Investigation Report

Investigation of a complaint against the Belfast Health & Social Care Trust

NIPSO Reference: 202001381

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

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

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Appendix 1 – The Principles of Good Administration
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Case Reference: 202001381
Listed Authority: Belfast Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complaint is about the care and treatment the Trust provided to the complainant's late mother (the patient) for her cancer during the period April 2019 to September 2020. The complainant said the Trust did not physically examine the patient to determine whether she remained 'cancer free'[1], and she believed the Trust's care plans should have included physical examinations. The complainant also said the Trust failed to communicate to the patient and her family about the patient's on going follow up care.

The investigation examined the details of the complaint, the Trust's response, and relevant internal guidance and national standards. I also sought advice from an Independent Professional Advisor (IPA). The investigation established the Trust provided the appropriate follow up care to the patient, and provided the patient with an appropriate care plan. The investigation also established the Trust provided the patient and her family with appropriate communication about the patient's on going care.

I asked the Trust to reflect on the learning and service improvements outlined by the IPA within their advice in order to further improve communication and the quality of information provided to patients and their relatives.

[1] Cancer free diagnosis is when a patient is entirely free of cancer.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complaint is related to the care and treatment the Trust provided to the complainant's late mother (the patient) from April 2019 to September 2020 in relation to her cancer diagnosis.

Background

2. The Trust previously diagnosed the patient with cervical cancer, and in April 2019, she was informed her cancer was in remission. Following this, the Trust provided the patient with follow up appointments to determine if her cancer remained in remission. During the patient's clinical review in April 2019, the Trust provided the patient with a Gynae[2] Follow Up leaflet, and the contact details of a Gynae Clinical Nurse Specialist[3] (CNS). At this consultation, the Trust advised the patient to contact her CNS if she had developed any abnormal symptoms.

3. During the period May 2020 to September 2020 the patient attended follow up appointments with the Trust. These appointments occurred virtually via telephone communication due to the Covid 19 pandemic. Following the development of a cough in September 2020 the patient contacted her GP, who subsequently referred her for a chest x-ray and a CT scan. The patient received both scans in September 2020 and the results of which showed a left hilar mass[4]. The GP referred the patient to the Southern Health and Social Care Trust's Respiratory Team who diagnosed her with secondary cancer. On 2 February 2021 the patient sadly passed away from metastatic carcinoma[5] of the cervix.

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[2] Gynaecology is the medical practice dealing with the health of the female reproductive system.
[3] Clinical Nurse Specialist are dedicated to a particular area of nursing; caring for patients suffering from long-term conditions and diseases such as cancer.
[4] A hilar mass is an abnormality in one or both of the hilar lymph nodes in the lung. It normally indicates cancer.
[5] Cancer that is able to grow at sites distant from the primary site of origin.

Issue of complaint

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

   Whether the care and treatment provided to the patient between April 2019 and September 2020 was appropriate and in accordance with relevant procedures and standards.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

   - The IPA is a Consultant Gynaecological Oncologist since 1989. MB. CHMB. MD. FRCOG. The IPA has extensive experience in treating and follow-up of women with cervical cancer.

   I enclose the clinical advice I received at Appendix three to this report.

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[6]:

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

9. 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:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- British Gynaecological Cancer Society Cervical Cancer Guidelines: Recommendations for Practice May 2020 (BGCS Guidance);
- National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology for Cervical Cancer V.3.2013 (NCCN Guidance);
- Scottish Intercollegiate Guidelines Network on the management of cervical cancer 2008 (SIGN Guidance);
- British Gynaecological Cancer Society BGCS framework for care of patients with gynaecological cancer during the COVID-19 Pandemic 22 March 2020 (BGCS Covid 19 Guidance); and
- Belfast Health and Social Care Trust Division of Cancer and Specialist Medicine Covid-19 Surge Plan April 2020 (Trust Covid Guidance).

I enclose relevant sections of the guidance considered at Appendix four to this report.

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

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient between April 2019 and September 2020 was appropriate and in accordance with relevant procedures and standards.

In particular this will consider:

- Examination of the patient and follow up care;
- Care plan for the patient;
- Communication with the patient and her family; and
- Impact of Covid 19 on treatment.

Detail of Complaint

12. The issue of complaint is about the care and treatment the Trust provided to the patient from April 2019 to September 2020. The complainant raised the following concerns:
    - The Trust did not physically examine the patient to determine if she remained ‘cancer free’ despite her complaining of pelvic pain. The patient did not receive scans or blood tests, and nothing was done until the patient developed a cough in September 2020;
    - The Trust should have put in place a care plan for the patient to include regular physical examinations to determine if the patient remained ‘cancer free’; and
    - The Trust left it to the patient to decide for herself if she was sick. The complainant believed this was not sufficient.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following policies and guidance:
    - The GMC Guidance;
    - BGCS Guidance;
    - NCCN Guidance;
    - SIGN Guidance;
    - BGCS Covid 19 Guidance; and
    - Trust Covid Guidance.

    I enclosed relevant sections of the guidance at Appendix four to this report.

The Trust's response to investigation enquiries

14. As part of the investigation enquiries the Trust provided a response to this Office. I enclose the Trust's response to my enquiries at Appendix six to this report.

Relevant Trust's records

15. The Trust provided the relevant clinical records and a summary of these records is enclosed in Appendix five to this report.

Response to the draft Investigation Report

16. Both the complainant and the Trust were given an opportunity to provide comments on the draft Investigation Report. Where appropriate, comments have been reflected in changes to the report.

Relevant Independent Professional Advice

Examination of the patient and follow up care

17. The IPA advised the follow-up care the Trust provided to the patient during the period April 2019 to September 2020 was appropriate. The IPA advised that traditionally a patient should be examined every four to six months, *'however there is no clinical examination that would have identified the lung metastases and with no lung symptoms there was no indication for imaging'*.

18. The IPA advised, the Trust's prescription of Vagifem[7] was *'appropriate as safe and possibly effective. No other treatment indicated'*.

19. The IPA advised it was the case that the Trust left it to the patient to determine whether or not she was 'cancer free' and this *'was appropriate'*. The IPA explained, *'most recurrences are diagnosed when symptoms occur, and not at routine appointments'*. The IPA advised, *'follow up clinics do give a chance to look for and manage treatment toxicity. They give reassurance to some women, but by no means all'*. The IPA further advised follow up clinics *'greatly cut back on face to face clinics and moved more to patient symptom reporting'*.

20. The IPA advised it was appropriate for the Trust to signpost the patient to her CNS if she should develop any abnormal symptoms. The IPA advised the only failing he had identified was that the Gynae Follow-Up Leaflet *'does not make plain that the symptoms to report are those which suggest recurrence as well as treatment side effects. Probably all oncology units are guilty of not explaining the limitations of imaging and lack of value of follow up'*.

21. The IPA recommended the Trust make a *'change to the post radiotherapy follow up information sheet to mention the possibility of those symptoms being recurrence'*. The IPA further recommended the Trust implements *'better counselling as to the true accuracy and prediction of post treatment scans and the poor ability of follow up to have any impact on the chance of surviving cancer'*. The IPA advised, *'the change in follow up due to Covid made no difference to the outcome'*.

Care Plan

22. The IPA advised the patient's care plan was appropriate. The IPA advised the patient should not have received any other imaging, and *'the role of routine imaging (scans) after chemo radiotherapy for cervical cancer is controversial and of limited value if there are no salvage options'*. The IPA advised he did not identify any failings.

[7] Vagifem is used to relieve menopausal symptoms in the vagina such as dryness or irritation.

Communication with the patient and her family

23. The IPA advised the level of communication between the Trust and the patient was appropriate. The IPA also advised the level of communication between the Trust and the patient's family was appropriate. The IPA advised, *'the individual clinicians acted the way that many would have done in an area with no specific guidance.'* The IPA highlighted the need for *'better counselling as to the true accuracy and prediction of post treatment scans and the poor ability of follow up to have any impact on the chance of surviving cancer would help prevent occurrences of patients and relatives feeling that something had been missed'*.

Impact of Covid 19 on Care and Treatment

24. The IPA advised it was appropriate for the Trust to delay the patient's review appointment from February 2020 to May 2020 but *'not ideal if the patient was awaiting an earlier appointment from an anxiety perspective'*. The IPA advised it was appropriate for the patient to receive virtual appointments as part of her follow up care during the period May 2020 to September 2020. The IPA explained this was because *'Covid changed everything'*.

25. The IPA advised Covid 19 did not have an impact on the patient's care and treatment as the patient did not report lung symptoms until September 2020.

Analysis and Findings

Examinations and Follow Up Care

26. The complainant said from April 2019 to September 2020 the Trust did not physically examine the patient to determine if she remained 'cancer free'. The complainant said the Trust left it to the patient to determine whether or not she was sick.

27. The Trust stated that during the patient's examinations, the Consultant assessed the patient and that she underwent a pelvic examination in April 2019. During this appointment, the Consultant gave the patient the contact details of a Gynae CNS, whom the patient was to contact if she should develop any abnormal symptoms. The Trust explained it also provided the patient with a Gynae Follow Up Leaflet at her appointment in April 2019. This leaflet provided

information to patients about the follow up care and side effects a patient can expect once they have finished radiotherapy and/or brachytherapy[8] treatment for gynae cancer. The leaflet provided contact information patients could avail of, should they be concerned about their symptoms. The Gynae Follow Up Leaflet also explained to patients the frequency of their clinical reviews following their diagnosis of 'cancer free'. The leaflet states, *'as part of your care you may be referred to the Gynae Oncology Nurse-Led Telephone Review Clinic as follows: Year 1 after treatment every 4-6 months, Year 2 after treatment every 6 months, Year 3-5 after treatment once a year'*. This leaflet provided the patient with advice on what to expect during these clinical assessments.

28. The Trust's records document the patient received an MRI on 3 April 2019 which showed no residual cancer. At this appointment the records document the Trust explained to the patient that following this MRI, the Trust would not be carrying out routine imaging. The Trust explained to the patient it would continue to follow up the patient clinically. The records document the Trust advised the patient further imaging would only be carried out if she developed concerning symptoms, and was signposted to her CNS should she have any concerns.

29. The Trust's records document the patient attended a clinical review on 14 August 2019, and the review was satisfactory. The Trust's records document the patient's next in-person clinical review was due in February 2020. However, I note the Trust delayed this clinical review to a virtual telephone review appointment in May 2020 due to the Covid 19 pandemic. The patient attended a virtual clinical review by telephone on 4 May 2020. During this review the Consultant documented that the patient was describing a dull pelvic pain and was prescribed topical oestrogen cream. The Consultant advised the patient that if her symptoms did not improve she should contact her CNS, and an MRI of her pelvis would be organised. In September 2020 the records document the patient attended with her GP with hoarseness and a cough. The patient received an x-ray, and the GP referred the patient to the respiratory team within

[8] Brachytherapy involves the insertion of radioactive material into a patient's body near the cancer.

the Southern Health and Social Care Trust following hoarseness and a chest x-ray abnormality.

30. I note the SIGN Guidance states, *‘follow up does not have a high sensitivity for detecting recurrence […] but may have other benefits such as detection of treatment side effects, psycho sexual or psychosocial morbidity’*. I further note the NCCN Guidance states, *‘history and physical examination should be performed every three to six months for two years; every six to 12 months for another three to five years, then annually’*. This guidance also states, *‘patient education regarding symptoms suggestive of recurrence should be provided’*.

31. I note the IPA’s advice that the follow up care the Trust provided to the patient during the period April 2019 to September 2020 *‘was appropriate’*. The IPA advised, *‘there is no clinical examination that would have identified the lung metastases and with no lung symptoms there was no indication for imaging’*. I am also satisfied it was appropriate that the patient received virtual telephone appointments during the period May 2020 to September 2020, given the circumstances of the Covid 19 pandemic.

32. I also note the IPA has advised, *‘there is no evidence that follow up (cervical) cancer treatment improves survival’* and that *‘most cases of recurrent cervical cancer present with symptoms between the fairly arbitrary clinical dates’*. I note the IPA’s assurance that it was appropriate for the Trust to signpost the patient to her CNS if she should develop abnormal symptoms, and the Gynae Follow Up leaflet the Trust provided to the patient documented these symptoms. I note that IPA has highlighted this Follow Up leaflet does not make it plain that the symptoms to report are those which suggest recurrence as well as treatment side effects. The IPA recommended as a service improvement, the Follow Up leaflet should include the mention that symptoms could be a possibility of recurrence. I ask the Trust to reflect on this and consider the addition of such clarification.

33. After consideration of all the available evidence, I accept the IPA’s advice that the follow up care the Trust provided to the patient during the period April 2019 to September 2020 was appropriate. I accept the frequency of follow up care

appointments the patient received from the Trust was in line with the NCCN Guidance. I accept the IPA's advice it was appropriate that the Trust left it to the patient to raise concerns about any of her symptoms which might have been a sign of cancer recurrence. The SIGN Guidance and the NCCN Guidance highlight that symptoms of cancer recurrence often occurs between follow up review appointments, and highlights the importance of patients checking for, and monitoring these symptoms. I accept the Trust continued to educate the patient of this, and what symptoms she should look out for, and appropriately signposted the patient to contact her CNS should she develop any symptoms of recurrence. I note the Trust made the patient aware of the role of the CNS frequently throughout her clinical reviews.

34. Overall, in relation to the examinations and follow up care, I am satisfied that the Trust provided the appropriate care and treatment to the patient. For this reason I do not uphold this element of the complaint.

Care Plan

35. The complainant said the Trust should have put in place a regular care plan for the patient to include regular physical examinations.

36. The Trust stated the patient had regular follow up appointments with the Trust's Oncology service, and the Consultant physically examined the patient during her face to face appointments. The Trust stated the Consultant discussed all of the patient's symptoms during her telephone review appointments. The Trust also stated, it discussed the patient at the Gynae and Lung Multidisciplinary Team meetings at all decision points in the patient's management plan. The Trust stated it provided the patient with contacts in different medical departments to contact if she had any concerns between clinical review appointments.

37. I note the Trust's records document the patient had an MRI on 3 April 2019 which showed no residual cancer. At this appointment the Trust's medical records document the Trust explained to the patient, following this MRI that the Consultant would not carry out routine imaging, and the Trust would continue to follow up the patient clinically. The Trust's Consultant advised the patient

further imaging would only be carried out if she developed concerning symptoms, and was sign posted to her CNS should she have any concerns. I note the records do not document the patient reporting any abnormal symptoms to her CNS until September 2020, when she reported a cough and hoarseness to her GP.

38. I note the BGCS guidance states, *'routine imaging has no place and should be used in symptomatic patients'*. The NCCN Guidance states *'imaging is not routinely recommended but may be indicated in women with symptoms or examination findings suspicious for recurrence'*.

39. The IPA advised the care plan in place for the patient following her diagnosis of 'cancer free' was appropriate. The IPA advised the patient did not have any additional scans or tests until her CT scan on 23 September 2020 and this was appropriate. The IPA advised, *'the role of routine imaging (scans) after chemo radiotherapy for cervical cancer is controversial and of limited value if there are no salvage options'*. The IPA advised the patient *'should not have had any other imaging'*.

40. I accept the advice of the IPA that the patient's care plan *'was appropriate'*. I consider the Trust's care plan was in line with the BGCS guidance, and the NCCN Guidance, as the records do not document that the patient contacted her CNS to seek advice on the development of any symptoms of possible cancer recurrence. I note that both pieces of guidance state that *'routine imaging has no place for asymptomatic patients'*, and I accept the advice of the IPA, *'most recurrences are diagnosed when symptoms occur and not at routine clinics'*. I acknowledge the Trust stated, if the patient's pelvic pain was persisting following the prescription of topical oestrogen replacement therapy, it would have organised an MRI for the patient. After consideration of all of the available evidence, including the advice of the IPA, I am satisfied that the Trust's care plan for the patient was appropriate, and I do not uphold this element of the complaint.

Communication with the patient and her family

41. The complainant said the Trust's communication with the family and the patient for the period April 2019 to September 2020 was not adequate. The complainant felt the patient did not fully understand what the Trust were advising her. The complainant said the Trust made no effort to clarify this information for the patient, and the Trust did not keep the family informed of the patient's progress during the period of April 2019 to September 2020.

42. The Trust stated, *'the oncology service invite patients for follow up review appointments not only to look for signs of recurrence, but also to manage any consequences of treatment, either physical or psychological'*. The Trust further stated it ensures, *'our patients have access to a clinical nurse specialist, so that they can make contact, and be seen promptly by the team if they have any concerns'*. The Trust stated, *'we are sorry [the complainant] did not get a clear picture from her mother regarding her condition'*. During local resolution, the Trust's Consultant apologised to the complainant and her family that their experience was she did not clarify all of the patient's pelvic scans findings during the complaints process.

43. I note the Trust records do not explicitly document what information the Trust provided to the patient's family during the period April 2019 to September 2020 regarding the patient's health. I also note the Trust's medical records do not document an instance in which the family contacted the Trust to clarify or obtain information about the patient's ongoing follow up treatment.

44. The Trust records document that the Trust provided the patient with a Gynae Follow Up leaflet. This leaflet provided the patient with advice regarding her follow up care, contact telephone numbers if the patient had any concerns, and symptoms for the patient to look out for. The Trust's records also document the Trust advised the patient several times of the role of her CNS, and that she could contact her if she had developed any abnormal symptoms.

45. The IPA advised the level of communication between the patient, family and the Trust was appropriate during the period of April 2019 to September 2020. The IPA advised, *'the individual clinicians acted the way that many would have*

done in an area with no specific guidance. There may be an understandable reluctance to stress negatives and limitations to patients and relatives'. The IPA advised, *'many oncologist may not fully explain the limitations of both follow up clinics and post treatment scans (though there is no guidance regarding this). Better counselling as to the true accuracy and prediction of post treatment scans and the poor ability of follow up to have any impact on the chance of surviving cancer would help prevent occurrences of patients and relatives feeling that something had been missed as in this case'*. The IPA advised he did not identify any failings in the area of communication between the Trust and the patient, and her family.

46. I acknowledge the IPA's advice that this area of communication has no specific guidance. I note the Trust's documentation does not state what information the Trust communicated to the family. However, I am satisfied the Trust made the patient aware of the role of her CNS during all of her follow up appointments, and the Trust appropriately provided the patient with a Gynae Follow Up leaflet.

47. For the reasons outlined above I do not uphold this element of the complaint. I understand the frustration the patient and her family had in relation to the communication the Trust provided to them about the patient's care. However I am satisfied the Trust provided appropriate communication to the patient during her follow up appointments.

48. I note the IPA's recommendation for the Trust to provide better counselling to patients and families to prevent occurrences of patients and relatives feeling that the Trust had missed something. Without specific guidance in this area, I do not consider this a failing, however I would ask the Trust to reflect on the IPA's recommendation.

49. In response to the draft Investigation Report, the Trust informed my Office *'the Gynae Oncology team is now fully supported by a CNS and a Clinical Specialist Radiographer'*. The Trust stated, *'this ensures that each individual patient and their family have access to a key worker for their entire patient pathway'*. The Trust explained this service enhances counselling and support for patients and their families given the challenging physical, psychological and

emotional consequences of a cancer diagnosis and its treatment. The Trust stated that the team will also review the content of the patient information sheets as suggested by the IPA as part of a service improvement.

Impact of Covid 19 on Care and Treatment

50. The complainant said the Trust delayed the patient's appointment in February 2020 to a virtual telephone appointment in May 2020 due to the Covid 19 pandemic.

51. The Trust stated due to the pandemic the Trust transferred all patients on the Gynae Oncology follow up waiting lists to virtual telephone follow up appointments. The Trust stated the initial telephone review with the patient was to optimise patient safety and minimise hospital visits.

52. The Trust stated during the assessment on 4 May 2020 if the patient had been experiencing any new symptoms such as a vaginal bleeding or discharge, the Trust would have invited the patient to come to the Cancer Centre for a face-to-face clinical assessment at which a Consultant would have carried out a pelvic examination. During the patient's virtual telephone appointment the Trust stated the Consultant specifically asked the patient about vaginal bleeding and discharge, and she confirmed she did not have either of those symptoms. The Consultant made the patient aware that if she experienced these symptoms to contact her CNS and an MRI scan of her pelvis would be organised. The Trust stated at this consultation in May 2020, the patient's major symptom was continued diarrhoea, which the Gastroenterology team at the Southern Health and Social Care Trust actively managed. The Trust would have booked a SeHCAT[9] test for the patient within the Trust once the service was again operational and the pandemic situation had improved.

53. The Trust Covid guidance states from 22 April 2020, *'all review clinics have moved to telephone review where possible'*. I note the BGCS Covid Guidance states, *'hospital face-to-face should be minimised and alternatives for routine*

[9] A diagnostic procedure to determine how well the gut is able to absorb bile acids.

follow-up such as virtual clinics (telephone or videoconference) or patient-initiated follow-up should be considered'.

54. The IPA advised it was appropriate to delay the patient's appointment from February 2020 to May 2020. The IPA further advised it was *'not ideal if the patient was awaiting an earlier appointment from an anxiety perspective'*. However the IPA advised this had no impact on the outcome for the patient as she did not report lung symptoms until September 2020. I accept this advice.

55. I acknowledge Covid 19 was a difficult time for all patients in Oncology, including the patient and her family. I accept the Trust acted in accordance with guidance when it moved the patient's in person appointments to virtual telephone appointments. I acknowledge the delay in the patient's appointment from February 2020 to May 2020 caused the patient and her family a great deal of anxiety. I wish to reassure the complainant this delay did not impact the patient's health and prognosis at that time. I recognise the Trust advised if the patient presented with the ongoing symptoms of the pelvic pain she reported in May 2020, the Trust would have invited her a physical examination within the Cancer Centre. However, I note from the Trust's documentation, the patient did not report changes to her GP until she developed a cough in September 2020. After consideration of all of the available evidence, including the advice of the IPA, I am satisfied the patient received the appropriate care and treatment during this time period and I do not uphold this element of the complaint.

CONCLUSION

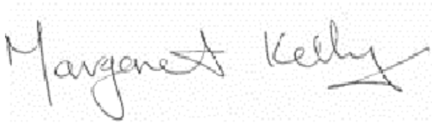
56. The complainant raised concerns about the care and treatment the Trust provided to the patient between April 2019 and September 2020.

57. The investigation found the Trust acted appropriately regarding the follow up care, the care plan, communication and Covid 19 on the patient's care and treatment.

58. I wish to highlight the IPA's learning and service improvement suggestion in relation to the Gynae Follow Up leaflet, and counselling to the patient and their

relatives and ask the Trust to consider the addition of the information the IPA has suggested.

59. I understand the issues in the complaint are a great source of concern for the complainant and her family. I hope the findings of this report provide some closure and reassurance that the care and treatment the patient received was appropriate.



Margaret Kelly
Ombudsman **2023**

Appendix 1

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.

- Including complaint management as an integral part of service design.

- Ensuring staff are equipped and empowered to act decisively to resolve complaints.

- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. 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.

4. 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 and actions 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

5. 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.

6. 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 learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.