notes. I am unaware of where this opinion has originated from, and on that basis do not consider that the comment is reasonable'*.

72. As part of the investigation, the Investigating Officer met with the complainant and posed a number of questions regarding her recollection of events. The complainant stated that she clearly recalled the consultation with Dr B on 19 December 2015

during which she signed the consent form. She considered that the consultation was very brief at that meeting. The Investigating Officer referred to the consent form, and in particular the risks inserted with a stamp. The complainant stated that '*none of those were explained to me'*. I comment on this issue below.

Analysis and Findings

73. The complainant raised concern about the outcome of her CTD surgery and that the symptoms that she had experienced prior to the surgery were exacerbated following it. The investigation of this issue of complaint included consideration of information given to the complainant (prior to the surgery) about what the outcome would be. Also, the investigation enquiries extended to consideration of whether there is available evidence to suggest that the outcome of the surgery is not as anticipated.

74. I have carefully considered the complainant's clinical records and the Trust's and Spire's responses to investigation enquiries in relation to this issue of complaint. I note that the Trust stated that 5% of all such procedures are unsuccessful. However, the Trust also stated that it does not consider her ongoing problems are related to her continuing to suffer from carpal tunnel syndrome. In an advice leaflet provided by the IPA, a figure of 10% for failed CTD surgery is noted.

75. I accept the advice of the IPA that the record of the surgery notes *'nothing untoward'.* However, I note the issues raised by the Trust in relation to the complainant's neuropathy condition. I also note the Trust now considers that her ongoing symptoms are not consistent with carpal tunnel syndrome. However, I accept the advice of the IPA that in his experience, symptoms of carpal tunnel syndrome can be atypical in nature.

76. The Trust has stated that following the complainant's review at King's College Hospital, London, it is unclear if she suffered from carpal tunnel syndrome in the first instance. Given that the diagnosis was made by the Trust's consultant orthopaedic surgeon and events occurring since that diagnosis, my findings are based on the IPA's conclusion that she was suffering from carpal tunnel syndrome.

77. I accept the advice of the IPA that the complainant may be continuing to suffer from carpal tunnel syndrome, meaning that the surgery was unsuccessful. However, I am unable to reach a conclusion on her diagnosis. As such, I cannot make a finding in relation to this element of the complaint. However, I note that the IPA included in his advice[9] a recommendation that the complainant should have a further opinion from a specialist hand surgeon. I have commented further on this recommendation in the conclusion section of this report.

78. As I have already recorded, the investigation of this issue of the complaint considered the information provided to the complainant when she gave her consent to the CTD surgery. I have examined the clinical record of the consent process, as documented in the consent form dated 19 December 2015 and the letter Dr B sent to her GP on the same date. I note the risks that are recorded as having been explained to her during the consent discussion.

79. I note the advice of the IPA that the only significant specific risk is that of median nerve injury. There is no evidence that this risk was outlined or explained to the complainant, as it ought to have been. Further, IPA advised that other risks such as DVT and PE were outlined to the complainant when these risks were irrelevant to the CTD surgery.

80. I have carefully considered the response from Dr B that was submitted by Spire in response to its consideration of the IPA advice. I note that Dr B stated his view that DVT and PE are risks of CTD surgery and that he does not accept the IPA's advice that the inclusion of such risks indicates the consent form was 'informed and considered'. I also note that having considered Dr B's letter dated 19 December 2015 to the complainant's GP, the IPA's advice was that consent was reasonably obtained. However, Dr B's statement that PE was a risk for her remains an outstanding issue. I have also taken account of the GMC Consent Guidance 2008. The lack of a record indicating that the specific risk of median nerve injury was explained to the complainant, together with the inclusion of irrelevant risks in the discussion, is contrary to the GMC requirements. The consent is therefore

[9] IPA's further advice (1) dated 31 July 2018

inadequate. I consider this constitutes a failure in the care and treatment that was provided to her.

81. The IPA also provided advice in relation to the consent form which was completed on 19 December 2015, two months prior to the procedure. I note that section 6, to be completed on admission for the procedure, is incomplete. I have taken account of Spire's response to this issue, in particular the view of Dr B, who accepts that completion of section 6 'would not have been unreasonable'.

82. I consider the failure to complete the consent form in its entirety to be of concern, particularly in light of the content of Spire's Consent Document and paragraph 52 of the GMC Consent Guidance 2008. There is no evidence that the consent decision was reviewed by Dr B, who carried out the CTD surgery. I consider the failure to review the decision is a failure in the care and treatment provided to the complainant.

83. The issue of participation in the context of decision making surrounding consent to a procedure raises human rights issues. The failure of Spire to take appropriate steps in relation to the obtaining of consent from the complainant had an impact on her ability to participate in a decision which affected her. The participation principle is a fundamental part of human rights based approach. I find that the failure by Spire to ensure the complainant's participation in the consent decision does not meet the First Principle of Good Administration because the clinician who made that decision failed to take account of the complainant's rights in this regard.

84. I consider that as a result of the failures I have outlined above, the complainant sustained the injustice of loss of opportunity to be appropriately informed about the risks associated with her surgery, and a loss of opportunity to reconsider the consent decision she had previously made.

85. Finally, I note the advice of the IPA regarding the assertion made by the Trust's Clinical Director of Orthopaedics at the complaints meeting. I conclude that the statement made had no factual basis and that it had the effect of misleading the complainant as to her treatment. I am critical of the Trust for making this comment to the complainant during its meeting with her.

Issue 2: The Trust's and Spire's handling of the complaint

86. My initial consideration of the complaint led to my investigation of a further issue, namely, how the Trust and Spire handled the complaints she had submitted previously to them. The complainant submitted a written complaint dated 30 April 2016 to Spire following her review appointment with Dr A. On 11 May 2016, she sent a copy of her complaint (to Spire) to the Trust, advising that Spire had acknowledged receipt of her complaint.

Evidence Considered

87. As part of the investigation of this issue of complaint, I considered the SLA in place between the Trust and the ISP at the time of the complainant's care and treatment. In particular, I note the following relevant extracts:

'25 Complaints

…25.3 Classic Hospitals Ltd shall inform HPSS patients that they are entitled to use the BHSCT's complaints procedure, and shall make details of the BHSCT's complaints procedure and any advocacy services available to HPSS patients on request.

25.4 On receiving any oral or written complaint from or on behalf of an HPSS patient, Classic Hospitals Ltd shall ask the person making the complaint whether that person wishes his/her complaint to be handled by Classic Hospitals Ltd under the BHSCT's complaint procedure and shall explain to that person that their decision in no way affect their rights…'

88. I also note Schedule 6 of the SLA, which is entitled 'Complaints Process'

'INDEPENDENT SECTOR PROVIDERS

On occasions the BHSC Trust may make use of independent sector providers (ISPs) to provide services for patients/clients. This form of treatment and/or care is sub-contracted to the ISP and funded by the respective HSC organisation…the Trust must ensure, and be assured, that contracted ISPs have appropriate in-house arrangements in place for effective complaints handling, management and monitoring of all complaints….

Receipt, Investigation and Responding to Complaints

Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust.

Receipt by the ISP

Should the ISP receive the complaint directly, the general principle would be that the ISP respond directly to [the complainant].

The ISP on receipt of a complaint should forward a copy to the Trusts Complaints Department…the ISP should acknowledge the complaint within two working days, investigate and respond within 20 working days. Should the ISP be unable to meet the specified targets they should send a holding letter and copy to Trust…on completion of final response this should be issued directly to [the complainant] and copied to the Trust.

Should [the complainant] remain dissatisfied they can then approach the Trust's complaints department who will arrange for review of the complaint. It would be the Trust's expectation that any recommendations made as a result of the review should be implemented.

Complaints received by the Trust

Should the Trust received the complaint directly it will be logged onto Datix[10], acknowledged by the Trust and [the complainant] advised that their complaint has been forward [sic] to the ISP for investigation and a response. [The complainant] will also be advised that they should they remain dissatisfied at any time during the process they should make direct contact with the Trusts complaints Department who will then review the complaint as stated above.

The ISP will then copy the Trust into the final response. Should [the complainant] remain dissatisfied they can then approach the Trust's Complaints Department who will then arrange for a review of the complaint…on the Trust's final response [the complainant] will be informed of their right to refer their complaint to the Ombudsman.'

[10] Trust's computer software

89. I have also considered the following relevant extracts from the HSC Complaints Procedure which came into effect on 1 April 2009:
*‘**2.33** Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to [the complainant].’*

90. In response to investigation enquiries on this issue, the Trust stated *‘[the complainant’s] complaint was first raised on 11 May 2016 with the Trust’s Complaints Department. As [the complainant’s] complaint set out her unhappiness with Carpel [sic] Tunnel surgery at Spire Healthcare on 2 February 2016, the complaint was redirected to Spire Healthcare for response in first instance. This is the complaints process agreed with all independent sector providers. This was explained to [the complainant] by the Trust’s Complaints department. [The complainant] stated at this point she had already raised the complaint with Spire Healthcare on 1 May 2016 and was awaiting response. The Trust’s Orthopaedic Services also received an MLA enquiry through Public Liaison on 31 May 2016…The Trust’s Orthopaedic Service Manager…responded to this on 10 June 2016 apologising if [the complainant] had been experiencing difficulties and had arranged an appointment with Dr C, Consultant Orthopaedic Surgeon at Musgrave Park on 27 June 2016.*

91. In its response to investigation enquiries about this issue of complaint, Spire’s Hospital Director, (the Hospital Director) stated *‘I can confirm that [the complainant]’s complaint was handled in line with Spire policy.* The Hospital Director provided, along with her written response, a copy of her written response dated 31 May 2016 to the complainant’s complaint dated 30 April 2016. Subsequently, in providing its comments on a draft of this report, Spire’s Head of Clinical Services provided me with a copy of a letter Spire sent to the complainant on 3 May 2016, acknowledging receipt of her complaint.

92. The Hospital Director also stated in response to investigation enquiries, ‘*I also wish to note that [the complainant] was offered the opportunity for a second opinion by*

any Orthopaedic surgeon of her choice at the cost of Spire. This offer was rejected by [the complainant] on the 29 June 2016. Subsequent to receiving this letter of rejection, no further communication has been made between Spire and [the complainant].' The Hospital Director provided copies of correspondence between her and the complainant on 20, 23 and 29 June 2016. I note from that correspondence that Spire's offer of a second opinion by an orthopaedic surgeon was made '*on a no admissions basis and in full and final settlement of [[the complainant]'s] complaint.'* The complainant was asked to '*confirm that* [she was] *happy with this arrangement by signing a copy of this letter and returning to* [Spire] *so we can proceed.*' I also note that the complainant responded, *'Having taken advice, I find myself unable to sign the letter dated 20th June 2016 with the clauses you have outlined.'*

93. The complaints handling records provided by the Trust and Spire were examined by the Investigating Officer and a chronology of how the complaint was handled was prepared. I was provided with a chronology of the Trust's and Spire's handling of the complaint.

94. The complaints handling records provided to my Investigating Officer during the course of the investigation indicate that the first substantive response to the complainant dated 30 April 2016 issued from Spire's Hospital Director on 31 May 2016. Spire had written previously to the complainant, on 3 May 2016, to acknowledge receipt of her complaint[11]. The Hospital Director's correspondence of 31 May 2016 provided responses to each of the questions posed by the complainant, and incorporated comments received from the operating Consultant Orthopaedic Surgeon, Dr B. The Hospital Director's correspondence also advised her that a copy of her letter had been forwarded to the Trust.

95. The complaints handling records obtained by my Investigating Officer also indicate that the Trust received the complainant's correspondence of 11 May 2016, along with a copy of her complaint of 30 April 2016 to Spire, on 11 May 2016. I note that

[11] Although not included within the complaints handling records originally provided to me, Spire, in commenting on a draft of this report, provided a copy of its acknowledgement letter of 3 May 2016 to the complainant.

on 12 May 2016, the Trust wrote to the complainant to acknowledge receipt of her correspondence. The Trust advised her at that time that it had noted that she had already sent her complaint to Spire *'as they provided* [her] *treatment'*, and that Spire '*need to investigate [her] complaint and respond to* [her] *in the first instance.'* The Trust further advised her, *'If you are unhappy following Spire's response you can reopen your complaint with ourselves and we will then investigate.* As I have recorded above, Spire provided its substantive response to the complainant's complaint on 31 May 2016.

96. I note that having received Spire's response of 31 May 2016, the complainant wrote to the Trust on 2 September 2016, by way of follow up to her original complaint. In her correspondence, she stated, *'I am writing* to outline *why I continue to be dissatisfied with the outcome of my carpel* [sic] *tunnel surgery and ollows* [sic] *my previous correspondence dated 11.05.2016*. The Trust wrote to the complainant on 5 September 2016, acknowledging receipt of her complaint and advising that the issues she had raised were receiving attention and that it would be in contact with her *'in due course.'*

97. The complaints handling records further indicate that during the following weeks, the Trust took a number of actions in response to the complaint:
    (i) The Complaints Department requested information from Spire about the issues the complainant had raised in her complaint (5, 12 and 20 September 2016);
    (ii) The Orthopaedic Assistant Service Manager met with the complainant (15 September 2016);
    (iii) The Complaints Department wrote to the complainant to advise that its response to her complaint would be delayed as a response from Spire was still awaited (23 September 2016);
    (iv) The Orthopaedic Assistant Service Manager requested the complainant's notes from Spire and arranged for them to be reviewed, on receipt, by Consultant Orthopaedic Surgeon, Dr D, (on or around 28 September 2016);
    (v) The Orthopaedic Assistant Service Manager provided to the complainant's Patient and Client Council advocate an update regarding the planned review of the complainant's Spire notes (30 September 2016);
    (vi) The Orthopaedic Assistant Service Manager provided an update to the

complainant about the planned review of her Spire notes (6 October 2016);

(vii) The Orthopaedic Assistant Service Manager provided a further update to the complainant (19 October 2016, following her enquiry of 17 October 2016);

(viii) The Orthopaedic Assistant Service Manager informed the complainant that Dr D considered it would be beneficial for him to see the complainant at clinic (24 October 2016);

(ix) The Orthopaedic Assistant Service Manager advised the complainant of an outpatient appointment with Dr D on 22 November 2016 (26 October 2016);

(x) The Complaints Department sought information from the Orthopaedic Assistant Service Manager to enable it to respond to a request from the complainant for further information about her forthcoming appointment with Dr D (27 October 2016);

(xi) The Orthopaedic Assistant Service Manager provided the Complaints Department with details of the purpose and scope of the complainant's forthcoming appointment with Dr D (31 October 2016); and

(xii) The Complaints Department passed that information on to the complainant (7 November 2016).

98. Following Dr D's review of the complainant on 22 November 2016, the Trust provided a substantive written response to her complaint of 2 September 2016. In its response, dated 19 December 2016, the Trust stated, *'From the outset, I would sincerely apologise for your experience*. The Trust further stated, *'As the commissioning Trust (Belfast Trust) who transferred your care to Spire Healthcare, I am extremely sorry that you feel the communication was disjointed and I would apologise for the significant time you have spent chasing up appointments and communication.'*

99. Having received the Trust's written response to her complaint, the complainant requested a meeting. The complaints records I obtained contain notes of the meeting, which was held on 7 March 2017. The minutes record that the complainant asserted that there was a breakdown in communication between the Trust and Spire. It is also recorded that at the meeting a Director from the Trust '*apologised and explained that the patient always has the option to remain with the Trust or can return their care back to the Trust*', and *'advised that the Trust will follow up with the*

ISPs and advise that they clearly stated in complaint responses that [the complainant] can contact the Trust if they remain unhappy with the provider response. This will be sent to all ISPs'.

100. There was further correspondence and telephone communication between the complainant and the Trust in the weeks that followed the meeting on 7 March 2017, primarily in relation to the agreeing of the meeting minutes and the Trust's response to issues that remained outstanding after the meeting. I note in its final response to the complainant's complaint, which issued on 8 June 2017, the Trust stated *'I want to assure you that the Trust does not discharge its duty of care when sending patients to the Independent Sector Providers (ISP). As noted in your previous Trust response dated 4 May 2017, the Trust has taken the learning from your complaint concerning the communication from the Trust's Contract's team with ISPs and clarifying the process for returning any patients who are not happy to Trust.'* With regard to the complainant's complaint about the damage to her hand, the Trust stated *'regrettably the Trust believes that there is nothing more we can do to help resolve this issue.'*

Analysis and Findings

101. As part of the investigation of the complaint, I considered how the Trust and Spire investigated and responded to the complaints the complainant submitted to them.

102. I note that the complainant first raised concerns about her care and treatment with Spire on 30 April 2016. There is no evidence that the complainant was asked whether she wished her complaint to be investigated by Spire, as required (see section 25.4 of the SLA). However, I note that this section of the SLA appears to conflict with Schedule 6 of the SLA, which outlines that patients may make a complaint to either the ISP or the Trust. There is no evidence that the Trust was informed of the complainant's complaint until she sent a copy of it to the Trust on 11 May 2016. This is contrary to the provisions contained within Schedule 6 of the SLA. The investigation has found evidence that learning from the complaint has been shared with the ISP, and I am pleased to note this.

103. I further note that the SLA (in accordance with the HSC Complaints Procedure) states that the complaint should be acknowledged within two working days and should be responded to within 20 working days. I note that the first of these timescales was met by both Spire and the Trust: Spire acknowledged receipt of the complaint on 3 May 2016, the same working day as its receipt[12], while the Trust's acknowledgment letter issued on 12 May 2016, one working day after its receipt of the complaint. I also note that Spire's substantive response to the complaint issued on 31 May 2016, which was 19 working days[13] after receipt of the complaint, and therefore within the 20 working day timescale stipulated in the SLA. It is evident that the Trust's substantive response to the complaint of 2 September 2016 did not issue within the same target timescale, which is set out in the HSC Complaints Procedure. In fact, it was 15 weeks before the Trust provided its first written response to the complaint.

104. However, I am satisfied that the complaints handling records I obtained disclose no evidence of avoidable delay on the part of the Trust in responding to the issues the complainant had raised. It is evident that the requirement to obtain the complainant's notes from Spire; to have those notes reviewed by one of the Trust's Consultant Orthopaedic Surgeons; and to wait for a suitable opportunity for that clinician to assess the complainant at clinic, all contributed to the length of time it took the Trust to provide its first substantive written response to her complaint. It is also evident that the Trust apologised for and explained the reason for its delayed response, and that it provided a number of updates to the complainant during the period September to December 2016. I have found no evidence either of the Trust having delayed its response to the complainant's subsequent request for a meeting or of it having failed to respond appropriately to her requests for amendments to the minutes of that meeting. Neither have I found any evidence of the Trust having failed to inform the complainant of its position on the issues that remained unresolved at the meeting.

[12] The complaint was dated 30 April 2016, which was a Saturday. The next working day was Tuesday 3 May 2016, as Monday 2 May 2016 was a Bank Holiday.
[13] Monday 30 May 2016 was a Bank Holiday

105. I note that during the handling of the complaint, two of the Trust's consultant orthopaedic surgeons undertook outpatient reviews of the complainant. Those reviews took place on 27 June 2016, with Dr C, and on 22 November 2016, with Dr D. I note that the first review, on 27 June 2016, came about as a result of contact to the Trust from the office of Jeffrey Donaldson MP about the complainant's dissatisfaction with the outcome of her surgery. The Trust arranged for the complainant to be reinstated to its outpatient waiting list to be seen by its orthopaedic surgeon, Dr C, for assessment. Copy documentation provided by the Trust, in response to investigation enquiries, indicates that an outpatient appointment letter was issued to the complainant, advising that an appointment had been made for her to attend an orthopaedic outpatient clinic with Dr C on 27 June 2016. The complaints handling records provided by the Trust also indicate that it communicated appropriately with the complainant in relation to the purpose and scope of the second of those reviews appointments, on 22 November 2016. Specifically, the Trust informed both the complainant and her Patient and Client Council advocate of the plan for Dr D to review her notes from Spire, it informed the complainant that Dr D, having reviewed the notes, considered it would be beneficial for him to see her at clinic; and having informed her of the date of the review appointment with Dr D, the Trust responded to her request for details of the purpose and scope of the review.

106. I have considered all the available evidence relating to the Trust's and Spire's handling of the complaints the complainant submitted to them about the care and treatment she received in relation to her carpal tunnel decompression surgery. I have found no evidence of maladministration on the part of either the Trust or Spire in relation to that matter. **I do not therefore uphold this issue of the complainant's complaint.**

CONCLUSION

107. The complainant submitted a complaint to me about the actions of the Trust in relation to the care and treatment she received in relation to carpal tunnel decompression surgery, which took place on 2 February 2016. I exercised my discretion in this case to extend the investigation to include the actions of Spire in

relation to the care and treatment it provided to the complainant. The investigation also considered how the Trust and Spire investigated and responded to the complaints she submitted to them.

108. I have investigated this complaint and have identified failures in care and treatment in respect of the following matters:

(i) Failure to communicate to the complainant that she was being discharged on 30 April 2016 (Spire);

(ii) Failure to arrange hand therapy at the review appointment on 30 April 2016 (Spire);

(iii) Failure to appropriately inform the complainant of the risks associated with carpal tunnel decompression surgery during the consent process (Spire), and to have regard to her human rights (Spire);

(iv) Failure to review the complainant's earlier decision to consent to the surgery, prior to treatment commencing (Spire); and

(v) Failure to record a contemporaneous note of the discharge discussion (Spire).

109. I did not identify any failure in care and treatment in respect of the following:

(i) The decision to discharge the complainant on 30 April 2016

(ii) The outcome of the surgery.

110. I am satisfied that the failures in care and treatment identified caused the complainant to experience the injustice of uncertainty, loss of opportunity to be appropriately informed about the risks associated with her surgery, loss of opportunity to reconsider the consent decision she had previously made; and distress as a result of a potential slowing down of her recovery.

111. My investigation did not identify and maladministration in respect of the Trust's and Spire's handling of the complaint.

Recommendations

112. I recommend:

(i) The Chief Executive of Spire issue an apology (which accords with NIPSO guidance on issuing an apology, as included at Appendix 6 to this report) to the

complainant for the failings I have identified, within **one month** of the date of my final report;

(ii) Spire make a payment of £500 to the complainant by way of solatium for the injustices identified, within **one month** of the date of my final report;

(iv) Spire clinicians are reminded of the importance of contemporaneous record keeping.

113. I also recommend that Spire implement an action plan to incorporate these recommendations and should provide me with an update within **one** month of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms, which indicate that staff have read and understood any related policies).

114. I am pleased to record that both the Trust and Spire have confirmed to me their acceptance of my investigation findings and my recommendations. I am also pleased to note that the Trust has shared with Spire learning from its investigation of the complaint about the care and treatment the complainant received. In commenting on a draft of this report, the Trust informed me that it had written to all Independent Sector Providers regarding the shared learning from the complaint.

115. Finally, I highlight the IPA's recommendation that the complainant should *"have a further opinion from a specialist hand surgeon who has been made fully cognisant of the complexities of the case so that a properly informed decision can be held with her regarding the possibilities that she has ongoing carpal tunnel syndrome, and that repeat surgery might be worth considering"*. It is my expectation that the Trust considers this recommendation of the IPA and that it informs the complainant of the outcome of that consideration.

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.