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The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201802594, Tayside NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary
Mrs C, an advocacy worker, complained to me, on behalf of Ms A, about the care and treatment that Tayside NHS Board (the Board) provided to Ms A.

From early 2012 onwards, Ms A experienced severe hip pain following her right hip replacement surgery. It affected her ability to walk and to carry out everyday tasks. Despite various orthopaedic reviews and investigations over the following five years, no underlying cause was identified for her pain. In mid-2017, Ms A's symptoms suddenly worsened and she experienced total right hip replacement failure. Ms A was referred for further surgery and a deep-seated infection was found in her right hip joint. Mrs C complained about an unreasonable delay in diagnosing Ms A's hip infection.

We took independent advice from a consultant orthopaedic surgeon, which we accepted. We found that there was a failure to properly investigate Ms A for a hip infection over a period of five years, in light of her symptoms. We found that concerning and obvious changes were apparent to Ms A's hip in her x-rays taken in 2015, 2016 and 2017. However, these changes were missed in her orthopaedic reviews. We found that when the changes in her 2017 x-rays were subsequently identified, there was an unreasonable delay in offering her an orthopaedics review as she waited over three months to be seen. We were critical that the Board's investigation did not identify and/or acknowledge the significant failings in the care provided to Ms A.

We upheld Mrs C's complaint. We made a number of recommendations to address the issues identified. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms A:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
There was a failure to properly investigate Ms A for a hip infection over a period of five years in light of her presentation; to appropriately report on and review her x-rays over this period; and an unreasonable delay in offering Ms A an orthopaedics review after her May 2017 x-rays showed concerning changes to her hip replacement	Apologise to Ms A for the failings in diagnosing and treating her right hip infection; and the unreasonable delay in offering her an orthopaedics review	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 26 August 2019

We are asking the Board to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There was a failure to properly investigate Ms A for an underlying right hip infection over a period of five years in light of her presentation	Patients, who have symptoms suggestive of an underlying joint infection, should be fully and appropriately investigated, in line with recognised guidelines	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails. Evidence that the Board have prepared a local guidance policy, which is in line with recognised guidelines for investigating hip replacement infections By: 24 September 2019
There was a failure to appropriately report on x-rays taken in 2015 and 2016	Orthopaedic x-rays should be appropriately reported	Evidence that a review of the Board's system for reporting orthopaedic x-rays has been carried out, in light of the findings of this investigation and details of the action taken on any areas identified for improvement By: 24 September 2019

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There were concerning and obvious changes in Ms A's x-rays in 2015, 2016 and 2017, which were missed in her orthopaedic reviews	The results of hospital tests and investigations should be carefully reviewed	Evidence that the findings of this investigation have been fed back to the clinicians involved in a supportive way that promotes learning, including reference to what that learning is. Confirmation that the relevant clinicians will discuss this case at their next appraisal By: 24 September 2019
When the changes in Ms A's May 2017 x-rays were subsequently identified, there was an unreasonable delay in offering her an orthopaedics review as she waited over three months to be seen	In similar circumstances, patients should receive an orthopaedics review in a timely manner	Evidence of the steps being taken to ensure that patients are given a timely orthopaedics review in similar circumstances By: 24 September 2019

We are asking the Board to improve their complaints handling:

What we found	Outcome needed	What we need to see
The Board's investigation did not identify and/or acknowledge the significant failings in the care provided to Ms A	The Board's complaints handling system should ensure that failings (and good practice) are identified, where appropriate remedied, and that it is using the learning from complaints to inform service development and improvement (where needed)	Evidence that the Board have demonstrated learning from this case and complaints in general By: 24 September 2019

Feedback

Points to note:

Included in the advice I received and accepted were the following points from the Adviser:

- a clinical audit facilitator regularly reviewed Ms A and checked her blood metal ion levels. This was appropriate and it was in line with the relevant Medicines and Healthcare Products Regulatory Agency (MHRA) guidance on metal-on-metal hip replacements.
- an MRI scan in 2012 was not a helpful investigation if a metal artefact reduction sequence (MARS) type of MRI scan was not available.
- after Ms A's hip replacement failed in August 2017, she was given entirely reasonable treatment by the Board.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C, an advocacy worker, complained to me, on behalf of Ms A, about the care and treatment that Tayside NHS Board (the Board) provided to Ms A.

2. For over five years, Ms A had experienced severe hip pain following right hip replacement surgery. It affected her ability to walk and to carry out everyday tasks. Despite various orthopaedic reviews and investigations, no underlying cause was identified. In 2017, Ms A's symptoms suddenly worsened and she experienced total right hip replacement failure. She was then referred for further surgery, when a deep-seated infection in her hip joint was identified.

3. The complaint I have investigated from Mrs C is that from January 2012 to August 2017, the Board unreasonably delayed in diagnosing Ms A's infected right hip joint (*upheld*).

Investigation

4. I and my complaints reviewer considered all the information provided by Mrs C and the Board. This included Ms A's relevant medical records and the Board's complaints file. We also obtained independent advice from a consultant orthopaedic surgeon (the Adviser) on the clinical aspects of the complaint.

5. I have decided to issue a public report on Mrs C's complaint because of the significant personal injustice suffered by Ms A and the systemic failings in care and treatment my investigation has identified. There might also be wider learning available to other health boards in relation to these failings; and in relation to complaints handling, as my report also highlights that there was a missed opportunity for the Board to identify and learn from Ms A’s complaint when they investigated it. I consider that this represents an additional failing in the care the Board provided to Ms A.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, Ms A and the Board were given an opportunity to comment on a draft of this report.

Background

7. Ms A had severe advanced osteoarthritis in her right hip. In May 2010, she underwent a total right hip replacement at Perth Royal Infirmary. Ms A was fitted with a cementless metal-on-metal hip replacement. It had a type of metal ball, which replaced the top of her thigh bone (femur) and a metal cup that acted like the socket of her pelvis. Afterwards, Ms A experienced intermittent pain.

8. In July 2010, Ms A was reviewed by an orthopaedic registrar. They noted that her pain was almost completely gone. They took an x-ray of her hip and it appeared satisfactory. Ms A was discharged from orthopaedics, with a plan to review her again in a year's time. In May 2011, Ms A attended an orthopaedic review. It was noted that she was experiencing no issues with her hip replacement.

9. In January 2012, Ms A was reviewed by an orthopaedic surgeon, as she had left knee pain. Ms A explained that she had also been experiencing severe right hip pain. She was referred for a bone scan, which was carried out in late January 2012. Ms A had an MRI scan in March 2012, followed by a CT scan and an ultrasound scan of her right hip.

10. In April 2012, Ms A was reviewed by a different orthopaedic surgeon. She complained about pain in her groin and difficulty getting up from a seated position. The orthopaedic surgeon did not consider the investigations had shown evidence of an underlying problem with her right hip. Ms A was referred to physiotherapy to help her try to manage her condition.

11. In the following years, Ms A was given regular reviews with a clinical audit facilitator to check her blood ion levels. This was because metal from a hip implant can release into the bloodstream and cause adverse reactions in some people. Ms A's severe right hip pain continued. She had to reduce her working hours due to exhaustion. Her social and family life was affected by her lack of energy and her limited mobility. She gained weight and the constant pain affected her mental health. Her confidence was affected, as she felt disbelieved or dismissed that something was seriously wrong with her hip joint.

12. In April 2015, Ms A went to see her GP about general pain in and around her right hip; flu-like symptoms and lethargy. Her GP referred her to orthopaedics, who arranged x-rays.

13. In August 2015, Ms A was reviewed by an orthopaedic surgeon. She was referred for an MRI scan. In November 2015, Ms A attended a further review with the orthopaedic surgeon. She was told the MRI scan had not shown any underlying problem. Ms A was referred for further physiotherapy.

14. In May 2016, Ms A attended a yearly review with a clinical audit facilitator and she was referred for x-rays. A year later, Ms A attended a further review with a clinical audit facilitator. As Ms A complained of ongoing hip pain, the clinical audit facilitator referred her to orthopaedics.

15. In May 2017, Ms A was reviewed by a different orthopaedic surgeon. Ms A was clinically examined and she was referred for further x-rays. She was told the x-rays showed nothing of concern and there was no requirement for any further investigations into her right hip pain.

16. In June 2017, Ms A attended a review with a clinical audit facilitator, where she complained of ongoing right hip pain. The clinical audit facilitator noted there were changes to Ms A's hip apparent in her May 2017 x-rays. The clinical audit facilitator referred Ms A to an orthopaedic surgeon, whom she had not previously seen, for a further opinion. In August 2017, while Ms A was waiting for that appointment, her symptoms suddenly deteriorated. Her GP arranged x-rays, which showed that Ms A's hip replacement had failed, as it had collapsed at the socket. Ms A was admitted to Ninewells Hospital as an emergency and she was referred for further hip surgery. During the surgery, the orthopaedic surgeon found a deep-seated infection in her right hip joint.

Complaint: From January 2012 to August 2017, the Board unreasonably delayed in diagnosing Ms A's infected right hip joint

Concerns raised by Mrs C

17. Mrs C complained that for over five years, the Board failed to diagnose Ms A's right hip joint infection. She said this was despite Ms A attending numerous orthopaedic appointments and reviews. Mrs C complained that the Board missed changes in Ms A's x-rays. She questioned why a joint aspirate was not carried out to check for any underlying infection. Mrs C raised concerns that when the changes in her May 2017 x-rays were identified a month later, Ms A was not given an urgent orthopaedic appointment. Mrs C complained that this delay led to Ms A's emergency hospital admission in August 2017 following the collapse of her hip replacement.

The Board's response

18. The Board said that Ms A's right hip pain was fully and repeatedly investigated by a number of consultant orthopaedic surgeons and by a clinical audit facilitator. The Board stated there had been no sign of Ms A's hip replacement loosening; she did not have raised blood ion levels; or any signs of a hip infection. The Board considered that a reasonable wait and watch approach was taken. The Board acknowledged that it might have been helpful to carry out a joint aspirate. However, they said there was no evidence of fluid in Ms A's joint so it was unlikely to have helped diagnose any underlying hip infection. The Board acknowledged that there were subtle changes in Ms A's May 2017 x-rays, which were missed by the orthopaedic surgeon at that time. They apologised to Ms A for this.

Medical advice: relevant clinical guidelines

19. The Adviser said there were various recognised clinical guidelines relevant to their consideration of this complaint. In particular, they referred to:

- *The Diagnosis of Periprosthetic Joint Infections of the Hip and Knee* AAOS (American Academy of Orthopaedic Surgeons) guidelines (June 2010); and
- *Proceedings of the International Consensus Meeting on Periprosthetic Joint Infection* guidelines (October 2013) circulated by EFORT (the European Federation of National Associations of Orthopaedics and Traumatology)

20. The Adviser explained that in the AAOS guidelines above, it says that a raised level of c-reactive protein (CRP) is an indication of an underlying joint infection. It recommends that when someone has a raised CRP, a joint aspirate should be carried out to test for any underlying joint infection. The Adviser explained that in the EFORT circulated guidelines, it recommends carrying out x-rays and blood tests as the initial tests for any underlying joint infection. It recommends a joint aspirate as the most useful investigation for diagnosing a joint infection.

Medical advice: early 2012 orthopaedics review

21. In January 2012, Ms A was reviewed by a consultant orthopaedic surgeon. They noted that Ms A was experiencing significant right hip pain. The Adviser said this would be unusual following a hip replacement surgery. The Adviser explained that given Ms A's symptoms, they considered the initial investigations carried out should have been x-rays, followed by blood tests.

22. The Adviser confirmed that Ms A was referred for x-rays in January 2012. The Adviser explained that in the x-rays, the socket part of her hip replacement looked well positioned. The Adviser said there was evidence of good bone on-growth to it (meaning Ms A's bone appeared to have fixed well to the socket part of the hip replacement). The Adviser said that the ball part of the hip replacement also appeared to be in a reasonable position. The Adviser explained there was no evidence of bone on-growth to that part of the hip replacement but that would not be particularly unusual.

23. The Adviser noted that Ms A was referred for a bone scan, which they described as a reasonable investigation. The Adviser explained that the bone scan was normal. Specifically, it reported no evidence of an infection or a loosening of Ms A's hip replacement. The Adviser said this would have been reassuring to the orthopaedic staff overseeing her care. However, the Adviser explained it was unreasonable that no blood tests were carried out at that time. The Adviser said that

if the blood tests showed Ms A's CRP to be high, she should have been referred for a joint aspirate. The Adviser explained that a joint aspirate would have been the most useful investigation to diagnose an underlying hip infection.

Medical advice: mid-2012 orthopaedics review

24. The Adviser explained that in March 2012, Ms A was referred for an MRI scan at Perth Royal Hospital. The Adviser explained that this is a scan that works on magnetism. Therefore, anything metallic (such as a hip replacement) will cause an interference or void. This can only be avoided by using a specific Metal Artefact Reduction Sequence ('MARS') in carrying out the MRI scan. The Adviser explained that not all hospitals will have access to this. The Adviser considered that if a MARS type of MRI scan was available at Perth Royal Hospital, the orthopaedics staff should have specified this when they made the referral. If this was not available, the Adviser considered that an MRI scan was not a helpful investigation, as it did not show the tissue next to Ms A's hip replacement. The Adviser explained that there was interference in her MRI scan results as a MARS was not used. For this reason, the Adviser told us the radiologist appropriately arranged for Ms A to also have an ultrasound scan and a CT scan.

25. Given the type of investigations that Ms A was referred for, the Adviser considered the medical staff seemed most concerned about the possibility she had a pseudo tumour. The Adviser explained that one of the causes of hip replacement failure is due to a mass of abnormal soft tissue destroying the surrounding soft tissue (a pseudo tumour). This can be caused by irritation from the hip replacement.

26. The Adviser explained that Ms A's ultrasound scan was abnormal, as it showed an area of soft tissue that was more dense than usual. The ultrasound report said it was unclear if this was due to metallosis (where metal debris is released into the body from a hip replacement) or surgical scarring. The Adviser said the ultrasound report noted that Ms A's symptoms were originating from that area of her body. The ultrasound report stated it might be appropriate to carry out a further ultrasound scan, a few months later, to check if the area of abnormal tissue had increased in size.

27. The Adviser explained that Ms A's CT scan was also not normal. It reported a thickening in the soft tissue over the ball part of her hip replacement. The CT scan reported that this could have been the onset of metallosis or surgical scarring.

28. Ms A was reviewed by a different consultant orthopaedic surgeon in April 2012. They noted that Ms A had groin pain; she had pain when she rotated her hip; and she was struggling to get up from a seated position. The Adviser explained that

these were all specific signs and symptoms consistent with a problem with Ms A's hip replacement. The Adviser said that, for the same reasons as in early 2012, they should have referred Ms A for blood tests to check her CRP level. If it was raised, the Adviser said that a joint aspirate should have been carried out. The Adviser described the failure to do so as unreasonable.

Medical advice: clinical audit facilitator reviews

29. From May 2013 onwards, a clinical audit facilitator regularly reviewed Ms A and they checked her blood metal ion levels. The Adviser confirmed this was appropriate and it was in line with the relevant MHRA guidance on metal-on-metal hip replacements.

Medical advice: 2015 orthopaedics reviews

30. In February 2015, Ms A was referred for blood tests by rheumatology. The results reported she had a CRP level of 37. The Adviser explained that a CRP level should be below 10 and anything over 20 would require further investigation. It was noted that Ms A was referred for subsequent blood tests by her GP and rheumatology in late 2015 and early 2016. From the results, the Adviser noted that Ms A's CRP level was shown to be persistently high (ranging from 27 to 42).

31. In April 2015, Ms A's GP referred her to orthopaedics. She had further x-rays in June 2015 (which were not reported by radiology). The Adviser explained that these x-rays showed increasing lysis (progressive loss of bone on-growth) around the ball part of her hip replacement. The Adviser commented that although these changes were subtle in one view of the x-rays (the AP or front to back view), they were more obvious in the other view (the lateral or sideways view).

32. In August 2015, Ms A was reviewed by an orthopaedic surgeon. The Adviser noted that the changes in her June 2015 x-rays were not identified at that time. The Adviser considered this was unreasonable. The Adviser commented that if the orthopaedic surgeon had identified the x-ray changes, it would have increased their awareness of the possibility of Ms A having an underlying hip infection. The Adviser commented that Ms A's February 2015 blood test results, showing a raised CRP level, was further suggestive of this. The Adviser stated it was unreasonable that Ms A was not referred for further blood tests to check her CRP level and/or a joint aspirate at that time.

33. The Adviser noted that instead, Ms A was referred for a further MRI scan. It did not report any evidence of a pseudo tumour or a collection of fluid in her hip joint. However, the Adviser explained that, for the reasons discussed above, this was not a

helpful test for investigating the area next to her metal hip replacement. The Adviser said that a further ultrasound scan would have been a better investigation to check for any collection of fluid in her hip joint. However, regardless of whether Ms A had fluid there or not, the Adviser said that a joint aspirate should have been carried out. The Adviser explained that even if there is no fluid, it is possible to flush water into the hip joint before carrying out a joint aspirate.

34. In November 2015, Ms A was reviewed by an orthopaedic surgeon and referred for physiotherapy. The Adviser said that a physiotherapy referral would have been reasonable if all other causes of her hip pain had been excluded. However, the Adviser considered that was not the case. The Adviser said that, as stated previously, further blood tests should have been carried out to check Ms A's CRP level and/or a joint aspirate should have been carried out.

Medical advice: 2016 x-rays

35. The Adviser noted that in 2016, a clinical audit facilitator referred Ms A for x-rays. The Adviser explained that these May 2016 x-rays again showed changes that were particularly visible in the lateral view. The Adviser considered it was unreasonable that the changes were not identified. The Adviser noted it was unclear who reported the x-rays. The Adviser explained that it should not have been the responsibility of the clinical audit facilitator, as they would not be expected to have the appropriate experience or training to do so.

Medical advice: 2017 orthopaedics review

36. In mid-May 2017, Ms A was referred for further x-rays. The Adviser explained that the x-rays showed increasing lysis around the ball part of Ms A's hip replacement, as well as a definitive loosening of the cup part. The Adviser confirmed that these changes were not subtle. When Ms A was reviewed by an orthopaedic surgeon in May 2017, the x-ray changes were not identified. The Adviser considered the failure to do so was unreasonable.

37. In June 2017, Ms A attended a yearly review with a clinical audit facilitator. According to the Board's complaints file, the changes in her May 2017 x-rays were identified at that time. Ms A was referred to a different orthopaedic surgeon for a further opinion. She was still waiting for an appointment when her hip replacement failed in early August 2017. This meant Ms A had been waiting around three months for an orthopaedic review, after her May 2017 x-rays showed definitive changes to her hip replacement. The Adviser considered this was an unreasonable delay in her care and treatment.

38. The Adviser noted that in August 2017, Ms A experienced a catastrophic failure of her hip replacement. She was admitted to Ninewells Hospital as an emergency. Ms A had further hip surgery and her underlying right hip infection was identified.

Medical advice: impact of delay

39. The Adviser said that the delay in diagnosing Ms A's underlying right hip infection would have caused her unnecessary pain and disability. The Adviser explained that, for example, Ms A would have experienced a limited ability to walk distances; difficulty going up and down stairs; problems getting up from a seated position; and difficulties with other activities of daily living such as getting dressed. However, the Adviser confirmed that Ms A would have needed the same treatment (a staged hip replacement) if her underlying hip infection had been diagnosed earlier. The Adviser also explained that the delay in diagnosis would not have affected Ms A's long-term outcome, after her right hip infection was diagnosed and treated.

Decision

40. The basis on which I reach conclusions and make decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. I do not apply hindsight when determining a complaint.

41. The advice I have received, and I accept from the Adviser, is that between 2012 and 2017, there was an unreasonable failure to fully investigate Ms A for any right hip infection. Specifically, that in her January 2012 orthopaedics review, Ms A should have been referred for blood tests to check if her CRP level was raised. If it was, a joint aspirate should have been carried out in line with the applicable guidelines, as this is the recommended test for diagnosing any underlying joint infection. I consider that the failure to do so was unreasonable.

42. Ms A’s ultrasound and CT scans were abnormal in March 2012 and she attended subsequent orthopaedic reviews on several occasions between April 2012 and May 2017. At these reviews, I was advised that there was a repeated failure to carry out blood tests and/or a joint aspirate to properly investigate her for any underlying hip infection in light of Ms A’s presentation. I am critical that these opportunities to properly investigate and diagnose Ms A were missed by medical staff over this period.

43. I was advised that Ms A's June 2015 x-rays were abnormal. They showed definite changes to her hip replacement, specifically increasing lysis around the ball part. However, these changes were missed by the orthopaedic surgeon who

reviewed Ms A in August 2015. Changes were also apparent in Ms A's x-rays in May 2016. They were again not identified but it was not clear from the medical records who reported them. My expectation is that health boards should have robust systems in place for reporting and reviewing orthopaedic x-rays. My investigation has demonstrated this was not Ms A’s experience and I am critical of this.

44. I was advised that in May 2017, Ms A's x-rays showed further definitive lysis around the ball part of her hip replacement and a loosening of the cup part. The Board accepted there were 'subtle' changes apparent in those x-rays. They acknowledged they were missed by the orthopaedic surgeon who subsequently reviewed Ms A and they apologised for this. However, the advice I received and I accept is that those May 2017 x-ray changes were not subtle and it was unreasonable they were not identified.

45. It is clear that Ms A was seen by a number of different orthopaedic surgeons over a five year period. Despite this, there were repeated failures to carry out appropriate tests; and to appropriately report on and review x-ray findings. I consider this points to recurring and systemic failings in care, which I am extremely critical of.

46. In light of the above, I consider there was a significant and unreasonable delay in diagnosing and treating Ms A's right hip infection from early 2012 onwards. Her underlying right hip infection was only diagnosed after the catastrophic failure of her hip replacement in August 2017.

47. The advice I received, and I accept, is that an earlier diagnosis would not have changed the treatment Ms A ultimately needed, which was a staged hip replacement. Also, that it would not have changed her long-term outcome. I hope this provides some measure of comfort to Ms A now. However, the delay would undoubtedly have caused her unnecessary pain and disability over that five-year period. I am deeply concerned about the impact this had on Ms A physically, mentally and emotionally. Her life was impacted by her severe daily pain and exhaustion. She was also affected by the experience of feeling disbelieved or dismissed by the orthopaedics staff that something was seriously wrong with her hip joint.

48. The Board’s failings in Ms A’s care and treatment were, in my view, compounded by their failure to adequately investigate her complaint. The failings in care my investigation has identified could, and should, have been established in the Board's complaints investigation. Particularly, given the fact that there are recognised clinical guidelines that apply as set out above. Not to do so was a missed

opportunity to identify and learn from Ms A’s experience which I consider represents a further failing.

49. In light of the failings identified, I uphold this complaint. My recommendations for action by the Board are set out below. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints
The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Ms A:

What we found	What the organisation should do	What we need to see
There was a failure to properly investigate Ms A for a hip infection over a period of five years in light of her presentation; to appropriately report on and review her x-rays over this period; and an unreasonable delay in offering Ms A an orthopaedics review after her May 2017 x-rays showed concerning changes to her hip replacement	Apologise to Ms A for the failings in diagnosing and treating her right hip infection; and the unreasonable delay in offering her an orthopaedics review	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 26 August 2019

We are asking the Board to improve the way they do things:

What we found	Outcome needed	What we need to see
There was a failure to properly investigate Ms A for an underlying right hip infection over a period of five years in light of her presentation	Patients, who have symptoms suggestive of an underlying joint infection, should be fully and appropriately investigated, in line with recognised guidelines	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails. Evidence that the Board have prepared a local guidance policy, which is in line with recognised guidelines for investigating hip replacement infections By: 24 September 2019
There was a failure to appropriately report on x-rays taken in 2015 and 2016	Orthopaedic x-rays should be appropriately reported	Evidence that a review of the Board's system for reporting orthopaedic x-rays has been carried out, in light of the findings of this investigation and details of the action taken on any areas identified for improvement By: 24 September 2019

What we found	Outcome needed	What we need to see
There were concerning and obvious changes in Ms A's x-rays in 2015, 2016 and 2017, which were missed in her orthopaedic reviews	The results of hospital tests and investigations should be carefully reviewed	Evidence that the findings of this investigation have been fed back to the clinicians involved in a supportive way that promotes learning, including reference to what that learning is. Confirmation that the relevant clinicians will discuss this case at their next appraisal By: 24 September 2019
When the changes in Ms A’s May 2017 x-rays were subsequently identified, there was an unreasonable delay in offering her an orthopaedics review as she waited over three months to be seen	In similar circumstances, patients should receive an orthopaedics review in a timely manner	Evidence of the steps being taken to ensure that patients are given a timely orthopaedics review in similar circumstances By: 24 September 2019

We are asking the Board to improve their complaints handling:

What we found	Outcome needed	What we need to see
The Board's investigation did not identify and/or acknowledge the significant failings in the care provided to Ms A	The Board's complaints handling system should ensure that failings (and good practice) are identified, where appropriate remedied, and that it is using the learning from complaints to inform service development and improvement (where needed)	Evidence that the Board have demonstrated learning from this case and complaints in general By: 24 September 2019

Feedback

Points to note:

Included in the advice I received and accepted were the following points from the Adviser:

- a clinical audit facilitator regularly reviewed Ms A and checked her blood metal ion levels. This was appropriate and it was in line with the relevant MHRA guidance on metal-on-metal hip replacements.
- an MRI scan in 2012 was not a helpful investigation if a MARS type of MRI scan was not available.
- after Ms A's hip replacement failed in August 2017, she was given entirely reasonable treatment by the Board.

Terms used in the report — Annex 1

Term	Meaning
bone scan	a scan that creates images of bones
blood ion levels	levels of metal particles in the blood
clinical audit facilitator	a hospital staff member who measures patient care and outcomes against national standards
CRP	c-reactive protein - a blood test marker for inflammation in the body
CT scan	a (computerised tomography) scan that uses x-rays and a computer to create detailed images of the inside of the body
joint aspirate	where fluid is removed from the space around a joint and tested for an infection
lysis	a progressive loss of bone on-growth
metal-on-metal hip replacement	a hip replacement where both the ball and the socket parts of the hip joint are made of metal
MARS	metal artefact reduction sequence - used to avoid an interference caused by metal in the body when carrying out MRI scans
metallosis	where metal debris is released into the body from a hip replacement
MHRA	the Medicines and Healthcare Products Regulatory Agency - responsible for ensuring that medical devices used in the UK work and are safe
MRI scan	Magnetic resonance imaging scan

Ms A	the aggrieved
Mrs C	the complainant and Ms A's advocacy worker
orthopaedic surgeon	a surgeon who specialises in the musculoskeletal system
orthopaedics	specialists in the musculoskeletal system
osteoarthritis	chronic breakdown of cartilage in the joints leading to pain, stiffness and swelling
physiotherapy	treatment that aims to restore movement and function when someone is affected by an injury or illness
pseudo tumour	a non-cancerous soft tissue growth caused by irritation
radiologist	a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans
rheumatology	the branch of medicine concerned with immune-mediated disorders of the musculoskeletal system
staged hip replacement	where all parts of a hip replacement are surgically removed and an infection is treated, before a further hip replacement is carried out
the Adviser	a consultant orthopaedic surgeon who provided medical advice on Ms A's care and treatment
the Board	Tayside NHS Board

total hip replacement	a surgical procedure where a damaged hip joint is replaced with an artificial (prosthetic) one
ultrasound scan	a scan that uses sound waves to create images of organs and structures inside the body

List of guidance considered **Annex 2**

The Diagnosis of Periprosthetic Joint Infections of the Hip and Knee guidelines issued by AAOS (American Academy of Orthopaedic Surgeons) (June 2010)

Medical Device Alert on all Metal-on-metal Hip Replacements guidance issued by the MHRA (Medicines & Healthcare Products Regulatory Agency) Ref: MDA/2012/036 (June 2012)

Proceedings of the International Consensus Meeting on Periprosthetic Joint Infection guidelines circulated by EFFORT (the European Federation of National Associations of Orthopaedics and Traumatology) (October 2013)

All Metal-on-metal Hip Replacements: updated advice for follow-up of patients guidance issued by the MHRA Ref: MDA/2017/018 (June 2017)