Health and Social Care Ombudsman Body

SUMMARY REPORT

Case Reference Number: HSCOB/2023/109

Regulation 24(6) of the Complaints Regulations 2022 requires the HSCOB to publish reports of its reviews and investigations on its website. Regulation 24(7) also requires the Body to give due regard to data protection legislation and the general duty of care and confidence.

Reports are therefore presented in a format that summarises the nature of the complaint together with the relevant key findings, conclusions and recommendations. They do not however contain any personally identifiable data or information.

Complainants receive a copy of the original unredcated report prior to their publication in a summary format. Reports intended for publication must be posted on the HSCOB website within one month of the unredacted original version being sent to the complainant.

Summary reports are intended to inform the public about the work of the HSCOB and raise awareness of the Body's role in contributing to the transformation and improvement of health and care services on the Isle of Man.

Manx Care Service(s) Complained About

Orthopaedic Services Nobles Hospital

The Complaints

1. The initial complaint concerned the delay in forwarding an urgent referral to the hand physiotherapist by the Orthopaedic Team at Nobles Hospital.

2. A subsidiary complaint concerned the lack of sufficient information given in the clinic regarding a proposed referral and transfer to Wrightington Hospital in Liverpool for further assessment/treatment.

The Complainant's Desired Outcomes

1. To determine what treatment and follow up will be provided by Manx Care to mitigate the ongoing impact and deficit in movement experienced by the complainant.

2. If further off island treatment is considered, then details to ensure attendance are agreed beforehand.

On the 8 August 2022 the complainant attended the Emergency Department in Nobles Hospital, and on 9 August 2022 (in their virtual clinic) a decision was made by the Orthopaedic Team to forward an 'urgent referral' to the hand physiotherapist for further assessment and treatment. On the 15 September 2022, and due to the complainant's intervention, a further urgent referral to the hand physiotherapist was booked. The complainant was told by the Emergency Department staff that the urgent referral had been sent, but on enquiry by the complainant to the Physiotherapy Department, it is noted that the referral had not been received. The reason for this omission was attributed to human error. Following an appointment with the hand physiotherapist, a referral was made to the Consultant Orthopaedic Surgeon and the complainant was seen by a member of the team. At this appointment it was decidied to refer the case to Wrightington Hospital in Liverpool for further assessment and management.

On 31 January 2023, a formal complaint was submitted to Manx Care. The acknowledgement does not include a summary of the complaint (as required by Regulation 10(8) of Part 2 of the National Health Service (Complaints) Regulations 2022), but it does advise that the complainant will be contacted "directly to offer the opportunity to meet or discuss the complaint in more detail" (Regulation 11(2)). However, there was no evidence in the complaint file that any subsequent contact to took place.

A letter from the Chief Executive of Manx Care dated 16 February 2023 confirms that the urgent referral for hand physiotherapy was "overlooked" and apologises for the delay in the referral being made. The letter states that the Consultant Orthopaedic Surgeon "has advised that with this kind of injury there is a risk that extension of the finger may not fully recover.....but we accept the range of movement in the finger may have been better if (the complainant) had been seen by the hand physiotherapist earlier." The complaint file does not include any direct correspondence from the Consultant Orthopaedic Surgeon expressing a view with regard to the mobility of the complainant's affected finger.

The correspondence further states that treatment options were discussed and a referral made to a specialist at Wrightington Hospital Liverpool for a second opinion. The subsidiary complaint arises from not appreciating that this appointment would be off island. That appointment had to be cancelled due to the arrangements not being specific or agreed beforehand and the complainant's unavailability to attend. There is no evidence that information about the procedures for off island medical appointments, being accompanied or responsibility for arranging travel were communicated to the complainant. Details of the process for off island travel were included in the Chief Executive's letter, but this constituted general information rather than an explanation of its application in the complainant's particular circumstances.

The letter from the Chief Executive does not state whether the complaint is upheld in full or in part, nor describe the investigation, summarise the conclusions reached or actions to be taken as a result of the complaint, as required by Regulation 11(3).

Key Review Findings & Conclusions

The Review undertaken by HSCOB established the following findings:

- No evidence that the policies regarding injuries sustained during assessment and or treatment by Manx Care had been fully complied with as required by the Duty of Cadour Regulations, or any entries made on the Datix system;
- The response to the complaint does not adequately address the concerns originally raised;
- The investigation conducted by the Orthopaedic medical staff lacked the necessary independence to ensure an objective and impartial consideration of the issues raised;
- Specific detail on the cause of the failure to process the referral had not been identified, e.g. whether or not it involved the use of ICE software;
- The length of the delay before being seen by the hand physiotherapist is not acknowledged in Manx Care's response (referral should have been made on 9 August 2022, but did not in fact occur until the 28 November 2022);
- A lack of explanation for how the delay came to be known to Manx Care and when;
- Details of what lessons have been learned and how they have been shared within the referring team and the changes made since the incident to prevent recurrence are not clear;
- A Lack of clarity concerning any steps taken by Manx Care in respect of the possibility of a claim arising from this complaint (which had been noted), and in regard to changes in their processing of referrals;

- No details have been provided to HSCOB regarding any ongoing assessment and/or treatment by the team or others in order to mitigate the continuing problems, e.g pain, further physiotherapy etc;
- No record of an invitation by Manx Care to review the complaint;
- Confirmation or otherwise that off island appointment arrangements are conveyed appropriately and mutually agreed beforehand and how has this aspect of the complaint had been considered.
- No information regarding establishing and improving communications with patients concerning off island referrals.
- Manx Care did not undertake thorough and extensive investigations with explanantions and responses when failures in the standards of care and treatment that may lead to a permanent injury (the complainant shared with the reviewing team the ongoing difficulties that living with the injury has created).
- Manx Care's response to the original complaint came shortly after a reference to a possible future claim by the complainant.
- An absence of detail concerning the specific senior medical supervision requirement for new or junior medical staff. There is no reference to the potential impact on patient experience arising from the annual commencement of junior medical staff rotation in the August of each year.
- No information supplied that the complaint and the outcomes have been made known to the Serious Incident Reporting Group and what, if any, recommendation or actions have been taken to share lessons learned.

Review Outcome

It is of some concern that a referral for ongoing assessment/treatment can be simply ''overlooked'' in this way. Further to HSCOB requesting clarification about the particular circumstances of the 'human error' that occurred, the response receieved from Manx Care lacked any specific detail of the reasons for the referral not being placed on the system which alerts the Physiotherapy Department of such a request. Alongside the absence of specific details concerning that particular process, there was also no evidence regarding the relevant Standard Operating Procedure (SOP) and indeed whether or not it has been amended to try and reduce any risk of recurrence.

The complainant was effectively 'left in limbo' with regard to their status within the healthcare system, and oblivious to any future plans concerning their further care and treatment. This aspect of the complaint represents a considerable failure on the part of Manx Care and warrants further explanation.

There was also a lack of acknowledgement in Manx Care's response of the physical impact upon the complainant arising from what may be seen superficially as a simple administrative mistake with a marginal consequence. This was not the experience of the complainant, who has had to adjust aspects of daily living tasks to accommodate the detriment arisng from the loss of opportunity to correct the injury that was sustanined.

Not inviting the complainant to a meeting to discuss their concerns in more detail was an oversight that ultimately resulted in a flawed consideration of the complaint. Furthermore, the perceived or actual lack of independence in the process could have been assuaged by the use of an off-line management investigator outwith the service area complained about. The overall conclusion in this case is that an unsatisfactory investigation took place that did not fullfill the statutory requirements of the Complaints Regulations 2022 or the best practice standards for effective complaints management.

Whilst the response of 16 February 2023 did acknowldege that a service failure had occurred, and indeed offered an apology for the omission to ensure a timely referral to the physiotherapist, it did not however provide for adequate remedy and redress. This is because it made no specific proposals for potential onward care and treatment to address the ongoing physical consequences of the injury. The Ombudsman is persuaded that the Chief Executive's adjudication therefore does not provide a reasonable outcome for the complainant.

Therefore, the complaints are upheld.

Review Recommendations

The following recommendations are made to Manx Care:

- Liaise with Wrightington Hospital and obtain confirmation of any further appointments for assessment and corrective treatment for the complainant;
- Arrange to meet with the complainant as a matter of urgency to agree with and provide details of the appointment, together with full details of the travel arrangements;
- Ensure compliance with the NHS (Complaints) Regulations 2022 with regard to acknowledgement of complaints including a summary of the complaint;
- Complainants to be unambiguously invited to meetings to discuss their complaint at the time of acknowledgement and as part of the investigation;

- Local resolution Investigation methodology and the associated findings, conclusions and recommendations to be clearly detailed in the written response to complainants.
- Responses to complainants to explicitly and unequivocably confirm whether their complaints are upheld, partially upheld, or not upheld.