Investigation of a complaint against the Western Health and Social Care Trust

Report Reference: 202002039

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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: 202002039
Listed Authority: Western Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's son (the patient), who in January 2018 was aged 15, when he attended Altnagelvin Hospital Emergency Department (ED) with an inflamed ankle. The complainant was concerned it took until August 2021 before Rheumatology reviewed the patient and a diagnosis obtained, and treatment commenced. The complainant believed misdiagnoses and delay had impacted upon her son's condition which continued to decline.

My investigation found that following the initial attendances at the ED, the initial working diagnosis of Achilles tendonitis and ligament damage was reasonable given the fact of a recent injury, the observed conditions and following examination. I also found that follow up from these attendances, in that physiotherapy and a referral to Podiatry was arranged, to be both reasonable and appropriate.

However, I found there to have been a failure in the care and treatment afforded to the complainant's son in a delay in progressing a referral to Rheumatology once the results of an MRI Scan became available in February 2020 and which suggested a form of Rheumatoid Arthritis may be present. I considered this delay to have extended to a period of approximately 18 months. Regrettably the system in place failed the patient. I found this failing caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the patient received. It also caused the patient a loss of opportunity to receive optimum earlier treatment for his condition. I also found it likely there to have been some damage to his condition during this period, although I was unable to quantify the extent.

I recommended that the Trust provide the complainant with an apology for the failure in care and treatment identified. I also recommended that the Trust provide me with the results of its investigations concerning referrals, its IT systems and communication between departments to evidence that lessons have been learned

from this complaint. Finally I recommended that the Trust review national guidance on the management of Rheumatoid Arthritis to ensure effective compliance with its content.

THE COMPLAINT

1. This complaint was about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's son (the patient), then 15 years old in January 2018 following attendances at Altnagelvin Hospital Emergency Department (ED) and subsequently until the Rheumatology Department reviewed the patient in August 2021.

Background

2. The patient attended ED on 9 January 2018 and was treated for Achilles tendonitis. He attended ED again on 25 January 2018 and a follow up with Physiotherapy was recommended. The patient's condition continued to deteriorate and he was sent for an MRI scan, which took place in January 2020. The results showed arthritis and ruptured ligaments. Following this the complainant was under the impression that her son was placed on a waiting list for an Orthopaedic and Rheumatology opinion. However, it transpired that he had not been placed on this waiting list. An Orthopaedic Consultant did not see the patient until 14 July 2021 and a Rheumatology Consultant on 9 August 2021. The complainant believed misdiagnoses and delays impacted on her son's condition.

Issue of complaint

3. I accepted the following issue of complaint for investigation:

   Issue 1: Whether the care and treatment provided to the patient, following a visit to Altnagelvin ED on 9 January 2018 and subsequent care was reasonable and appropriate?

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included the Trust's response to the complainant during the complaints process together with the patient's medical records relating to the attendances at ED on 9 and 25 January 2028 and subsequent attendances.

Independent Professional Advice Sought

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

- A Consultant in Emergency Medicine from 2005 to present. The ED Consultant qualified as a doctor in 1995 and completed higher training in Emergency Medicine with a particular interest in critical care delivery in emergency care. He is an active clinician in Emergency Medicine and has 24 years' experience working in this field. He has published over 70 peer reviewed articles on various aspects of emergency medicine, prehospital care and aeromedical critical care transport. He has contributed to several UK national and international groups concerned with delivery of emergency and prehospital care and has undertaken specific training on medicolegal report writing and worked with the GMC on competence question writing and OSCE conduct.

- A Consultant Rheumatologist with 14 years of experience in the NHS and a clinical lead for his department. He is also chair of the joint medicines management group for his Trust for the past 5 years. He has clinical expertise in management of rheumatological disorders including Early Inflammatory arthritis, connective tissue disease and other autoimmune and inflammatory conditions. He provides second clinical opinions on complex rheumatological disorders at the request of regional colleagues and has established a referral triage system with local musculoskeletal services and has established pathways for urgent referrals to secondary care rheumatology department. He has also authored inflammatory pathways for his NHS Trust.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

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

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

8. 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 and guidance relevant to this complaint are:

   - NICE (National Institute for Health and Care Excellence) Guideline Rheumatoid arthritis in adults: management (Published July 2018, updated October 2020).
   - 2010 Rheumatoid Arthritis Classification (2010 ACR -EULAR classification for Rheumatoid Arthritis)

9. I did not include all 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.

10. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. Both the complainant and the Trust accepted my conclusions.

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

THE INVESTIGATION

Whether the care and treatment provided to the patient, following a visit to Altnagelvin ED on 9 January 2018 and subsequent care was reasonable and appropriate?

Detail of Complaint

11. The complainant believed her son was wrongly diagnosed and treated for Achilles tendonitis following attendances at ED on 9 and 25 January 2018 and that a failure to consider 'arthritis[2]' at this stage was a factor in the delay in her son receiving treatment for this condition until August 2021. In short, the complainant believed that initially her son was wrongly diagnosed and treated for Achilles problems in ED. Furthermore, 'arthritis' should have been detected from blood results earlier and he should have been referred for a MRI scan earlier, rather than waiting almost two years. The complainant believed that the delay in seeing rheumatology meant that his arthritis progressed and the impact of this delay is that her son is now a 21-year-old who is incapable of work, who is constantly sick, depressed and unable to leave home.

Trust's response to investigation enquiries

12. In relation to the patient's attendance on 9 January 2018 the Trust stated the patient complained of intermittent foot pain and swelling since he went over on his ankle three months previous. An ED Nurse Practitioner reviewed the patient. On examination there was swelling on the lateral and posterior sides of the ankle and tenderness over the insertion of the Achilles tendon.

13. An ED Physiotherapist assessed the patient on 25 January 2018. He reported a three-month history of intermittent Achilles tendon and lateral ankle pain. The ED Physiotherapist organised follow up with Physiotherapy and referred the patient to a podiatry clinic for pronation. [3]

[2] Arthritis - Inflammation of one or two joints with pain swelling and stiffness, the most common type of which is osteoarthritis and which is commonly caused by excessive wear and tear on the joints. Rheumatoid arthritis is an autoimmune disease in which the body's own immune system attacks the body's joints, and of which there are different forms.

[3] Pronation refers to the way the foot rolls forward for impact distribution upon landing

14. The Trust apologised that a diagnosis of an inflammatory arthritis was not considered at this time. It stated this would have been a difficult diagnosis to make given the recent injury which may have clouded the diagnostic process. An isolated inflammatory arthritis of the foot such as in this case is a relatively rare presentation in the ED, however the patient was safety netted by having a Physiotherapy follow up and a Podiatry referral.

15. The Trust stated a Physiotherapy appointment was organised for 21 February 2018, however the patient did not attend this appointment. Thereafter Podiatry received the referral from the ED Physiotherapist on 1 February 2018 and partial booking letters were sent on 25 April 2018 and 8 May 2018 which were not responded to which resulted in the patient being discharged on 22 May 2018. I note that the complainant denies receiving these letters. Podiatry then received a GP referral on 9 July 2018 and the patient attended an appointment on 12 November 2018.

16. The Trust explained the patient was seen again in Podiatry on 4 October 2019 with an MRI scan being undertaken on 30 January 2020. Following this scan an internal referral to Orthopaedics and Rheumatology was made on 17 February 2020. While the referrals were forwarded to the Patient Access Department, the Rheumatology referral was not registered on the Patient Administration System (PAS) until 7 December 2020. The Trust accepted this represented a delay and was not in line with service expectations. The Trust apologised for this delay in the care and treatment which the patient received. It stated it was committed to ensuring that lessons were learned to avoid a recurrence for any other patient.

17. Following registration on the PAS of 7 December 2020, Rheumatology did not accept the referral in late January 2021 as it (Rheumatology) stated it required more information. The patient's GP then made a further referral on 22 June 2021, and a Consultant Rheumatologist reviewed him on 9 August 2021. The patient has been under the care of the Trust Rheumatology Team from that date.

18. In relation to the Orthopaedic referral of 17 February 2020, the Trust stated this referral was graded as routine and the patient was placed on a waiting list

(waiting time was in excess of three years). His GP referred him again in June 2021 and an Orthopaedic Consultant saw him on 14 July 2021 with the referral now graded as urgent.

19. As a result of this complaint the Trust stated the delay in processing the internal referral to Rheumatology has been reviewed. As a consequence, all Podiatry referrals are now sent to a central referrals desk and are entered onto the PAS system within 24 hours of receipt. It stated the Trust are now working with an information and communications technology supplier to ensure all referrals can be tracked electronically to provide added controls assurance and to prevent a recurrence.

Relevant Independent Professional Advice

Consultant in Emergency Medicine advice

20. The Consultant in Emergency Medicine (CEM IPA) provided advice on the patient's attendance at ED on 9 January 2018 and 25 January 2018. Given the circumstances and the presentation upon examination he provided advice on the reasonableness of the working diagnosis of Achilles Tendonitis at this time.

21. The CEM IPA advised that '*The patient was seen in ED on 9 January 2018 by ED doctor 1, approximately 5 weeks after an injury to the right ankle. There was a clear history of an inversion injury[4], followed by intermittent pain and swelling.*

There is clear documentation of the patient being able to weight bear, and with focal signs of tenderness over the outside of the ankle and over the insertion of the Achilles tendon. An X-ray of the ankle was undertaken and was interpreted as normal. Given all these facts, the CEM IPA advised that in his opinion, *'a diagnosis of Achilles tendonitis is reasonable'.*

22. The CEM IPA further advised that *'The patient was seen in ED on 25 January 2018 by physiotherapist 1. Again, there is a detailed history and examination*

[4] There are two types of ankle sprains, an eversion sprain occurs when the ankle rolls outward and tears the deltoid ligaments, inversion sprains occur when the foot is twisted upward and the ankle rolls inward.

documented. The working diagnosis at this point also considers the possibility of lateral ligament sprain on the right ankle. I also consider this (right ankle lateral ligament sprain) to be a reasonable working diagnosis at this point.'

23. Responding to the question as to whether a diagnosis of inflammatory arthritis should reasonably have been suspected in 2018 and if further tests or investigations for this condition should have been undertaken at this time, the CEM IPA advised that '*the plan made at the attendances of 9 January 2018 and 25 January 2018 was reasonable. There was a clear history of a recent right ankle injury and an examination that was compatible with the diagnosis of Achilles tendonitis or lateral ligament sprain. The diagnosis of Achilles tendonitis and lateral ligament sprain is a clinical one, based on history and examination. There are no specific investigations such as blood tests that are diagnostic. Investigations such as MRI can be helpful but are not routinely undertaken for the diagnosis of Achilles tendonitis or ankle ligament sprain. Whilst other diagnosis, such as inflammatory arthritis, should always be considered when a young person presents with limb symptoms, in this case there were no red flags such as inability to weight bear or systemic symptoms that would prompt further investigations such as ultrasound or blood tests.*

24. In relation to the treatment on 9 January 2018, which was prescribed, that is a support bandage, ibuprofen and referral to physiotherapy, the CEM IPA advised that in his opinion, '*the initial treatment given to the patient when they attended ED on 9 January 2018 was entirely appropriate. A working diagnosis of Achilles tendonitis had been made and the treatment plan of support bandage, NSAIDs (Ibuprofen) and referral to physiotherapy was entirely appropriate.*

In relation to the treatment on 25 January 2018, the CEM IPA advised *'When the patient attended on 25th January 2018, further physiotherapy was arranged along with podiatry assessment'.* The CEMIPA advised he was not aware of any strong evidence that these treatment options would be detrimental to a patient with inflammatory arthritis.

25. As to the question of whether there was sufficient safeguarding following the attendances at the ED Department the CEM IPA advised that, in his opinion '*there was appropriate safeguarding in this case. From a child protection viewpoint, which should be considered for all presentations in under 16s, a screening survey has been conducted on attendance on 9 January 2018. Regarding the Achilles tendonitis diagnosis made on 9 January 2018, the follow up/safeguarding plan is appropriate with referral to physiotherapy. The patient was subsequently seen on 25 January 2018. At the appointment on 25 January 2018, the presumptive diagnosis of lateral ligament sprain is also considered, and the patient is then referred onto podiatry for consideration of further treatment. A further physiotherapy appointment was also made for 21 February 2018 which the patient did not attend'.*

26. In conclusion the CEM IPA advised that '*Overall, the assessment and treatment plans made at the ED visits on 9 January 2018 and 25 January 2018 were reasonable. Whilst inflammatory arthritis was a possible diagnosis, there were no features in the presentation on 9 January 2018 that should have prompted further investigation at this time. An appropriate follow up plan was made via physiotherapy and podiatry following the ED visits of 9 January 2018 and 25 January 2018'.*

Consultant Rheumatologist advice

27. The Consultant Rheumatologist (CR IPA) advised on the diagnosis, current treatment and potential effects of delay. He advised that '*Letters from rheumatology department indicates the diagnosis to be an inflammatory arthritis/ inflammatory monoarthritis*[5] *or a seronegative arthritis. These can all be different subtypes of rheumatoid arthritis. The clinic letter from August 2021 states that the presentation was unusual for an inflammatory arthritis. Rheumatoid arthritis is one form of an inflammatory arthritis of which there are many types. From the information provided the patient has not been given a specific label of Rheumatoid Arthritis and his blood tests for Rheumatoid*

[5] Inflammation of one joint characterized by joint swelling, pain, redness and warmth.

arthritis have been negative but he appears to have been diagnosed with a seronegative arthritis which is also a form of rheumatoid arthritis and treatment would be the same as for any form of rheumatoid arthritis.'

28. In providing an opinion on the progress of the patient's conditions from the MRI results of February 2020 until being seen by Rheumatology 18 months later in August 2021 and if earlier treatment or medication could have slowed the progress of his condition, the CR IPA advised that '*The progress of the patient's condition cannot be accurately determined from the MRI results of February 2020, till being seen by rheumatology, as there is no comparative MRI scan, or XRAY report for us to assess the difference from initial presentation. An ultrasound scan was undertaken but this was after the patient commencing treatment on steroids which showed an improvement, but this is a different modality of imaging. In general, the longer inflammation lasts at a joint there can be more damage at the joint and hence the urgency to treat and resolve the inflammation. It is worth noting that there was swelling and effusion on an Xray dating back to 2018, so it is reasonable to conclude that with no specific intervention to settle the swelling this is likely to have caused some degree of damage at the joint although we do not have specific and documentary evidence of this with a repeat Xray or MRI scan'.*

29. The CR IPA advised that *'The widely accepted diagnosis of rheumatoid arthritis is now based on the ACR/EULAR 2010 classification criteria which focuses on earlier recognition of this condition and prompt and early institution of treatment. If we apply this criterion, then the patient may not necessarily fulfil this criterion for a specific diagnosis of rheumatoid arthritis. There were several unusual features in presentation such as a history of injury, a single lower limb joint being involved and absence of blood markers which could have led to this delay in referral and diagnosis'.*

30. In this case the patient presented with a suspected persisting synovitis (inflammation of the membrane lining a joint capsule) of a single joint. The guidance for Rheumatoid arthritis in adults is covered by NICE guidance 100 which clearly states that the patient should be referred for a specialist

opinion if there is suspected persistent synovitis of undetermined cause. The guideline also states that an urgent referral should be made if there has been a delay of more than 3 months or longer between onset of symptoms and seeking medical advice. This should be the case even if blood tests do not show any abnormalities as in this case. It also provides further guidance on referral for an early specialist surgical opinion if the patient does not respond to optimal non-surgical management.

31. In concluding his advice, the CR IPA advised in this case

- There appears to have been a delay in the initial referral process in this patient where there was evidence of swelling at the ankle. There were diagnostic uncertainties leading to referral to more than one service in secondary care.
- The symptoms were atypical for rheumatoid arthritis and could have led to some of this delay.
- The Rheumatology department has instituted a correct treatment and management plan following review.
- It is unclear from the evidence provided, if there was any evidence of joint damage due to the delays in referral processes.
- Communication issues can be addressed in various ways as recommended above within various referral and treatment services.
- Referral management services should be designed to ensure that NICE guidelines are being implemented.

Analysis and Findings

32. In my consideration of this complaint, I note there are two distinct periods of time when the patient sought attention and was under the care of the Trust. The first was from the patient's attendance at the ED as an outpatient on 9 January 2018 until his discharge on 22 May 2018. The second period covered the time from the GP referral being received by Podiatry on 9 July 2018 until a Consultant Rheumatologist saw the Patient on 9 August 2021. I shall give my

consideration as to the care and treatment received during these periods in turn.

9 January 2018 -22 May 2018

33. The ED attendance record of 9 January 2018 records the patient attended the ED as an outpatient at 16.55 complaining of pain and swelling to his right ankle which had been previously injured. It documented he was weightbearing fully, with bruising, swelling and tenderness over the Achilles. Achilles tendonitis was diagnosed, treated with a support bandage, medication and an onward referral to physio was made.

34. The patient attended again on the morning of 25 January 2018. The comprehensive assessment documented there was pain on the Achilles tendon of the right ankle with possible lateral ligament sprain. The plan was for follow up physiotherapy and an appointment for this was made for 21 February 2018 which the patient did not attend. Two letters were sent on 25 April 2018 and 8 May 2018 to which the patient did not respond. The complainant has stated that these letters were not received. This resulted in the patient being discharged on 22 May 2018.

35. Having carefully considered the advice of both the CEM IPA and the CR IPA, I am satisfied that the working diagnosis following the attendances at the ED on 9 and 25 January 2018, of Achilles tendonitis and/or lateral ligament sprain, was reasonable. I am satisfied that the patient's presentation, in particular the ability to weight bear, the fact of a recent injury, the presence of swelling in a single joint rather than in the hands or multiple joints did not present 'red flags' which would prompt further investigations, and which made the working diagnosis of Achilles tendonitis and/or lateral ligament sprain the most likely. I am aware in many cases diagnosis of a condition or complaint is not an exact science. In this case the working diagnosis of Achilles tendonitis and/or lateral ligament sprain was considered to be the most consistent with observed conditions and following examination. I accept the IPAs' advice and I am satisfied this was a reasonable diagnosis to make and that the patient was

appropriately treated for this condition. The CEM IPA advised he was not aware of any strong evidence the treatment options prescribed would be detrimental to a patient who turned out to have an inflammatory arthritis.

36. As described in the preceding paragraph, sometimes the most likely choice is acceptably designated to be the working diagnosis. This means, a condition diagnosed which is most likely but this has not been confirmed and that other possibilities have not been ruled out. In this case, which proved to be complex with atypical, unusual symptoms for what proved to be the final diagnosis, I agree with the CEM IPA that proper safeguarding was provided in that the patient was referred for further treatment and within which would have contained the opportunity for a more exact or differential diagnosis[6]. Unfortunately, the patient did not attend the arranged physiotherapy appointment on 21 February 2018 or Podiatry, so any potential opportunity for reconsideration of his condition was missed at that time. I note the patient was discharged on 22 May 2018. At this juncture it is impossible to speculate what the patient's outcome would have been or if he would have received an earlier diagnosis had he continued engagement with the Trust during this period. Nonetheless I am satisfied that up to 22 May 2018, the care and treatment provided was both reasonable and appropriate.

9 July 2018 - 9 August 2021.

37. It is evident the patient's condition did not improve and his GP made a further referral to Podiatry on 9 July 2018 with the patient being offered an appointment for 12 November 2018. At this appointment the patient was assessed, and a rehabilitation programme was advised.

38. Podiatry reviewed the patient again on 4 October 2019, this time an MRI (Magnetic Resonance Imaging) scan was requested. This was completed on 30 January 2020 and reported on 7 February 2020. The conclusion of this scan stated, '*Given the appearances inflammatory arthrosis should be considered,*

[6] Differential diagnosis is the process of differentiating between two or mor conditions which share similar signs or symptoms

impression of high-grade injury to the anterior talofibular ligament.' This is the first time the possibility of an inflammatory arthritis appears in the records and unfortunately it is from this date things began to go amiss in the Trust's response to the patient.

39. As a result of the reading of the MRI scan the Trust referred the patient to Orthopaedics (regarding the ruptured ligament) and to Rheumatology (regarding the appearances associated with inflammatory arthritis) on 14 February 2020. The Trust has accepted while the referrals were forwarded to the Patient Access Department, which organises referrals, it was not placed on the PAS until 7 December 2020, almost 10 months later. To compound this delay when Rheumatology triaged the referral on 6 January 2021 it was referred back to Podiatry as it was deemed to contain insufficient information. The Trust, in its response to my enquiries stated that Podiatry then contacted Rheumatology to better understand what further information was required. However no record of this conversation exists and from the timeline of events, despite this interdepartmental contact, it appears that no further action was taken to progress the patient's Rheumatology assessment and management.

40. It was only following further referrals from the patient's GP on 22 June 2021 that the Trust showed some urgency in arranging for the patient to be seen by an Orthopaedic Consultant on 14 July 2021 (his referral now being treated as urgent) and a Consultant Rheumatologist on 9 August 2021. In response to my enquiries the Trust apologised for the delay in registering the Rheumatology referral of 14 February 2020 on the PAS system until 7 December 2020, a period of 10 months, stating that this would not be in line with service expectations. I note this accepted delay was not acted upon and did not lead to the patient being seen on a Rheumatology accelerated pathway. Even with contact being made between the Podiatry and Rheumatology Departments in January 2021, there was a further delay of approximately seven months before he was seen. If it had not been for the persistence and tenacity of the patient's GP in making a further referral in July 2021, it is possible the patient may have faced even further extended delay before he received treatment from

Rheumatology. Following this further GP referral, the patient was also seen quickly by Orthopaedics, where thankfully no intervention was required, despite the presence of a three-year waiting list.

41. The CR IPA described the importance of providing an assessment and treatment to those patients with inflammatory arthritis at as early a date as possible to reduce long term damage. The question then arises, has the delay in this case caused damage to the patient's condition. In answering this question, I note the advice of the CR IPA which states that *'in general the longer inflammation lasts at a joint there can be more damage at the joint……With no specific intervention to settle the swelling, this is likely to have caused some damage at the joint…'.*

42. I accept this advice and consider it is most likely that the patient suffered some degree of damage at his ankle joint which could have been avoided with earlier treatment. I also accept, at this juncture, it is impossible to quantify how much damage was caused. The reason being that there is no MRI scan results available following that of January 2020 with which to make comparison. I make no criticism of the Trust for this as I accept the advice of the CEM IPA that while the results of an MRI scan can be helpful an MRI scan would not routinely be taken with a diagnosis of Achilles tendonitis or ligament strain which was initially the acceptable working diagnosis. I also recognise that once the patient was seen in August 2021 in Rheumatology, he was placed on a course of steroids which led to some improvement making comparison difficult. Nonetheless this has led to the situation whereby the progress of the patient's condition from January/February 2020 to August 2021 cannot be accurately determined. However, I am satisfied that the patient did suffer likely damage to his condition caused by the delay.

43. Overall, I am concerned to note a delay of approximately 18 months (February 2020 – August 2021) between the patient being referred to Rheumatology with the '*appearance of inflammatory arthrosis'* and actually being seen and treatment commencing. I note the advice from the CR IPA, quoting NICE guidelines which are designed to ensure patients are referred as early as

possible for specialised assessment and treatment with the intent to achieve disease remission early and to prevent long term damage. I note the complainant's contention that there was delay even before this period, in that it was October 2020 before an MRI scan was ordered (carried out in January 2021). However, I accept the advice of the CR IPA that the symptoms displayed by the patient were atypical for rheumatoid arthritis which made an accurate diagnosis more difficult. I also note that a large part of the interaction between the patient and the Trust occurred during the recent Covid 19 pandemic which placed huge strains upon Trust staff and services. Nonetheless, I consider the delay, between February 2020 and August 2021 to represent a failure in the care and treatment afforded to the patient by the Trust. I consider this failing to have caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the patient received. I also consider the failing of delay to have caused the patient a loss of opportunity to receive optimum earlier treatment for his condition and for there likely to have been some damage to his condition during this period.

44. In relation to the complainant's understanding that the patient had been placed on a waiting list when it transpires that for a period of time he had not, I acknowledge that waiting lists are at record levels throughout the health service and recognise that this can cause patient frustration. In June 2023 I published an 'Own Initiative' report into communication provided to patients following placement on a waiting list. While I recognise this complaint represents a somewhat different scenario, in that for a period of 10 months the patient had not reached a waiting list, in my report I noted that Trusts provide patients with little to no communication regarding their progress on waiting lists. I recognise the significant challenges Trusts face and welcome the acknowledgement that improvements are required in this area. In response to the June 2023 report Trusts stated their assurance that they have already taken steps to implement my recommendations to improve communication with patients. In this particular case it could have informed the complainant of the delay in placing the patient on a waiting list prior to the receipt of a complaint. I would ask that the Trust reflect on my recommendations within the June 2023 report in this context.

45. The complainant believed the delay in seeing a Rheumatologist led to the patient's condition progressing from arthritis to rheumatoid arthritis, that is, an inflammatory arthritis. The advice which I received is the patient in this case presented with several unusual features which have led to a difficulty in diagnosis. He had a history of injury, as evidenced by the presence of ruptured ligaments (which thankfully required no orthopaedic intervention following his assessment on 14 July 2021), he had single lower limb joint involvement rather than multiple limb involvement which would be more usual, and indeed there is an absence of the specific blood markers used as the criteria for a diagnosis of rheumatoid arthritis. The advice I received indicates that the patient has been diagnosed with a subtype of rheumatoid arthritis, a seronegative arthritis, for which he is currently being correctly and clinically appropriately treated but which involves medication and treatment which would be the same as for the treatment of rheumatoid arthritis. The provisional diagnosis from the MRI which showed the appearance of an inflammatory arthritis, and the final diagnosis of seronegative arthritis does not show a new diagnosis. Arthritis, a different condition and which the patient has no appearance of having, is generally caused by mechanical wear and tear on the joints. I would hope that the complainant can take some comfort from the information that her son is now receiving appropriate treatment for the condition which he does have.

CONCLUSION

46. I received a complaint about the care and treatment the Trust provided to the patient in January 2018 following attendances at Altnagelvin Hospital ED and subsequent referrals.

47. I upheld elements of the complaint for the reasons outlined in this report. I consider the failures identified, that is delay which caused unquantified damage in the patient's condition to represent a failure in the Trust's care and treatment provided to the patient. I also consider this failing to have caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the patient received, and which caused the patient a loss opportunity to receive an earlier diagnosis and earlier treatment options.

Recommendations

48. I recommend that the Chief Executive of the Trust,

i. in accordance with NIPSO guidance on issuing an apology (July 2019), provides a written apology to the complainant for the failures in the care and treatment identified in this report. The Trust should provide the apology to the complainant within **one month** of the date of my final report.

ii. The Trust should provide me with an update on its investigations and actions taken as a result of its investigation of this complaint to include details of the steps which have been taken concerning referrals, IT systems and communications within Departments to evidence that lessons have been learned from this complaint and to avoid a reoccurrence for any other patient journey.

iii. The Trust should review its implementation of the NICE guidance referenced in this report (Rheumatoid arthritis in adults: management (Published July 2018, updated October 2020) to ensure effective compliance with its content and to provide me with evidence of this review and its conclusions.

MARGARET KELLY
OMBUDSMAN 13 November 2023

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.