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

Report Reference: 202000264

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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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SUMMARY

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Northern Trust) provided to the complainant from June 2013 to March 2019.

The complainant said the Northern Trust did not inform him of the presence of a Ground Glass Opacity[1] (GGO) prior to January 2019. The complainant said during the period June 2013 to March 2019 he received a few CT scans which showed changes in his right lung. He said the Trust failed to make him aware of these changes and that these changes related to the presence of a GGO within his lung.

During a review appointment in January 2019, the complainant's Gastroenterologist referred him to a Respiratory Consultant, and he subsequently received a CT scan of his chest. The complainant said the Northern Trust informed him at this appointment the GGO had grown within his lung and *'it had been there for years'*. The Respiratory Consultant within the Northern Trust referred the complainant for surgery to remove the GGO which he received on 7 August 2019. He said he would have preferred to have had this surgery when he was younger. The complainant believed this would have meant he would not have had as much of his lung removed. The complainant said the Northern Trust's lack of communication left him *'traumatised both mentally and physically'*.

The investigation examined the details of the complaint, the Northern Trust's response, clinical records, and relevant guidance. I also sought advice from a consultant in respiratory and internal medicine.

The investigation established the Belfast Trust informed the complainant of the presence of a GGO within his right lung whilst he was receiving care and treatment

[1] Ground Glass Opacity are generally considered to be type of lung nodule. Lung nodules are divided into solid and sub (or non) solid.

from the Belfast Trust prior to June 2013. The investigation established the Northern Trust failed to follow guidance relating to annual follow up of the GGO during the period November 2015 to June 2016 and July 2017 to February 2019. The investigation also established the Northern Trust failed to inform the complainant about the growth of the GGO in September 2016 and July 2017.

The investigation established the Northern Trust failed to consider the resection or non-surgical treatment of the GGO in accordance with the evaluation guidelines. I am satisfied the Northern Trust's delay in the consideration of the complainant's surgery did not impact on the complainant's health or prognosis. However as a consequence of the failings identified, the complainant sustained the injustice of uncertainty, as he *'now lives in fear the cancer will come back'* and he *'will not be told'*. The investigation also established the complainant sustained the injustice of upset and loss of opportunity, as the Northern Trust did not inform him of the growth of the GGO, and did not consider the resection or non-surgical treatment of the GGO upon discovery it had grown in size.

I recommended the Northern Trust apologises to the complainant for the failings in communication, and monitoring of the GGO's size. I also recommend the Northern Trust apologises to the complainant for its failure to consider resection or non-surgical treatment from July 2017 to March 2019. I also recommended action for the Northern Trust to take to prevent the failures recurring.

THE COMPLAINT

1. I received a complaint about the care and treatment Northern Health and Social Care Trust (the Northern Trust) provided to the complainant from June 2013 to March 2019. The complainant raised concerns about the communication he received from the Northern Trust in relation to his diagnosis, several CT scan results, and the appropriate time to refer him for surgery.

Background

2. The complainant was diagnosed with small cell cancer in April 1995, and had surgery, chemotherapy, and radiotherapy. He recovered from the cancer and the Belfast Health and Social Care Trust (Belfast Trust) discharged the complainant from its care in May 2013. He was under the care of the Northern Trust from June 2013 to March 2019.

3. During this period, the complainant received regular CT scans, which showed the growth of a *'ground glass'* opacity[2] (GGO) within his right lung. The complainant said the Northern Trust failed to make him aware of this growth prior to January 2019.

4. In January 2019, the complainant attended a review appointment with his Gastroenterologist. At this stage, the complainant had lost three stone in weight. The Gastroenterologist referred the complainant to a Respiratory Consultant and received a CT scan of his chest. The Respiratory Consultant informed the complainant the tumour within his right lung had grown. He subsequently received surgery for the removal of the tumour in August 2019.

5. The complainant raised concerns with the Northern Trust in May 2020 about the treatment he received. The Northern Trust provided its response to the complaint on 14 September 2020. The Northern Trust held a meeting with the complainant on 5 November 2020 to discuss his concerns. The Northern Trust provided its final response to the complaint on 21 December 2020.

[2] Ground Glass Opacity are generally considered to be type of lung nodule. Lung nodules are divided into solid and sub (or non) solid.

Issue of complaint

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

Issue 1: *Whether the care and treatment provided to the patient between June 2013 – March 2019 was appropriate and in accordance with relevant procedures and standards.*

INVESTIGATION METHODOLOGY

7. To investigate this complaint, the Investigating Officer obtained from the Northern Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Northern Trust's complaints process. I also obtained relevant records relating to the complainant's care and treatment for the period 2010 to 2013 from the Belfast Trust. These records included the complainant's oncology records, radiology records and medical correspondence.

Independent Professional Advice Sought

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

    - MBBS MD FRCP, Consultant in Respiratory and Internal Medicine since 2004, subspecialty interest in lung cancer, member of the British Thoracic Society pulmonary nodule guideline group 2015.

9. 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 is a matter for my discretion.

Relevant Standards and Guidance

10. In order 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[3]:

- The Principles of Good Administration

11. 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);
    - Guidelines for Management of Small Pulmonary Nodules Detected on CT Scans: A Statement from the Fleischner Society 2005 (Small Pulmonary Nodule Guidelines);
    - Recommendations for the Management of Subsolid Pulmonary Nodules Detected at CT: A Statement from the Fleischner 2012 (Management of Subsolid Pulmonary Nodules Guidelines);
    - Evaluation of Individuals with Pulmonary Nodules: When is it Lung Cancer? American College of Chest Physician guidelines 2013 (ACCP Guidelines); and
    - The British Thoracic Society Guidelines for the Investigation and Management of Pulmonary Nodules published in 2015 were applicable in 2017 (BTS Nodule Guidelines).

12. I shared a draft of this report with the complainant, the Northern Trust and the clinicians whose actions are the subject of the complaint to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Northern Trust submitted comments in response. I gave careful consideration to all the comments I received before finalising this report.

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

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient between June 2013- March 2019 was appropriate and in accordance with relevant procedures and standards.

In particular this will consider:

- Communication to the patient regarding CT scan results; and
- Appropriate time to refer patient for surgery.

Detail of Complaint

13. The issue of complaint is about the Northern Trust's care and treatment to the complainant from June 2013 to March 2019. The complainant raised the following concerns:
    - The Northern Trust did not inform the complainant that a GGO was present on his right lung;
    - The Northern Trust did not inform the complainant that the GGO had increased in size;
    - The complainant said the Northern Trust's lack of communication to him left him traumatised both mentally and physically;
    - The complainant said he is living in fear the cancer will come back and he will not be told;
    - The Northern Trust did not consider options for treatment/removal of the tumour prior to 2019;
    - The complainant would have preferred surgery when he was younger, and felt his recovery would have been much easier, and would not have had as much of his lung removed; and
    - The complainant said due to having to endure invasive surgery to remove the upper right lobe of his lung, he experienced numerous side effects, and was left in immense pain during the post-operative period.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies/guidance:
    - The GMC Guidance;
    - Small Pulmonary Nodule Guidelines;
    - Management of Subsolid Pulmonary Nodules Guidelines;
    - ACCP Guidelines; and
    - BTS Nodules Guidelines.

The Trust's response to investigation enquiries

Communication about the CT scans.

15. The Northern Trust stated: *'[the complainant's] care and follow up was entirely appropriate throughout the 6 year period June 2013 – March 2019. He had multiple CT scans at short intervals over the timeframe and it was only in 2019 that the CT scan reported a subtle change. This change was investigated robustly and unfortunately showed that he had a tumour which was fully treated by resection.'*

16. In a letter addressed to the complainant dated 21 December 2020 the Northern Trust stated *'Unfortunately there is no written record of what discussions have taken place during your consultations, we acknowledge that all the relevant information should have been discussed with you in detail and the discussions recorded. We apologise for the distress caused by this.'*

Referral for surgery.

17. The Northern Trust stated in a letter addressed to the complainant dated 21 December 2020: *'time taken to diagnose this did not make any significant change to the outcome; scarring was mentioned in previous scans but no change concerning for malignancy[4] identified prior to this'*. *'[The Doctors] have offered their reassurance that you did not require surgery prior to this and surgery was performed at the point in time when it was needed which was when the area had increased in size.'*

[4] The state or presence of a malignant tumor; cancer.

Relevant Trust records

June 2013 – October 2016

18. The Northern Trust records document that the complainant had the following scans:
    - 5 June 2013 11mm GGO;
    - 5 September 2013 GGO unchanged;
    - 5 November 2014 GGO stable;
    - 4 February 2015 Thoracic clinic. CT result noted. Review in three months;
    - 27 August 2015 Thoracic clinic. Chest pain settled. Chest x-ray. No interval change. Review in six months;
    - 9 March 2016 Thoracic clinic. Chest x-ray no interval change. Review in six months;
    - 28 June 2016 Scan preformed to check for pulmonary embolus[5]. Infection noted. GGO not reported; and
    - 22 September 2016 Infection resolved. 14mm GGO.

July 2017

19. The Northern Trust records document that the complainant had the following scan:
    - 27 July 2017 CT scan stable 16mm (an increase of 2mm since September 2016) GGO right upper lobe. Letter to the complainant (22 August 2017): recent CT unchanged compared to September 2016.

February 2019 – May 2019

20. The Northern Trust records document the Northern Trust took the following actions:
    - 18 February 2019 CT scan of chest: ground glass nodule in right upper lobe mild increase in size compared to previous CT;
    - 1 May 2019 CT guided biopsy; and
    - 13 May 2019 Refer for surgical resection of the ground glass lesion.

[5] Blood clot to the lung.

21. In response to the draft Investigation Report the Northern Trust stated this Office's investigation ought to have included consideration of the complainant's medical records from when he received care and treatment from the Belfast Trust. Upon request, the Belfast Trust subsequently provided the complainant's medical records for the period January 2010 to May 2013.

Relevant Independent Professional Advice

Communication about the CT scans.

June 2013 – October 2016

22. During the period June 2013 to October 2016 the IPA advised *'there is no set of communication procedures specific to ground glass opacities and so GMC good medical practice applies'*. The IPA advised the thoracic clinic letter dated 19 June 2013 noted the presence of a GGO and the need for a three month follow up scan. The IPA advised the records did not specifically state the complainant was informed of the presence of the GGO and that it required follow up.

23. The IPA advised the complainant received management in line with Fleischner guidance until November 2014. The IPA advised the Northern Trust deviated from the guidance from November 2015 as the complainant should have had the annual follow up scan at that point but did not. The IPA advised the scans performed in June and September 2016 were performed to investigate a possible pulmonary embolus, and not for GGO follow up.

July 2017 (Growth in GGO)

24. The IPA advised the Northern Trust wrote to the complainant to inform him the CT scan showed no significant change compared to 2016 and it would not take further action or follow up. The IPA advised, *'[the complainant] should have been informed of the increase in size of the GGO, as per the GMC good medical practice…This did not happen.'*

February 2019

25. The IPA advised the Northern Trust informed the complainant of the increase in size of the GGO at the Thoracic clinic on 4 April 2019.

Referral for surgery.

June 2013 – October 2016

26. The IPA advised the size of the GGO in September 2016 was 14mm which had increased in size compared to 11mm in 2013. The IPA advised this growth should have prompted further evaluation and/or consideration of resection as per the ACCP guidelines. The IPA advised this evaluation should have taken place during the discussion of the complainant's case at the lung cancer MDT[6] meeting.

July 2017

27. The IPA referenced BTS Nodule Guidelines in his advice and advised the Trust should have considered referring the complainant for surgical removal of the GGO in July 2017. The IPA advised, *'this should have taken place via discussion of the patient's case at the lung cancer MDT meeting.'*

February 2019

28. The IPA advised it was appropriate the complainant underwent surgery for the removal of the GGO in August 2019 and this was in line with BTS Nodule Guidelines.

29. The IPA concluded he identified failings in adherence to the relevant lung nodule follow up and evaluation guidelines, which meant the Northern Trust delayed the surgical removal from 2016 to 2019. The IPA advised, *'the delay did not impact on the patient's health or prognosis'*. The IPA advised, *'this was because the GGO turned out to be adenocarcinoma[7] in situ which was completely removed'*. The IPA advised in-situ cancers are a form of 'pre-cancer' which do not normally cause harm to health or survival.

[6] Multidisciplinary Team Meeting is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding treatment of individual patients.
[7] Abnormal cells.

30. The IPA advised the complainant underwent extensive testing for his fitness for surgery in 2019 which demonstrated he was well above the threshold for being able to have safe surgery at this time. The IPA advised, *'although [the complainant] developed a chest infection after the surgery, this was not linked to the delay in undertaking the surgery and could equally have happened had the operation been undertaken in 2016.'*

31. The IPA recommended the Northern Trust should continue a formal lung nodule follow up service, which is a suggested protocol in the BTS Nodule Guidelines. The IPA further recommended the Northern Trust should consider a standardised template of clinic letters to ensure all relevant diagnoses are included on each clinical attendance.

Analysis and Findings

Communication about the CT Scans.

June 2013 to October 2016

32. I note the complainant raised concerns about the Northern Trust's communication of a GGO present within his right lung. I refer to the GMC guidance which states *'a doctor must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including their condition, its likely progression and the options for treatment, including associated risks and uncertainties. A doctor must give patients the information they want or need to know in a way they can understand.'*

33. The Northern Trust's records include a thoracic letter between the Trust's Consultants dated 19 June 2013 which noted the presence of a GGO, and the need for the complainant to have a three month follow up scan. The letter documents the Consultant informed the complainant of his bronchoscopy result however, the IPA advised the letter does not specifically state that the Consultant informed the complainant of the presence of a GGO. I note the Northern Trust's medical records for this period do not provide a written record of communication to the complainant of the presence of a GGO within his right lung.

34. In response to the Northern Trust's comments I obtained the Belfast Trust's medical records. The Belfast Trust radiology reports document the presence of the GGO in December 2010. Following its discovery the medical records document the Lung MDM[8] discussed the complainant's case on 10 January 2011. The Lung MDM established the Belfast Trust should follow up the complainant's GGO with a follow up scan in three months and the presence of the GGO was not a sign of lung cancer recurrence.

35. The Belfast Trust's Oncology records document a consultation between the Oncologist and the complainant on 5 June 2013. The consultation record documents *'a small ground-glass area in the right upper lobe measuring 11mm is unchanged'*.

36. The Belfast Trust's Oncology also records document the complainant, and the Oncologist had a consultation on 20 June 2013, where the Oncologist states, *'I have reassured [the complainant] and suggested that the pathway being followed is entirely appropriate and I would not envisage any need to vary from this based on the information to date'*.

37. I am satisfied the Belfast Trust diagnosed the GGO in 2010. I am also satisfied the Belfast Trust's Oncology records document the Belfast Trust informed the complainant of the presence of the GGO in 2013. Based on this evidence I consider the complainant was aware of the presence of the GGO within his right lung before the Belfast Trust transferred his care to the Northern Trust.

38. The Northern Trust's medical records document the complainant's CT scans during the period June 2013 to September 2016. The IPA advised the complainant underwent management in line with the Fleischner guidelines until November 2014.

39. In response to the draft Investigation Report the Northern Trust informed this Office it performed the complainant's CT scans within the appropriate time frame, and stated its view that it is irrelevant these scans were for another indication. The medical records document that following November 2014's CT

[8] Multi-Disciplinary Meeting (MDM)

scan, the complainant received CT scans and chest X-Rays on the following dates: 4 February 2015, 27 August 2015, 9 March 2016 and 28 June 2016. I note the records for these scans and X-Rays do not document that the Radiologist reported the presence of the GGO and took its measurements. I accept the IPA's advice that the Trust deviated from the Fleishner guidance from November 2015, *'as the patient should have had the annual follow up scan at that point but did not'*.

40. I examined the CT scan report for September 2016. The scan report documents the Northern Trust performed this scan for another indication. However I note the scan report documents the Radiologist reported the presence of the GGO and took its measurements. Given this evidence I am satisfied the Northern Trust monitored the GGO's presence during the CT scan in September 2016.

41. Overall, I considered the available evidence, including the Belfast Trust's medical records. I am satisfied the Belfast Trust informed the complainant of the GGO's presence prior to the transfer of his care and treatment to the Northern Trust. Therefore the complainant would have known about the GGO prior to this transfer. However I do not consider the Northern Trust appropriately monitored the GGO during the period November 2015 to June 2016. I consider this a failure in the complainant's care and treatment. I partially uphold this element of the complaint.

July 2017 (growth of GGO)

42. On 27 July 2017 the Northern Trust's radiology reports document the complainant attended a CT scan of his chest and the GGO had increased to 16mm in size[9]. In a letter dated 22 August 2017, the Northern Trust informed the complainant the recent CT scan *'remained unchanged compared to September 2016'* and the Northern Trust did not undertake further action or follow up. I note the Northern Trust's records do not document a conversation between the Northern Trust and the complainant where it informed the complainant of the growth in size of the GGO.

[9] GGO reported as 14mm in September 2016.

43. I refer to the GMC guidance which states *'a doctor must work in partnership with patients, sharing with them the information they will need to make decisions about their care'* and *'a doctor must give patients the information they want or need to know in a way they can understand'*. I accept the IPA's advice *'the patient should have been informed of the increase in size of the GGO, as per the GMC good medical practice [...]. This did not happen'*.

44. In response to the draft Investigation Report the Northern Trust stated it more than likely shared this information verbally with the complainant, however it acknowledges there are no formal records of these discussions to evidence this. I would have expected a written record documenting the Northern Trust's communication to the complainant that the GGO had grown in size. I refer to the GMC guidance which requires medical staff to *'record your work clearly, accurately and legibly'*. I consider a clinical record should precisely record the information a clinician provides to a patient to ensure clarity for other clinicians taking over their care. I am satisfied the Northern Trust did not communicate the change in size of the GGO as per the GMC guidance.

45. Following the complainant's scan in July 2017, I note the records document the complainant did not attend another CT scan until 18 February 2019. The Northern Trust offered this scan to the complainant following a referral from the complainant's GP. I refer to the Fleishner guidance as referenced in paragraph 38 which requires the Northern Trust to conduct annual monitoring of the GGO. I consider the Northern Trust also deviated from Fleishner guidance during the period July 2017 to February 2019.

46. Overall I considered the available evidence, and I am satisfied the Northern Trust did not inform the complainant that the GGO had increased in size. I am also satisfied the Northern Trust did not appropriately monitor the GGO during the period July 2017 to February 2019. I consider these failures a failure in the complainant's care and treatment. I uphold this element of the complaint.

February 2019

47. The Northern Trust's medical records document the Northern Trust informed the complainant about the GGO's increase in size at the Thoracic clinic on 4 April 2019.

48. In line with the GMC guidance, I accept the Northern Trust followed the procedure to inform the complainant of the presence of a GGO within his lung in 2019. I do not uphold this element of the complaint.

Referral for surgery.

June 2013 – October 2016

49. The complainant said as the Northern Trust left his tumour for several years, he was *'forced to endure a brutal surgery'* much later in life than he would have preferred.

50. The Northern Trust's medical records document the size of the GGO had increased from 11mm in June 2013 to 14mm in September 2016. In accordance with ACCP Guidelines this change should have promoted further evaluation and/or consideration of the resection. I accept the IPA's advice that the growth in the GGO *'should have prompted further evaluation and/or consideration of resection'*. The IPA advised this evaluation and/or consideration *'should have taken place via discussion of the patient's case at the lung cancer MDT meeting'*. There are no records of any consideration of referral to the lung cancer MDT for further evaluation and/or consideration of resection of the complainant's right lung prior to 2019.

July 2017

51. I refer to the BTS Nodule Guidelines which states: *'consider resection (surgical removal) or non-surgical treatment (for example radiotherapy), or observation (with CT scans) for pure ground-glass nodules that enlarge >2mm in maximum diameter. Take into account patient choice, age, comorbidities and risk of surgery. Favour resection (surgical removal) or non-surgical treatment (for example radiotherapy) over observation for ground glass nodules that develop a solid component.'*

52. I accept the IPA's advice, *'the consultant should have considered referring the patient for surgical removal of the GGO in July 2017. This should have taken place via discussion of the patient's case at the lung cancer MDT meeting.'* The Northern Trust's records do not document an MDT meeting discussing the complainant's case during this period, nor do the records document that the MDT considered the complainant's case for surgery.

February 2019

53. The IPA advised the Northern Trust's actions during the period February 2019 to August 2019 were in line with the BTS Nodule Guidelines. Following a referral in February 2019, the Lung MDT meeting discussed the complainant in April 2019. I accept the IPA's advice: *'the patient underwent surgery for the GGO in August 2019 which was in line with BTS guidance.* I accept the IPA's advice that despite the Trust's delay in the consideration of the complainant for in surgery, it did not impact on the complainant's health or prognosis.

54. I consider the Northern Trust's failure to consider resection or non-surgical treatment from July 2017 to March 2019 a failure in the complainant's care and treatment, and I uphold this element of the complaint.

Injustice

55. I consider the identified failures in care and treatment caused the complainant to experience the injustice of upset and uncertainty. This is because at the time of diagnosis in February 2019 he would have worried about his prognosis given the delay in the consideration for surgery/non-surgical treatment and the lack of communication about the GGO's increase in size. I also consider this caused the complainant a loss of opportunity to receive consideration for earlier treatment. I consider the complainant will always have an element of doubt about his care and treatment. The complainant said the treatment the Trust provided left him *'traumatised both mentally and physically'*, and he is now living in fear that the cancer will return and he will not be told. I am satisfied the Northern Trust's actions will have caused the complainant to lose faith in his future care and treatment.

56. The complainant also said he would have preferred the surgery when he was younger and experienced numerous side effects and was in immense pain during the post-operative period. I accept the IPA's advice the delay in the Northern Trust's consideration for surgery did not impact on the complainant's health or prognosis. The IPA advised this is because the GGO turned out to be adenocarcinoma in situ, which the Northern Trust completely removed. The IPA advised this does not normally cause harm to the health or survival of patients. I note the IPA advised the complainant underwent extensive testing for his fitness for surgery in 2019 which *'demonstrated that he was well above the threshold for being able to have safe surgery at this time. Although [the complainant developed a chest infection after the surgery, this was not linked to the delay in undertaking the surgery and could equally have happened had the operation been undertaken in 2016'*.

57. I hope the advice I received from the IPA and the findings in this report offers some reassurance to the complainant that the delay in the Northern Trust's consideration for surgery did not impact his health and prognosis.

CONCLUSION

58. The complainant raised concerns about the care and treatment the Northern Trust provided to him between June 2013 and March 2019.

59. The investigation found the Northern Trust should have informed the complainant about the growth of the GGO in July 2017. The investigation also established the Northern Trust did not appropriately monitor the GGO in accordance with the relevant guidelines during the period November 2015 to June 2016, and July 2017 to February 2019.

60. The investigation found there were failures by the Northern Trust in adherence to the relevant lung nodule follow up and evaluation guidelines, which meant the Northern Trust delayed its consideration for the surgical removal/non-surgical treatment from 2016 to 2019. I hope this investigation assures the

complainant that this delay should have had no further impact on his health or prognosis.

61. I understand the issues in the complaint are a great source of concern for the complainant, and hope the findings and recommendations provide some closure for him.

Recommendations

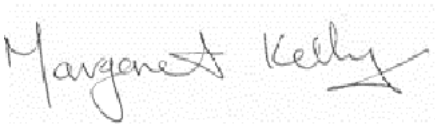
62. I recommend within **one** month of the date of this report the NHSCT:
    i. Provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019), for the injustice caused to him as a result of the failure identified; and
    ii. Discusses the findings of this report with staff involved in the complainant's care, and staff members reflect on the case and discuss it as part of their next appraisal.

63. I recommend the Northern Trust conduct a random sampling audit of patients diagnosed with GGOs within their lungs within during the period 1 January 2016 to 30 June 2016. The Trust should advise this Office on the outcome of this audit within **six** months of the date of my final report, including any recommendations or improvements in the practices and identify any shortcomings.

64. I further recommend that the Northern Trust provides training to all clinicians involved in the complainant's care during the period November 2015 to February 2019 to incorporate the following:
    i. The importance of communicating the results of CT scans with patients, and recording this conversation within the medical records in accordance with the GMC Guidance;
    ii. The importance of monitoring GGO in accordance with guidance; and
    iii. The importance of the consideration of surgical/non-surgical treatment upon discovery that a GGO within a patient's lung has increased in size.

65. I recommend the Northern Trust follow the learning and service improvements outlined by the IPA in their advice.

66. I recommend the Northern Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).



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 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.