Investigation Report

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

NIPSO Reference: 202000037

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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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Case Reference: 202000037

Listed Authority: Southern Health and Social Care Trust

SUMMARY

I received a complaint regarding the actions of the Southern Health and Social Care Trust (the Trust). The complaint concerned the care and treatment the Trust's staff provided to the complainant's partner (the patient) between December 2018 and May 2019.

The complainant said the patient was not satisfied with the Trust's assessment of her condition between December 2018 and May 2019. The complainant said during a holiday in Bulgaria in August 2020, the patient sought a second and third opinion about her symptoms. The complainant said the patient was advised on 23 August 2020 in Bulgaria she needed emergency surgery, which was carried out the following day. The complainant believed if the Trust had treated the patient appropriately, she would not have needed this emergency surgery.

The investigation examined the details of the complaint, the Trust's response, clinical records and relevant local and national guidance. I also obtained advice from an independent Consultant Gynaecologist.

I acknowledge the need for emergency surgery in Bulgaria must have been distressing for the patient. However, my investigation found no evidence of failing on the part of the Trust in relation to any of the concerns the complainant raised about the care and treatment the patient received. I did not uphold the complaint.

THE COMPLAINT

1. I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). The complainant raised concerns on behalf of his partner (the patient) about the care and treatment she received between December 2018 and May 2019 in Craigavon Area Hospital (the hospital). The complainant believed the hospital staff did not investigate a myoma[1] on the patient's uterine wall appropriately. The complainant said that the patient required emergency surgery while on holiday in Bulgaria in August 2020 because of the Trust's failure to investigate the myoma correctly.

Background

2. On 21 December 2018 the patient experienced vaginal bleeding and attended the hospital Emergency Department (ED). The patient's GP made a separate gynaecology referral on the same date for a transvaginal examination[2].

3. The patient attended gynaecology outpatients on 25 January 2019. The patient provided information at this appointment regarding the episode of bleeding she had experienced in addition to a history of her menstrual cycle, other episodes of bleeding and any abdominal pain experienced. The patient's GP had previously prescribed Provera[3], which had stopped the episode of bleeding she had encountered.

4. An examination of the patient's abdomen took place as well as a transvaginal ultrasound on 25 January 2019. This showed a 5cm posterior wall uterine fibroid (myoma). The hospital arranged an urgent outpatient hysteroscopy[4] plus or minus mirena coil insertion[5].

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[1] Uterine fibroids, also called leiomyomas or myomas, are growths that appear in the uterus and composed of uterine muscle.

[2] Transvaginal examination or transvaginal ultrasound is a type of pelvic ultrasound used by doctors to examine female reproductive organs.

[3] Provera is used to treat abnormal uterine bleeding and is also used to prevent thickening of the lining of the uterus or womb.

[4] A procedure used to examine the inside of the womb (uterus).

[5] A contraceptive which is inserted into the womb and can also be used to treat heavy periods.

5. The patient underwent a pelvic ultrasound on 18 February 2019 which noted the myoma to be similar in size. Due to the presence of a small haemorrhagic cyst on the right ovary, a follow up scan was organised.

6. On 15 March 2019, the Trust carried out a hysteroscopy and biopsy of the patient. The Trust offered the patient the mirena coil as treatment for bleeding however she declined. The pathologist's report dated 2 April 2019 confirmed there was no evidence of endometrial hyperplasia[6] or malignancy. The hospital communicated this to the patient via letter on 15 April 2019 to explain the results from her hysteroscopy and biopsy were normal.

7. A follow up ultrasound took place on 30 May 2019 which noted the patient did not need further intervention. The Trust stated the fibroid was still present but with no significant change in size. Medical records document there is no need for follow up appointments '*as per Southern Trust guidelines*'. The cyst on left side was in keeping with normal follicular function of the ovaries and did not require onward referral.

8. A full chronology can be found at Appendix four to this report.

Issue of complaint

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

Whether the care and treatment provided to the patient by the Southern Health and Social Care Trust at Craigavon Area Hospital was reasonable and in accordance with relevant standards and procedures.

This will examine:

- *The treatment of the myoma*
- *Follow up and aftercare of the myoma*

[6] A condition in which the lining of the uterus grows too thick.

INVESTIGATION METHODOLOGY

10. 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 information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

12. A Consultant Gynaecologist with 32 years' experience, who has also carried out extensive research into surgery for heavy menstrual bleeding. In addition to this, the IPA has also been a member of a National Institute for Health and Care Excellence (NICE) Guideline group into Heavy Menstrual Bleeding from 2007.

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

14. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA 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

15. 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[7]:

- The Principles of Good Administration

16. 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 Good Medical Practice, updated April 2019 (GMC Guidance);
- NICE Guideline 88 - Heavy Menstrual Bleeding: Assessment and Management, March 2018 (NG88);
- NICE Clinical Guideline 44 - Heavy menstrual Bleeding, updated August 2016 (CG44); and
- Business Services Organisation (BSO) Guidelines on working with Interpreters for HSC Staff and Practitioners, 2018 (BSO Guidelines).

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

18. I did not include all information obtained during the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

19. 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

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

Whether the care and treatment provided to the patient by the Southern Health and Social Care Trust at Craigavon Area Hospital was reasonable and in accordance with relevant standards and procedures.

This will examine:

- *The treatment of the myoma*
- *Follow up and aftercare treatment of the myoma*

Detail of Complaint

20. The complaint is about the care and treatment the patient received between December 2018 and May 2019 from the hospital. The complainant said the hospital did not treat his wife appropriately in 2019 which meant she had to undergo emergency surgery while on holiday in Bulgaria. The complainant also believed that the hospital should not have discharged the patient from Gynaecology and is unhappy that her name was taken off the waiting list for further reviews and/or investigations.

21. The complainant is unhappy with the inaction of the Trust which he said was the reason his wife needed surgery while on holiday. The complainant said that the patient needed a total laparoscopic hysterectomy[8].

Evidence Considered

Legislation/Policies/Guidance

22. I considered the following guidelines, relevant extracts of which are included at Appendix two of this report.

- The GMC Guidance
- NICE NG88 and

[8] Laparoscopic hysterectomy is the surgical removal of the uterus (womb)

- NICE CG44

The Trust's response to investigation enquiries

23. *Treatment of myoma*
The Trust stated that ED, on 21 December 2018, referred the patient to the general Gynaecology clinic due to an episode of prolonged vaginal bleeding. The Trust noted that the patient's periods had returned to normal at her attendance at the general Gynaecology clinic on 25 January 2019.

24. The Trust stated the patient underwent a transvaginal ultrasound on 25 January 2019 which showed *'a 5cm posterior wall uterine fibroid. No other abnormalities were detected'*. Following this, the hospital planned an urgent outpatient hysteroscopy with the option for the mirena coil to be inserted. The Trust stated *'a biopsy was taken which was subsequently reported as normal'*. The patient underwent a pelvic ultrasound which noted the fibroid to be of similar size.

25. *Follow up and aftercare treatment of the myoma*
The Trust stated a follow up scan took place on 18 February 2019 *'due to a small haemorrhagic cyst on the right ovary'*. A further scan was then carried out on 30 May 2019 which stated *'a cyst was noted on the left side but was in keeping with normal follicular function of the ovaries and did not require onward referral'*.

26. The Trust also explained that fibroids will fluctuate in size in women with normal premenstrual hormone activity. The Trust stated that a change in the size of the fibroid of 1-2cm would not have prompted surgical intervention and the patient *'was appropriately treated'* in relation to her myoma.

27. The Trust stated that there is no learning from this case and both consultants who treated the patient feel that their clinical management was appropriate and in keeping with NICE guidelines.

Relevant Trust Records

28. I reviewed the relevant Trust records. Relevant extracts from the clinical records are included at Appendix five to this report.

Relevant Independent Professional Advice

29. The full independent professional advice I received is attached at Appendix two to this report.

30. *Treatment of the myoma*
The IPA advised that *'Fibroids (myomas) are a very common benign tumour of the uterine wall'*.

31. The IPA advised the doctor examining the patient made an urgent hysteroscopy appointment which the IPA believed was not necessary as *'most fibroids require no treatment at all unless very large'*.

32. The IPA on reviewing the patient's medical notes advised that the care and treatment of the patient was appropriate, referring to NICE NG88. The IPA advised that the treatment and approach the Trust took was appropriate. *'Arrangements were made for a hysteroscopy and endometrial biopsy as per NICE (1.5.7). Mirena IUS was suggested as a treatment as per NICE 1.5.10 [NG88]'*.

33. *Follow up and aftercare treatment of myoma*
The IPA advised, following the patient's outpatient appointment on 25 January 2019, the patient did not require any further advice or aftercare at this time as an appointment for a hysteroscopy had been scheduled. Following further appointments on 18 February 2019, 15 March 2019 and 30 May 2019, the IPA advised that the follow up and aftercare was appropriate, and the patient would not have needed any further intervention *'except on systematic grounds, i.e. if the bleeding continued or worsened'*.

34. The IPA advised that the patient did not require follow up care from Gynaecology and *'NICE make no reference to any need for follow up or monitoring'*. It was appropriate that the patient did not remain on any waiting lists. Further to this, the IPA advised the care the Trust provided to the patient was entirely appropriate, well managed and in keeping with NICE guidance and again referenced NICE NG88 sections 1.3.12[9].

Conclusion

35. The IPA advised that based on the information provided, the Trust's actions in terms of both the treatment of the myoma and the follow up and aftercare of the patient was *'entirely appropriate'*. The IPA also advised the treatment and management of the patient was well managed and in keeping with NICE NG88. Further to this, the IPA referenced the relevant sections of the NG88 guidance to illustrate the Trust adhered to appropriate guidelines.

Analysis and Findings

36. *Treatment of the myoma*

The patient attended Gynaecology outpatients on 25 January 2019 due to her ED attendance on 21 December 2018. The hospital obtained a history of the patient's menstrual cycle and performed a transvaginal ultrasound. The IPA advised *'arrangements made for a hysteroscopy and endometrial biopsy as per NICE (1.5.7) [NG88]. Mirena IUS was suggested as a treatment as per NICE (1.5.10) [NG88]'*. The IPA advised that the Trust's actions during this appointment were appropriate. I accept this advice that there was consideration given to undertaking additional investigations and a discussion of treatment options with the patient.

[9] Offer pelvic ultrasound to women with Heavy Menstrual Bleeding if any of the following apply:

• their uterus is palpable abdominally

• history or examination suggests a pelvic mass

37. In relation to the pelvic ultrasound carried out on 18 February 2019, the hospital again noted the myoma, including a small haemorrhagic cyst. Due to this, Gynaecology arranged a follow up scan for a hysteroscopy. I accept the IPA's advice that this course of action was appropriate. I also accept the IPA's advice in relation to the urgent referral for a hysteroscopy and endometrial biopsy[10], that most fibroids require no treatment, thus an urgent referral was not needed. The Trust offered the patient the mirena IUS as treatment for her vaginal bleeding as per NICE NG88 1.5.10, which the patient subsequently declined.

38. Based on the available evidence, including the IPA's advice I am satisfied the care and treatment the patient received was appropriate. Therefore, I do not uphold this element of the complaint.

39. *Follow up and aftercare treatment of myoma*
When looking at the follow up and aftercare of the patient, I note the IPA's advice regarding different treatment options. If further bleeding had occurred, I accept the IPA's advice that non-hormonal or hormonal drugs should have been looked at including consideration of the mirena IUS. The IPA highlights NICE Heavy menstrual Bleeding 2007 (CG44) section 12.3.1 which states that hysterectomy should not be used as a first line treatment solely for heavy menstrual bleeding. Treatment was offered in the form of the mirena IUS which the patient declined.

40. The GMC Guidance, Standard 15, point 'e' states; *'investigations must be promptly provided and arranged'*. I am satisfied the Trust did act appropriately in providing and arranging all necessary investigations and provided appropriate care. Following the patient's initial attendance at ED on 21 December 2018, and the appointments on 25 January 2019 and 18 February 2019 (referred to above) she had further appointments on,15 March 2019 and 30 May 2019. The follow up ultrasound carried out on 30 May 2019 noted that the patient did not require further treatment. The ultrasound noted the fibroid

[10] Endometrial biopsy is a medical procedure that involves taking a tissue sample of the lining of the uterus.

to be present however the Trust stated, '*there was no significant change in size'*. The records document '*Fibroid is again noted. Haemorrhagic cyst has resolved – normal right ovary. Left ovary is expanded by 4.5 cm cyst containing a daughter cyst. No need for follow up as per southern trust guidelines'*. The Trust stated, the cyst on the left side was in keeping with normal follicular function of the ovaries and did not require onward referral.

41. The complainant raised concerns about the follow up care and queried the patient not remaining on any waiting lists or having follow up checks. I accept the IPA's advice that *'NICE make no reference to any need for follow up or monitoring'* and Gynaecology did not need to follow up the patient or the patient did not need to remain on any waiting list. I accept this advice. I therefore do not uphold this element of the complaint.

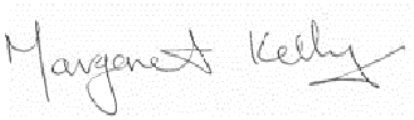
CONCLUSION

42. I received a complaint regarding the actions of the Trust. The complaint concerned the care and treatment provided to the patient in relation to heavy menstrual bleeding between December 2018 and May 2019.

43. I recognise the distress and upset the complainant and patient have been through, particularly following the patient's surgery in Bulgaria. This has been further exacerbated by the thought and worry that the care and treatment the Trust provided to the patient may not have been to an acceptable standard.

44. I did not find any failings in the care and treatment the Trust provided. I am satisfied the Trust acted appropriately and in accordance with all relevant policy and guidance. I therefore do not uphold the complaint for the reasons outlined in this report.

45. I hope that this report provides some closure and the knowledge that the care and treatment the Trust provided was appropriate.



MARGARET KELLY

Ombudsman **23 March 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 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.