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

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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 actions of the Southern Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to his son (the patient) between 11 January 2021 and 17 August 2022. The patient is an adult who has spina bifida and is paralysed from the waist down. In particular, the complainant was concerned clinicians left a stent in the patient's urinary tract for a period of 18 months which damaged the patient's kidney and urinary tract.

I found significant failures in care and treatment in relation to the following matters: the failure of clinicians to exchange the patient's stent within a reasonable and appropriate amount of time. In particular that the patient's stent should have been removed within one month of placement according to the Trust response. However, it was some eighteen months later that the stent was actually removed. Upon removal the surgeon found an encrusted stent which had obstructed the patient's kidney and contained pus. The surgeon noted the risk of sepsis on the patient's notes. Ultimately these failings resulted in permanent avoidable damage to the patient's left kidney.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements and to prevent further recurrence.

THE COMPLAINT

1. The complainant raised a complaint about the actions of the Southern Health and Social Care Trust (the Trust) in relation to the care it provided to his son (the patient) between 11 January 2021 and 17 August 2022

Background

2. The patient is an adult and has spina bifida and is paralysed from the waist down. He was admitted to Craigavon Area Hospital (CAH) on 8 January 2021 where clinicians found he had a ureteric stone[1].

3. On 11 January 2021 surgeons inserted a temporary stent[2] in the patient's ureter in an emergency operation. The Trust discharged the patient on 13 January and added him to the Urology waiting list for an urgent flexible ureteroscopy[3].

4. The patient presented to CAH again on 21 January 2021 with worsening shortness of breath. Clinicians identified the presence of a stone in his left kidney. The Trust discharged him on 9 February with a follow up plan for a flexible ureteroscopy and an urgent laser stone fragmentation[4].

5. The patient underwent a scan on 16 July 2022 to assess his kidney stones prior to surgery. On 17 August 2022 a surgeon operated on the patient to exchange his stent. He reported the patient had '*likely*' lost some kidney function.

Issue(s) of complaint

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

Issue: Whether the Trust's actions surrounding the review and removal of a temporary urinary tract stent inserted on 11 January 2021 were appropriate and in accordance with relevant standards and guidance.

[1]A mineral mass (kidney stone) in the ureter, which is the tube that connects the kidney to the bladder
[2] A small tube inserted into the ureter to treat or prevent a blockage that prevents the flow of urine from the kidney to the bladder.
[3]A method for the treatment of small- to medium-sized kidney stones located in any part of the urinary tract.
[4] A procedure used to remove or break up stones in the ureter. The stone is disintegrated using a laser and removed

INVESTIGATION METHODOLOGY

7. In order 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.

8. In relation to events which occurred at the height of the COVID-19 pandemic, I carefully considered whether the care delivered was appropriate within this context. I took into account the severe pressure on health and social care bodies at the time and the impact on the organisation's ability to balance the demands on its resources and capacity to provide treatment, when reaching a decision about whether the care and treatment was appropriate. In doing so, I considered the explanations of the organisation complained about and whether its approach to care and treatment was appropriate at the time.

Independent Professional Advice Sought

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

    - A Consultant Urologist MD FRCS with a special interest in the treatment of upper urinary tract kidney stones for the past 33 years. (IPA).

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

10. 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

11. 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[5]:

- The Principles of Good Administration

12. 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:

- Federation of Surgical Speciality Associations (FSSA) Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic, February 2021, updated bimonthly thereafter (FSSA, COVID Surgical Prioritisation);
- The General Medical Council's Good Medical Practice, updated April 2014 (the GMC Guidance);
- The National Institute for Health and Care Excellence (NICE) Renal and ureteric stones: assessment and management, NG118, January 2019 (NG118); and
- The National Institute for Health and Care Excellence (NICE) Renal or ureteric colic - acute, Clinical Knowledge Summary, updated August 2020 (NICE CKS Renal or Ureteric Colic management).

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

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

14. I shared a draft copy of this report with the complainant and the Trust for

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

comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant said that he was content with the report's findings. The Trust stated it accepted the report's findings, but wished to highlight that it considered that the failings identified were '*capacity issues*' and not clinical. The Trust provided details of the significant backlog it faced while the patient was awaiting a stent change.

THE INVESTIGATION

Issue: Whether the Trust's actions surrounding the review and removal of a temporary urinary tract stent inserted on 11 January 2021 were appropriate and in accordance with relevant standards and guidance?

Detail of Complaint

15. The complainant said the following: the Trust left the patient's stent '*in situ'* from January 2021 to August 2022, during which time he experienced '*months of pain*'. When the Trust inserted the stent in January 2021, it informed him it was temporary, and clinicians would remove it after a '*maximum*' period of eight weeks. He rang the Trust '*on a monthly basis*', for updates but '*nothing happened*' until the Trust operated on the patient in August 2022. When the Trust finally operated on the patient, the stent was calcified '*from top to bottom*' and the surgeon found a stone '*the size of man's fist*' in the patient's kidney. While he accepted that COVID restrictions caused delays to surgery, the complainant did not accept the Trust's '*lack of monitoring and checkups*' during the period. He believed that the Trust '*forgot*' about the patient and that it '*would have known*' a stent left in place for so long would create '*problems*.' The Trust's actions left the family '*deeply concerned*' for the patient's wellbeing.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following guidance:
    - GMC Guidance;

Trust's response to investigation enquiries

17. The Trust stated the following: it placed the stent during the COVID pandemic. The Urology team '*is currently*' short staffed, short of theatre time and many patients require urgent surgery. The patient had '*complex needs*' which made him '*higher risk'* for surgery. This meant he required an inpatient stay during his procedure. This was only available at CAH which further contributed to the delay to surgery. The patient had a '*large encrusted stent*' and renal stones. This '*likely*' caused '*some ischaemia*[6]' to his upper ureter.

18. The Trust stated it '*accepted*' Urology Services had an '*extensive*' review backlog due to COVID and the '*significant difficulties*' in recruiting Urology Consultants. '*Many*' patients were in the '*same position*' as the patient and demand '*outstrips*' capacity. Waiting times for review remain '*significant*. Consultants have worked '*tirelessly*' to prioritise '*clinically urgent*' patients. The timeline to treat the patient '*should have been*' within one month. However, due to '*capacity and demand challenges*' it did not meet the target.

Relevant Trust records

19. I carefully considered the patient's clinical records and the Trust's complaint file. A chronology of the patient's treatment is enclosed at Appendix four to this report.

20. The complaint file documents the following: in an internal email dated 18 August 2022, the surgeon who removed the patient's stent the previous day wrote the '*kidney in question has likely lost some function*'. On 23 August 2022, a Trust staff member asked the surgeon who operated on the patient if the '*waiting time for surgery caused damage to* [the patient's] *left kidney?'* The surgeon replied the '*change to the kidney…is very likely due to the delay in surgery*'.

Relevant Independent Professional Advice

21. The IPA advised the following: the patient presented to CAH with an '*obstructed, infected kidney*'. This '*could have*' led to the patient developing

[6] Diminished blood supply to any tissue or organ of the body

sepsis and dying. The Trust inserted a stent on 11 January 2021 to '*urgently*' relieve the blockage as it is '*inadvisable*' to attempt to remove stones from infected kidneys due to the '*risk*' of spreading the infection. It is '*normal practice*' to surgically remove a stent and clear the stones once an infection has '*settled*'.

22. The IPA advised the Trust had '*decided*' in January 2021 that the patient needed an urgent ureteroscopy to clear his renal stones. On this basis he was '*doubtful*' if it would have been '*helpful*' for the Trust to have reviewed the patient before it operated on him. Ureteric stents '*are known*' to become encrusted with calcified material which can lead to '*pain…obstruction and infection'*. The IPA referenced a study from the Journal of Urology in 2011 suggesting 48% of stents become encrusted after three months (Appendix Two refers). It was therefore '*important*' to leave a stent in place for the '*minimum amount of time possible*' to avoid related '*complications*.' The IPA also advised that there were no published guidelines for how long a stent should remain in place, however '*most*' manufacturers of stents specify a '*maximum of 6 months.*'

23. The IPA further advised the scan the Trust took of the patient's kidneys on 16 July 2022[7] showed the stent had '*migrated*' within the left kidney. He had '*no doubt*' the Trust's '*unprecedented*' delay in removing the patient's stent led to '*significant morbidity*' for him. In particular, the out of position stent '*likely*' obstructed the patient's kidney and led to '*long term renal[8] injury*'. The delay also resulted in the patient having to undergo a total of three procedures to completely remove the stones. The Trust's actions were '*unacceptable*' and the length of time the patient waited for an operation was '*excessive*'.

Analysis and Findings

24. In assessing whether the Trust's care and treatment of the patient was reasonable and appropriate I considered if it should have reviewed the patient in the period between inserting and removing his stent. I also considered the

[7] Incorrectly referred to as 11 August 2022 in the IPA's advice.
[8] Relating to the kidneys

delay to the procedure and the surgeon's findings after the operation.

Requirement to review patient.

25. The complainant questioned why the Trust did not carry out monitoring and checkups on the patient between the period it inserted his stent in January 2021 and the operation to remove it in August 2022. He said he made monthly telephone calls to the Trust to query when it would operate on the patient. He said that during this time the patient experienced '*months of pain*'. He believed the Trust '*forgot*' about the patient. I examined the patient's medical records, and I was unable to find any evidence that the complainant contacted the Trust. However, I have no reason to doubt the complainant's account. In addition, the complainant spoke to the patient's Consultant in Rehabilitation Medicine at the Belfast Trust on 14 July 2021 during a telephone clinic. The Consultant noted the complainant told her that the patient's stent was still in situ and that the (Southern) Trust had not made any follow up appointments. The Consultant sent a copy of the clinic notes and an '*urgent urology letter*' to the patient's Urologist at the Southern Trust. I have not been able to locate the urgent urology letter in the patient's Southern Trust medical file, however the file contains a copy of the clinic notes which were date stamped received 19 July 2021. It is therefore evident the (Southern)Trust was aware of the outstanding issue of the stent in July 2021.

26. The patient's medical notes record that following the initial operation to insert the stent the Trust discharged the patient from CAH on 13 January 2021. The discharge letter follow-up details record '*URS (flex) + laser urgent OP (urology)*'. The patient attended CAH again on 21 January 2021 for an unrelated issue. The Trust discharged him on 10 February 2021; the discharge note reiterated the follow-up '*for a Flexible Ureteroscopy + an *URGENT* Laser Stone Fragmentation as an outpatient*'. The IPA advised that it would not have been '*helpful*' for the Trust to have reviewed the patient before it operated on him as it had already '*decided*' he required urgent treatment to remove his renal stones. Having reviewed the medical notes it is evident that clinicians had concluded the patient required urgent medical treatment following the insertion of the stent. I therefore accept the IPA's advice and I consider the issue is why

clinicians did not operate on the patient during the period when they deemed it *'urgent*', rather than why they did not review him. I will address this below. However, I remain concerned there is no evidence that the Trust ever provided the complainant with an update on when the patient could expect to have his stent removed or gave a reason for the delay.

Delay in procedure and outcome of surgery

27. In its response to this Office the Trust stated the Urology department was short staffed which delayed the patient's operation. It also stated that the patient's high-risk status meant he required an inpatient stay prior to the operation which further contributed to the delay. The Trust stated that the timeline for operating on the patient '*should have been within one month*' of the insertion of the stent. I examined the patient's medical records which do not record any actions undertaken by the Trust between the patient's discharge from CAH on 13 January 2021 and a Urology Consultant's letter dated 19 May 2022 to the patient advising him he had requested a scan to assess his stone burden before surgery.

28. The IPA advised that ureteric stents '*are known*' to become encrusted with calcified material. I examined the patient's medical records which document the Trust operated on the patient on 17 August 2022. The notes record that the surgeon found an '*encrusted stent*'. He recorded that the patient's kidney was obstructed and contained pus. The surgeon also recorded '*risk of sepsis*' in the operation notes. The notes also document that the patient underwent two additional procedures to remove the remaining stones on 14 September 2022 and 25 October 2022.

29. I could not find any recommendations for how long a ureteric stent should remain in place under any of the current guidance. However, I note the IPA referenced a study from the Journal of Urology from 2011 which suggested that 48% of stents become encrusted after three months. In addition, the IPA advised that most manufacturers of stents specify a '*maximum of 6 months*' in situ. He also advised that it was '*important*' to leave a stent in place for the '*minimum amount of time possible*' to avoid complications. I accept the IPA's

advice.

Overall

30. In summary, the Trust fitted the patient with a stent on 11 January 2021. When it discharged him, it documented that he required an '*urgent*' procedure to clear his renal stones. It stated that it '*should have*' removed the stent within one month. The complainant said he contacted the Trust on a monthly basis to enquire when it would be removing the patient's stent. In addition, there is evidence that a clinician in the Belfast Trust informed the Trust that the stent was still in place in July 2021. I am therefore satisfied the Trust was aware of the ongoing delay. The Trust did not exchange the patient's stent until August 2022. By this time stent was '*encrusted*' and had '*migrated*' and obstructed the patient's left kidney.

31. GMC Guidance requires doctors to '*provide effective treatments based on the best available evidence*', '*promptly provide or arrange suitable advice, investigations or treatment where necessary*' and to '*take all possible steps to alleviate pain and distress whether or not a cure may be possible*'. It also requires doctors to respond to risks to patient safety, specifically doctors '*must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised*', and if '*patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken*.'

32. The IPA described the Trust's actions in relation to this issue as '*unacceptable*'. Having considered the relevant guidance, the patient's medical records and the Trust's complaint file, I accept the IPA's advice. I consider that having identified the patient's stent should have been removed within one month, the Trust's failure to remove it for approximately 18 months when it was aware the stent was still in place is a failure in care and treatment. As a result of the failures identified, I am satisfied the patient sustained the injustice of the loss of opportunity to have his ureteric stent removed within an appropriate and

reasonable amount of time.

33. The surgeon who exchanged the stent stated the patient's kidney had '*likely lost some function*', which was '*likely due to the delay in surgery*'. The IPA also advised the delay caused the patient '*significant morbidity*' in the form of '*long term renal injury*'. I am therefore satisfied on the balance of probabilities that the delay in removing the patient's stent caused damage to his left kidney. The complainant also advised the patient suffered '*months of pain*' while awaiting surgery and that he continues to have issues due to the encrusted stent scarring his urinary tract. I am satisfied that the pain the patient experienced while he was awaiting surgery caused him to sustain the injustice of frustration and distress. I therefore uphold this issue of complaint. In addition, I am satisfied the complainant sustained the injustice of frustration, anxiety, and uncertainty about the appropriateness of the care and treatment the Trust provided to his son.

CONCLUSION

34. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to the patient between 11 January 2021 and 17 August 2022.

35. The investigation established failures in the care and treatment in relation to the following matters:

    - The failure to exchange the patient's ureteric stent within a reasonable and appropriate amount of time.

36. I am satisfied the failures in care and treatment caused the patient to sustain the injustice of the injustice of frustration and distress and the loss of opportunity to have his ureteric stent removed within an appropriate and reasonable amount of time. In addition, I am satisfied the complainant sustained the injustice of frustration anxiety and uncertainty. In my view the failures referred to above led to the patient suffering avoidable damage to his left kidney.

37. I acknowledge the Trust's explanation that staff shortages and the patient's high-risk status contributed to the delay in exchanging the stent. I also acknowledge the pressures the Trust currently faces due to its continuing inability to recruit Urologists. I am also mindful that the patient was awaiting his operation during an upsurge in cases during the COVID pandemic. I accept that staff were navigating through uncertain and unprecedented times with stretched resources. However, I do not consider that it is acceptable that a vulnerable patient should have to wait over 18 months for a procedure that the Trust by its own admission should have carried out within one month. I note the IPA described the delay of 18 months as '*unprecedented*'. I find this significant and extremely concerning.

38. I thank the Trust for the additional information it provided following the draft report. I accept the Trust's explanation that the failures identified arose due to '*capacity*' rather than clinical issues. Indeed, the complainant acknowledged the care clinicians provided to the patient was generally of an excellent standard when he was in CAH. However, the fact remains that the patient undoubtedly suffered detriment due to the unacceptably long delay in changing his stent. In addition, there is no evidence that the Trust ever proactively contacted the complainant to advise of the delay or check the patient's clinical condition during the relevant period. I am therefore satisfied my original findings were correct.

Recommendations

39. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

40. I further recommend for service improvement and to prevent future recurrence, the Trust:

    - Carry out a random sample audit of patient records within the Urology department where the patient has been fitted with a ureteric stent between 1 April 2023 to the date of issue of the final report. This is to

ensure that clinicians are removing the stent within one month in accordance with the Trust's internal guidance. The Trust take action to address any shortcomings issued;

- Review how it updates Urology patients of any delays to pending operations to ensure it provides realistic timeframes to patients awaiting surgery and provides evidence of this to the Ombudsman;
- Provide evidence that my findings in this complaint are discussed at Trust clinical governance level and any agreed action monitored by the Trust: and
- Arrange for a copy of this report to be shared and discussed with the clinicians involved in the patient's care.

41. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

42. I am pleased to note the Trust accepted my findings. However, the Trust explained that it was unable to comply with several of the report's recommendations. I reviewed the Trust's response and I consider the Trust's reasons for its inability to comply with the recommendations were reasonable. However, the fact remains that the patient who required urgent treatment suffered detriment due to the excessive time he remained on the waiting list without review or treatment. I therefore invited the Trust to suggest ways in which it could improve its service to avoid future recurrence of the issues identified in this report.

43. I am pleased to note that the Trust responded promptly to all requests for additional data. It also provided evidence of how it sought to improve patient experience and reduce waiting times within the constraints it currently operates under. This included additional emergency treatment options for patients with ureteric stones, the recruitment of additional staff within the Urology department and the utilisation of regional centres outside the Trust to

treat patients. The Trust stated that this had led to a significant reduction in its backlog.

MARGARET KELLY

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.