SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 202202065, Forth Valley NHS Board

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

The complainant (C) complained to my office about the care and treatment provided by the Board. C was admitted to hospital in August 2021 with severe abdominal pain, nausea and vomiting. C underwent a CT scan of the abdomen, which showed localised perforation of the bowel. They were diagnosed with complicated diverticulitis and treated with intravenous (IV) antibiotics and discharged four days after being admitted. C was re-admitted to hospital within a few days and underwent an emergency Hartmann's procedure in which most of their bowel was removed and a stoma created. C complained that the original decision to discharge them was unreasonable.

At the time of discharge home following their surgery, C was told they would have consultant follow-up in six to eight weeks. They complained that did not happen and they had to chase the Board for an appointment. They developed hernias at the surgery site and complained about the length of time taken to provide them with further treatment. C's consultant follow-up appointment took place in April 2022, seven months after their discharge. They were advised they may require further surgery in relation to the hernias that had developed. C faced further wait times for scans, and in January 2023 they underwent hernia surgery.

In their complaint, C explained that, following their surgery on 25 August 2021, they were advised that most of their bowel had been removed and that they had been left with a permanent stoma. During my investigation, I sought independent advice from a Consultant Colorectal and General Surgeon (the Adviser). The Adviser explained that, in their experience, it is almost always technically possible to reverse a stoma created during a Hartmann's procedure such as C had. The Adviser commented that there was no indication of a discussion having taken place with C regarding their stoma being temporary. With C's agreement, we expanded our investigation to include the complaint that communication with C was unreasonable in relation to the permanence of the stoma.

In responding to the complaint, the Board considered that the decision to discharge C had been reasonable. They acknowledged there had been an unreasonable delay in providing C with a follow-up appointment with a consultant, which they explained had

been due to human error. The Board considered that C had been prioritised correctly for their hernia surgery. After we expanded our investigation to include the complaint about communication in relation to the permanence of the stoma, the Board arranged a consultation with C during which the possibility of stoma reversal was discussed.

Having considered the advice received, I found that:

- The decision to discharge C from hospital in August 2021 was unreasonable and was not supported by evidence of repeat tests and appropriate clinical review.
- There was an unreasonable delay to C being offered a follow-up appointment post- surgery and a subsequent delay in them receiving hernia repair surgery.
- The Board failed to communicate reasonably with C regarding the possibility of their stoma being reversible.
- The Board's complaint response was unreasonable.

As such, I upheld C's complaints.

Recommendations

What we are asking the Board to do for C:

Rec number	What we found	What the organisation should do	What we need to see
1	The decision to discharge C from hospital in August 2021 was unreasonable and not supported by evidence of repeat tests and appropriate clinical review, in particular before switching to oral antibiotics. There was a failure to document the rationale for discharge and complete the safety checklist which could have prompted a better assessment of C's suitability for discharge. The discharge summary documentation was not completed timeously, including to C's GP and there is no evidence that C was provided with appropriate advice on discharge. There was an unreasonable delay to C being offered a follow-up appointment post-surgery and a subsequent delay in	Apologise to C for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets Given the delays C has experienced the Board should, as a matter of urgency, provide them with a clear treatment plan and timeline for the follow up assessments required including any future surgical treatment that is decided on following assessment.	A copy of the apology letter A copy of the treatment plan By: 15 September 2023

Rec number	What we found	What the organisation should do	What we need to see
	them receiving hernia repair surgery. The Board failed to communicate reasonably with C regarding the possibility of their stoma being reversible. The Board's complaint response was unreasonable.		

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

Rec. number	What we found	Outcome needed	What we need to see
2	The decision to discharge C from hospital in August 2021 was unreasonable and not supported by evidence of repeat tests and appropriate clinical review, in particular before switching to oral antibiotics. There was a failure to document the rationale for discharge and complete the safety checklist which could have prompted a better assessment of C's suitability for discharge. The discharge summary documentation was not completed timeously, including to C's GP and there is no evidence that C was provided with appropriate advice on discharge.	Patients' suitability for discharge should be appropriately assessed and their condition appropriately reviewed, including where appropriate antibiotic therapy regimes, prior to discharge. The rationale for discharge should be properly documented and any relevant documentation completed (for example, safety checklist) timeously. Immediate discharge letters should be issued at the time of discharge and patients should receive appropriate advice on discharge which should be documented.	Evidence that the Board have reviewed their management of complicated diverticular disease with specific reference to: (i) the assessment and clinical review of patients prior to discharge (including decision-making in relation to antibiotic therapy) (ii) ensuring the rationale for discharge is clearly documented and, where appropriate, the safety checklist is completed, and (iii) the provision of discharge information to the patient and their GP on discharge. Confirmation of the action taken and details of any resulting action points or procedural changes Evidence that this decision and findings have been fed back to relevant staff, in a supportive manner, for reflection and learning. By: 16 October 2023

Rec. number	What we found	Outcome needed	What we need to see
3	There was an unreasonable delay to C receiving a follow-up appointment post-surgery and a subsequent delay in them receiving hernia repair surgery.	Patients should receive timely follow up and any subsequent surgery that may be required without delay.	Evidence the Board has in place a robust system to arrange follow-up appointments for emergency admissions that ensures appointments are made and are on the system in a timely manner Evidence that the Board have reviewed their processes for listing patients requiring hernia repair to ensure that cases are expedited appropriately Confirmation of the outcome of the Board's consideration including any resulting action points. By: 16 October 2023
4	The Board failed to communicate reasonably with C regarding the possibility of their stoma being reversible.	Patients should be fully advised of any potential future treatment options to enable them to make an informed choice without delay.	Evidence that this decision and findings have been fed back to relevant staff, in a supportive manner, for reflection and learning. By: 16 October 2023

We are asking The Board to improve their complaints handling:

Rec. number	What we found	Outcome needed	What we need to see
5	The Board's complaint response was unreasonable. There was a failure to investigate and respond to all the concerns raised by C and provide an appropriate response that recognised the significance of the events for C.	The Board's complaint handling monitoring, and governance system should ensure that (i) complaints are properly investigated and responded to in line with the NHS Scotland Model Complaints Handling Procedure. (ii) failings and good practice are identified, and learning from complaints is used to drive service development and improvement. (iii) complaint responses recognise and acknowledge the significance and human impact of the events complained about.	Evidence that the findings on the Board's complaint handling have been fed back in a supportive manner to relevant staff and that they have reflected on the findings of this investigation. (For example, a copy of a meeting note of summary of a discussion.) By: 16 October 2023

Who we are

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

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

Introduction

1. C complained about the care and treatment they received from Forth Valley NHS Board (the Board).

2. C had two hospital admissions at Forth Valley Royal Hospital (the Hospital) from 15 to 19 August 2021 and 22 August to 1 September 2021. They were initially admitted with severe abdominal pain, treated with antibiotics and discharged. C said that, soon after their discharge, they developed severe pain again, and were re-admitted to hospital on 22 August 2021. C underwent emergency surgery on 24 August 2021 during which most of their bowel was removed and a stoma (an opening in the abdominal wall to divert the flow of waste matter) formed. C said that, when they were discharged home on 1 September 2021, they were told that they would have consultant follow-up in six to eight weeks' time. However, they complained that this did not happen, and they had to chase the Board for a follow-up appointment.

3. Following their surgery, C developed hernias. They complained about the length of time taken by the Board to provide them with further treatment. C was seen in April 2022 regarding their hernias. C said that the doctor who saw them advised that they required surgery and that this may have been avoided had they been seen sooner. C required a scan before their surgery could take place. Again, they complained of delays in this being arranged.

4. The complaint from C I have investigated is that:

(a) The decision to discharge C from hospital on 19 August 2021 was unreasonable (*upheld*); and

(b) There was an unreasonable delay in providing a follow-up appointment with a consultant after C's surgery (*upheld*).

During the course of the investigation, and with C's agreement, I decided to expand the investigation to also include the following:

(c) Communication with C was unreasonable in relation to the permanence of the stoma (*upheld*).

Investigation

5. In order to investigate C's complaint, I and my Complaints Reviewer reviewed all of the documentation submitted to us by C and by the Board including C's medical and nursing records and complaint correspondence. We also obtained medical advice from an appropriately qualified medical adviser (the Adviser: a Consultant

Colorectal and General Surgeon). In advising on the case, the Adviser had sight of C's relevant medical records and the Board's complaint file.

6. I appreciate that at the time some of the actions investigated took place, and at the time of reporting, the NHS was and continues to be under considerable pressure due to the impact of COVID-19 and other significant issues. Like others, I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) has made, and continues to make. However, much as I recognise this, I also recognise that patient safety, personal redress, and learning from complaints are as relevant as ever and it is important that collectively we do not miss opportunities to learn and improve for the future.

7. In this case, I have decided to issue a public report of my investigation because of the significant personal injustice suffered by C and my concern about the failings I have identified. I also consider there is the potential for wider learning from the complaint.

8. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My Complaints Reviewer and I have reviewed all of the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report. The Board confirmed they accepted our findings and recommendations.

Timeline

9. This section contains a summarised chronology of C's care and treatment.

10. 15 August 2021 - C was admitted to the Hospital with severe abdominal pain, nausea and vomiting. C underwent a CT scan of the abdomen, which showed localised perforation of the bowel. They were diagnosed with complicated diverticulitis and treated with intravenous (IV) antibiotics.

11. 19 August 2021 - C was discharged from the Hospital.

12. 22 August 2021 - C's condition deteriorated. They experienced severe abdominal pain, abdominal swelling and vomiting. C was taken to the Hospital by ambulance and was treated with antibiotics and morphine.

13. 24 August 2021 - C underwent emergency surgery (Hartmann's procedure). This was following a CT (Computerised Tomography: an imaging technique used to obtain detailed internal images of the body) scan which showed that C's bowel had

ruptured. They were told following the surgery that most of their bowel had been removed and they understood they would require a permanent stoma.

14. 1 September 2021 - C was discharged home with a plan for follow-up with a consultant in six to eight weeks' time.

15. 6 September 2021 - C had a telephone appointment with a nurse from the stoma clinic.

16. 21 September 2021 - C attended the stoma nurse-led clinic in person, with follow-up scheduled for three months' time.

17. 13 January 2022 - C attended the stoma clinic. C expressed concern about the surgery outcome, having started to develop hernias, and the stoma team agreed to chase the follow-up appointment with the consultant.

18. In February 2022, C complained to the Board about their discharge from hospital on 19 August 2021, and about the attitude and manner of the Consultant they initially saw in A&E when they were readmitted on 22 August 2021. They also complained about the lack of follow-up appointment with the Consultant who carried out the surgery, which the Board agreed to try to resolve under stage one local resolution.

19. 7 April 2022 - C was seen for follow-up by the Consultant who carried out the surgery, and was advised they would need a further scan and may require additional surgery in relation to the hernias that had developed. When C enquired with the relevant department as to the wait time for the scan, they were advised it would be at least 16 weeks.

20. 25 June 2022 - C underwent a scan in connection with the hernias.

21. September 2022 - C had a further follow-up appointment with the Consultant, with reference to the scan carried out in June 2022. The Consultant confirmed that surgery was required.

22. 31 January 2023 - C underwent surgery to correct the hernia.

23. Around four weeks after the hernia surgery, C was seen by a different doctor at the Consultant's clinic. The doctor confirmed further surgery would be required as the hernia had reappeared.

24. 11 May 2023 - C was seen again by the Consultant. The Consultant confirmed the stoma could potentially be reversed, discussing risks. According to C, the

Consultant indicated they may have to wait until January 2024 if they wish to go ahead with surgery.

(a) The decision to discharge C from hospital on 19 August 2021 was unreasonable

Concerns raised by C

25. C told us that, on 14 August 2021, they began experiencing severe abdominal pains which worsened throughout the day. They attended the Emergency Department (A&E) at the Hospital and were admitted in the early hours of 15 August 2021. C was treated with IV antibiotics before being discharged home on 19 August 2021.

26. C explained that, a few days after their discharge, they experienced a repeat of the severe abdominal pain. They were taken by ambulance to A&E. A scan was performed. C was subsequently advised that their bowel had ruptured and that they may require a stoma.

27. C said that they underwent surgery to remove most of their bowel and were told that they would require a permanent stoma. They were discharged from the Hospital on 1 September 2021 with a plan to follow-up in six to eight weeks.

28. C complained that they were discharged from the Hospital on 19 August 2021, before being well enough to go home.

The Board's response

29. The Board noted that C was admitted to the Hospital and seen in the Surgical Admissions Unit in the early hours of 15 August 2021. They explained that C was treated with IV antibiotics and a CT scan was performed within six hours of their attendance at A&E. The Board noted that the CT scan confirmed a localised, contained, perforation of C's bowel, which they commented was most likely secondary to diverticular disease (the name for a group of conditions that cause small sacs to form in the large intestine).

30. The Board said that C's bowel perforation was treated conservatively, commenting that this is standard practice for a contained perforation, in an attempt to avoid major surgery with its associated risks.

31. The Board noted that C was seen daily by a consultant surgeon and that their clinical condition improved on the IV antibiotics. The Board said that C's blood tests (inflammatory markers) were improving and they were eating and drinking. There

were no further episodes of raised temperature and C's high heart rate, which had been noted on admission, had settled to a normal level. The Board explained that, in light of these clinical improvements, a decision was made to change C's antibiotics to oral and they were deemed clinically safe and well enough for discharge on 19 August 2021.

32. The Board acknowledged that C was readmitted three days later with a worsening of their condition and that they required emergency surgery on 24 August 2021. The Board said that the standard practice would be to convert patients to oral antibiotics at a suitable time and to discharge with a course of oral antibiotics. However, they commented that the nature of diverticular disease is that there is always the possibility of recurrent episodes, or a worsening of the underlying condition requiring surgery. The Board said that this was communicated to C by the clinical team.

33. In response to our enquiries, the Board said that they considered C's clinical management between 15 and 19 August 2021 was entirely appropriate and in keeping with current guidelines. They reiterated that C had responded well to antibiotic treatment, their inflammatory markers were improving, and they were eating and drinking. The Board said that C had no further episodes of raised temperature and their high blood pressure had returned to normal. They told us that, in light of these clinical improvements and that surgery was not necessary at that point, C was deemed clinically safe for discharge with a clear plan in place in terms of follow-up.

Medical advice

34. We asked the Adviser to review C's clinical records and comment as to whether or not it had been reasonable for the Board's staff to discharge them from the Hospital on 19 August 2021.

35. The Adviser noted that C was admitted with severe left lower abdominal pain and increasing nausea and vomiting. A diagnosis of *"diverticulitis/ bowel perforation/ colitis"* was recorded and a CT scan and other tests were arranged. The Adviser noted that, upon admission, C's C-reactive Protein (CRP: an indicator in the blood tests for inflammation) was recorded at 190 (mg/ litre), and their white blood cell count (WCC) was recorded at 18.8 (cells/ microlitre). IV antibiotics were prescribed pending the CT scan results.

36. The Adviser noted that C was observed to be more comfortable on 16 August 2021. Their IV antibiotics continued and a colonoscopy (examination of the bowel with a camera on a flexible tube) was requested for six weeks' time.

37. On 17 August 2021, it was noted that C would have bloods taken the following day and that their IV antibiotics should continue until their inflammatory marker (CRP level) improved. Their CRP was recorded as being high at 381 at that time.

38. The Adviser highlighted that, on 18 August 2021, a plan was made noting that, if C's CRP level improved to approximately 150, then they could be switched to oral antibiotics and discharged home. If their CRP continued to be high, then they would remain on IV antibiotics. Notes recorded at 16:30 hours that day stated that C was tolerating food, their bowel was active, and their observations were stable. C's spouse had commented that C was confused. However, this had not been observed by the note-maker. It was noted that C was to be discharged if their bloods improved.

39. On 19 August 2021, it was noted that C had had a settled night. They had been given pain relief and anti-nausea medication due to a small vomit. It was noted that C was to be switched to a ten-day course of antibiotics and discharged home if their CRP was down. The notes stated that C had a settled day and had been eating and drinking. A note was made that they were *"for home"*; however, the Adviser noted that there was no comment regarding their blood test results at that time.

40. The Adviser noted that C's blood tests from 14 to 18 August showed WCC levels of 15.4, 21.8. 17.2 and 13.4. Their CRP levels were recorded as 53, 403, 381 and 237.

41. The Adviser noted that C had a diagnosis of complicated diverticulitis. The CT scan showed a localised perforation. The Adviser noted that C's initial CRP level was 53 and climbed significantly (403), as did their WCC. The Adviser highlighted that, the day prior to their discharge, C's WCC was 13.4 and their CRP 237. The Adviser explained that these results were significantly high. The Adviser commented there was "too early introduction of diet and encouragement of laxatives in the presence of a localised diverticular perforation and infection and the still very high CRP of over 200."

42. The Adviser highlighted that it was documented on 18 August 2021 that C's CRP should be approximately 150 for discharge to be considered. The Adviser said that a CRP of 237 would not be considered reasonable for discharge with C's diagnosis and treatment. The Adviser explained that, in complicated diverticulitis such as this, a CRP of 150 is still relatively high when switching from IV to oral antibiotics. They commented that the records indicated the need for C's CRP to decrease and this was reiterated in the notes for 19 August 2021. They said that there was no record of these results being reviewed or that C's results satisfactorily met the criteria for discharge.

43. The Adviser noted that, in the early hours of 19 August 2021, C was being treated with buscopan for pain and had a vomit, for which cyclizine was given. They commented that there was no documentation of any abdominal examination from 15 August 2021 onwards. The Adviser explained that perforation can lead to localised tenderness, abscess formation and a risk of ongoing infection if not adequately treated. They told my office that without any further imaging to assess suitability for discharge, assessment should include observations, examination and investigation as well as review of symptoms. The Adviser commented that converting to oral antibiotics (an administration that can be less predictable in significant infection) without full assessment of resolving symptoms and signs increases the risk of a flare-up of infection. The Adviser said that C was downgraded from triple therapy and antibiotics to oral dual treatment without adequate assessment that there was ongoing improvement. They said that it would have been prudent to assess C's response to the switch to oral antibiotics before discharge, or to have at least warned C to look out for worsening symptoms.

44. The Adviser commented that there was also a failure to use the safety checklist in the notes which could have prompted a better assessment of C's suitability for discharge. They said that it was not clear how, or why, the decision to discharge C came about in view of their overall clinical picture as well as the last recorded CRP of 237.

45. With regard to the day of C's discharge, the Adviser said that there appeared to be no adequate assessment of C's condition. They noted that C's National Early Warning Score (NEWS: a tool used to assess how unwell a patient is) was recorded as zero. However, no reference was made to the overnight issues of pain treated with buscopan, or the vomiting. The Adviser considered that the documentation was vague and was not supported by review, including examination, to establish C's suitability for discharge. They further commented that there appeared to have been no advice given to C regarding discharge and what to expect upon returning home, or what to do should their symptoms worsen.

46. The Adviser noted that C's discharge letter appeared to be from A&E, with minimal information. They also commented that the immediate discharge summary lacked immediacy, given that C was discharged on 19 August 2021, but the discharge summary was dated 19 September 2021. There was no letter to C's GP to indicate that they had been discharged and what diagnosis and treatment they had had to better inform them should there be a need to review or readmit soon after discharge. The Adviser explained that it would be expected that on discharge the patient should be given a letter of discharge with details of diagnosis, salient test (CT showing perforated diverticulitis) and the treatment that had been given.

47. The Adviser was asked to comment on the Board's response to this aspect of C's complaint. The Adviser noted that the Board had commented that C was seen daily, that clinical parameters were coming down and that they were deemed safe for discharge. The Adviser commented that it was correct that C's NEWS had improved and their blood tests were improving. They said that there was no clinical examination on the daily rounds.

48. The Adviser noted that C's CRP was above 150 and at a level that, given the diagnosis, would be regarded as still active inflammation/ infection. They said that, with no repeat scan or clinical examination, it would not be regarded as sufficient or safe to discharge. They reiterated that, on the day of discharge, there appeared to be no repeat blood tests, no review to deem that C was fit for discharge and no account taken of their ongoing pain and vomiting overnight. The Adviser considered that, on balance, the statement that C was fit for discharge could not be regarded as reasonable given the overall findings.

49. Noting that C was readmitted to the Hospital three days after their initial discharge and required significant surgery we asked the Adviser whether the decision to discharge on 19 August 2021 could have had any implications in relation to C's condition and requirement for readmission and surgery.

50. The Adviser commented that, taking into account C's deterioration leading to their readmission, the lack of attention to clinical examination, the lack of repeat scanning or repeat blood tests on the day of discharge, the available evidence suggests that this was an ongoing deterioration. The Adviser said that, in this case, continued IV antibiotics, appropriate treatment and investigations could have led to a different and lesser outcome, although this could not be guaranteed. They commented that, on balance, this was a failed discharge as well as being too early and inappropriate and likely led to a worse outcome for C. The Adviser acknowledged that C's NEWS score was normal at the time of their discharge. However, they considered that there was a failure to overall assess a seriously ill patient and an over-reliance on NEWS.

(a) Decision

51. C has complained to my office that the decision to discharge them from hospital on 19 August 2021 was unreasonable. I recognise and acknowledge from the outset the very significant impact these events have had and continue to have on C and the importance of the issues for them.

52. In investigating this complaint, I have obtained professional advice from the Adviser as outlined above. I have carefully considered this advice, which I accept. I

am satisfied that the available evidence demonstrates that when C was admitted on 15 August 2021 the Board took C's condition seriously, appropriately carried out a CT scan and blood tests, and reached a clear diagnosis of complicated diverticulitis. A plan was made to manage this conservatively with a view to avoiding surgery. C was given IV antibiotics with a decision subsequently made to keep them on these until their CRP level dropped to around 150. They would then be switched to oral antibiotics and discharged. I am satisfied this was reasonable and appropriate.

53. On 19 August 2021, the day of C's discharge, although their NEWS had normalised, and their CRP and WCC levels were improving, their CRP and WCC levels remained significantly high. The Adviser was unable to find evidence of repeat scans or blood tests, or of a clinical examination. As such, the available records do not explain how the decision to switch C to oral antibiotics and discharge them was reached, despite their ongoing high CRP level.

54. I accept the advice I have received that

a. given C's condition, it was not appropriate to discharge them on 19 August 2021. It is clear that C was a seriously ill patient at the time and I note the Adviser's position that the decision to discharge C at that time may have contributed to the overall deterioration in C's condition and the subsequent need for them to undergo surgery;

b. continued IV antibiotics, appropriate treatment and investigations could have led to a different and lesser outcome, although this could not be guaranteed.

55. While I am unable to conclude definitively that had a different decision been taken in relation to discharge the eventual outcome could have been prevented it will undoubtedly be difficult for C to learn that, had they received better treatment, the outcome might have been different.

56. Overall, I consider that the decision to discharge C on 19 August 2021 was unreasonable and not supported by evidence of repeat tests or clinical review. I am also critical of the lack of a documented rationale for the decision to discharge. In particular I am concerned at the failure to complete the safety checklist given its completion could have prompted a better assessment of C's suitability for discharge.

57. It also appears the discharge documentation was issued some considerable time after discharge and there is no evidence of a letter to C's GP about diagnosis and treatment. Nor does it appear that appropriate advice was provided to C on discharge. Given the seriousness of C's condition I would have expected this to have

happened and discharge documentation to have been issued without delay including to C's GP. I am critical this didn't happen.

58. With all of the above in mind, I uphold this complaint. I have made recommendations to address the failings identified at the end of this report.

(b) There was an unreasonable delay in providing a follow-up with a consultant after C's surgery

Concerns raised by C

59. C told us that, on 22 August 2021, their condition deteriorated. They experienced severe stomach pain, abdominal swelling, and vomiting. C was taken back to the Hospital via ambulance and was treated with antibiotics and morphine.

60. C said that a CT scan was performed. They were reportedly advised by clinicians that their bowel had ruptured and that they would require surgery. They underwent emergency surgery (Hartmann's procedure) on 24 August 2021. C said that, following the procedure, they were told that most of their bowel had been removed and that they required a permanent stoma.

61. On 1 September 2021, C was discharged home with a plan for follow-up with a consultant in six to eight weeks' time.

62. C explained that, following their surgery, they developed hernias. They said that these caused them a great deal of pain and impacted on their mental and physical health and ability to live their life. They complained that, despite chasing the Board, they did not receive a follow-up appointment until 7 April 2022 (some 32 weeks after surgery).

63. At their follow-up appointment, C's Consultant advised that they would require another CT scan and further surgery. The Consultant reportedly explained that this may have been avoided had C been seen in the clinic sooner.

64. Around two weeks after this consultation, C contacted the Hospital to enquire about the date for their scan. They said that they were advised that they would have to wait around 16 weeks for an appointment. After chasing this up, C underwent a scan on 25 June 2022.

65. They subsequently experienced a further wait of several months for surgery. Hernia repair surgery was eventually carried out on 31 January 2023.

66. C complained that there had been unreasonable delays in relation to follow-up and treatment after they were discharged from the Hospital on 1 September 2021.

The Board's response

67. The Board told us that they acknowledged and accepted that there had been an unreasonable delay in providing C with a follow-up appointment with a consultant. They explained that this had been due to human error.

68. The Board explained that it had been C's consultant's plan to see C three months after their surgery and it was not clear why this appointment did not happen. They noted, however, that C had been reviewed by a stoma nurse who would have alerted the Consultant if there had been anything untoward prior to C's April 2022 appointment.

69. In their response to C's formal complaint, the Board acknowledged that they had expected to undergo hernia repair surgery around the end of October or early November 2022. They explained that C had been placed on the waiting list for this surgery on 9 August 2022. They had been prioritised as "routine" and the Board explained that the average waiting time was around 53 to 58 weeks for patients to be seen from the date they were listed for surgery. The Board said that, following their complaint, it was checked that C's surgery had been prioritised correctly. They noted that the Consultant was working towards a date for surgery around the end of October to early November 2022. However, the Board highlighted that this would be dependent on clinical priorities at the time as well as pressures on the site and staff availability.

Medical Advice

70. The Adviser told us that a Hartmann's procedure (removal of section of bowel and formation of a stoma), carried out as an emergency, is stage one of treatment. They told us that in their experience it is almost always technically possible to reverse the stoma (stage two). They told us that in formation of the stoma, the rectum or lower end of the bowel is not removed and the remnant of the large bowel is sufficient to consider re-joining. They said it is uncommon to find that it is not possible to re-join the bowel. They said there should be an expected timeframe for completion of treatment following an emergency Hartmann's procedure, including reversal of the stoma, within six months to one year. The Adviser noted no indication that C's stoma was deemed a temporary one.

71. The Adviser highlighted that, although C was seen in the stoma clinic, on their second visit, it was noted that they still had not had an appointment with the Consultant. An email was sent to the clinical team and a six-month review was planned. The Adviser commented that it would have been prudent to raise the issue of a Clinical Consultant appointment at the first stoma clinic appointment. They

explained that patients such as C should have an outpatients appointment made at the time of discharge for a three-to-four-month review since it is inevitable that they will need follow-up treatment.

72. I asked the Adviser whether the delay in follow-up was likely to have had an impact on the hernias developing, and whether this might have been avoided if C had been seen sooner. The Adviser said that hernias can increase in size over a period of time. Delays in review and consideration of reversal will increase the risk of the hernia getting bigger and make surgery more difficult for repair and reversal.

73. I accept the advice.

(b) Decision

74. I understand fully why C was concerned about the length of time they had to wait for a consultant follow-up appointment given during this period they developed painful and debilitating hernias. It is clear that a follow-up appointment with a consultant was initially planned to take place around six to eight weeks after their surgery. The Adviser commented that such follow-up appointments typically take place three to four months following discharge, which in C's case would have meant an appointment reasonably taking place no later than January or February 2022.

75. I acknowledge that the Board have already accepted and apologised to C for the fact that they did not receive their follow-up appointment in the timescale they could have reasonably expected. There was no explanation for this failure other than human error.

76. Whilst I welcome that the Board acknowledged their failure in this respect, I am concerned at the lack of explanation and lack of engagement about the potential impact of this oversight. C had to wait around seven months for a follow-up appointment, which the Adviser highlighted should have been routine given the likelihood that further treatment will be required for patients with C's condition.

77. C developed complications following their surgery and required further treatment to remove hernias. It appears that C was initially listed for hernia surgery in August 2022 as routine with an average wait of 53 to 58 weeks. This is despite there being an expectation, as acknowledged by the Board, that they would undergo surgery in October or November 2022. It is deeply concerning that it appears the position was checked only after C made a complaint about this. The hernia repair procedure was eventually carried out on 31 January 2023. I consider this further delay was also unreasonable.

78. I cannot comment as to whether the treatment C required for their hernias would have been any less had they been seen by the Consultant within a reasonable timescale, but I note the Adviser's comment that hernias can increase in size over time, making surgical repair more complicated. In the circumstances, I consider it important to recognise that the initial delay of seven months to be seen by a Consultant meant that C would undoubtedly have been subjected to additional pain and distress unnecessarily and that their recovery would have been delayed.

79. With all of the above in mind, I uphold this complaint.

(c) Communication with C was unreasonable in relation to the permanence of the stoma

Background

80. In their complaint, C explained that, following their surgery on 25 August 2021, they were advised that most of their bowel had been removed and that they had been left with a permanent stoma.

81. During my investigation, the Adviser commented that there was no indication of a discussion having taken place with C regarding their stoma being temporary. The Adviser further explained that, in their experience, it is almost always technically possible to reverse a stoma created during a Hartmann's procedure such as C had. They explained that the difficulty in surgery varies from straightforward, to difficult, to (uncommonly) not possible. The Adviser explained that this is usually only known at the time of undertaking surgery to reverse the stoma.

82. The Adviser said that, in forming the stoma, the rectum or lower end of the bowel is not removed and the remnant of the large bowel is sufficient to consider re-joining. They commented that it is uncommon to find that it is not possible to re-join the bowel.

83. I accepted this advice, and with C's agreement I decided to expand the investigation to consider whether or not the Board had reasonably communicated with C with regard to the permanence, or otherwise, of their stoma.

The Board's response

84. In response to our enquiries, the Board initially explained that the Consultant who carried out C's surgery (the Consultant: a Consultant in General and Colorectal Surgery) had commented that the 25 August 2021 surgery had involved removing part of C's large and small bowel. The Consultant commented that, whilst the small bowel was joined up, the large bowel was not, and a stoma was created. The

Consultant noted that the stoma was potentially reversible. However, reversing it by joining one end of the large bowel to the other would entail a major operation, putting C at risk of complications. The Board advised that, as a result of this, the Consultant was not planning to reverse C's stoma "any time soon". They noted that the Consultant would have to see C in their clinic first and discuss any further surgery in great detail since the risk of complications was high.

85. Following a subsequent enquiry, the Board provided us with a copy of a clinic letter dated 9 March 2023. This detailed the discussions C had in a clinic with a specialty doctor in the general surgery department following their January 2023 hernia repair surgery.

86. The clinic letter stated:

"After discussion with [the Consultant] and at the request of the patient we would consider potentially reversing [their] stoma but prior to that we are going to request a CT scan and an endoscopic assessment of [their] stump. We will have a discussion about surgery following that.

Today I informed [C] and [their spouse] who was present that due to [their] severe inflammatory process that was associated with [their] diverticulitis in the past this has probably left [them] with a lot of scar tissue down in the pelvis which may restrict us from joining the bowels but that could be confirmed only if we attempt surgery. I also emphasised that unfortunately surgery would be associated with severe risks like breakdown of the anastomosis which would again require further surgery and potentially bring [their] stoma back. All these thoughts would need to be put into consideration if we are thinking about reversing [their] stoma".

Medical advice

87. The Adviser commented that there did not appear to be any evidence of C being advised that their Hartmann's procedure should have been regarded as temporary. They explained that, unless a patient is unfit, an emergency Hartmann's procedure should always be viewed as a temporary solution to arrest a situation. The Adviser said that that is the principle of this surgery in an emergency setting.

88. The Adviser acknowledged that reversal of a Hartmann's procedure is a major operation. However, they noted that this was also the case for C's original surgery. The Adviser said that retaining a stoma permanently when there is the possibility of reversal is a patient choice rather than a surgeon's prerogative, provided it is technically possible and deemed safe. They explained that the latter is primarily a matter of patient fitness.

89. The Adviser reiterated that Hartmann's reversal can be relatively straightforward to impossible, but this is only known at surgery. They explained that patient recovery of between six months to a year is long enough to consider surgery again and the timing from this point is not, and should not be, surgeon driven, but a matter of patient choice. The Adviser commented that, whilst it is understandable that there is variation amongst surgeons in terms of confidence in proceeding, the options are either to discuss based on evidence the risks and offer the patient the reversal, or to refer the patient to a surgeon with experience in Hartmann's reversal.

90. I accept this advice.

(c) Decision

91. My investigation of this aspect of C's complaint relates to whether or not communication with C was unreasonable in relation to the permanence of the stoma It is not my role to assess or comment on future treatment options for C.

92. I am satisfied that the 9 March 2023 clinic letter demonstrates evidence of a detailed and clear discussion with C regarding the possibility of reversing their stoma and the risks and complications that may be associated with this. C was appropriately advised that the question of whether it was technically possible to reverse their stoma could only be answered by starting the surgery. With this in mind, I am satisfied that C has now been provided with the type of information that I would expect them to have regarding stoma reversal and that they have been appropriately involved in any subsequent decision to proceed with a reversal or keep their stoma.

93. That said, I am extremely concerned that this discussion took place nearly 18 months after C's initial surgery and only after the Adviser's comments had been shared with the Board as part of my investigation. Prior to this clinic, there was no evidence to suggest that C had been involved in discussions in relation to the possibility of stoma reversal. In fact, the Board provided us with comments from the Consultant which indicated that they were not planning to consider a reversal "any time soon". It is clear to me that when they complained to my office C considered the stoma was permanent and indicated that they had been advised that they required a permanent stoma. The comments provided by the Board appear to support this.

94. Whilst I acknowledge that it may have been the Consultant's clinical opinion that reversal was not advisable in C's case, I accept the Adviser's position that this was a matter of choice for C. Given this I am deeply concerned to find no evidence of C being involved in discussions in this regard prior to March 2023. As noted above this was only discussed with C after we shared the advice we had received with the Board. Patients should be central to the decisions being made in relation to care and

treatment including future treatment options. I am extremely critical of the lack of communication with C on this issue and consider it demonstrates a lack of patient centred care.

95. I uphold this complaint. I am mindful that C has not yet had stoma reversal surgery. Given the unreasonable delays C had already experienced as evidenced by my investigation I am also concerned by the potential impact of any unnecessary delays on C. I have made recommendations to address the failings I have identified and I expect the Board to implement these recommendations and C's further treatment without delay.

Complaint handling

96. Under section 16G of the SPSO Act 2002, I am required to monitor and promote best practice in relation to complaints handling. This means I can make recommendations on complaints handling issues without a specific complaint having been made by the complainant.

97. In terms of the NHS Model Complaints Handling Procedure, the Board's investigation of a complaint should fully address all the issues raised and demonstrate that each element has been fully and fairly investigated. It should also include an apology where things have gone wrong.

98. I found that the Board's investigation of C's complaint failed to address all the issues raised and did not demonstrate that each element had been fully and fairly investigated. In particular, when making their complaint C asked why they had been discharged while suffering from such a serious condition which they said had made matters much worse for them. The Board's complaint response failed to address this central issue.

99. The complaint response was also lacking in detail and did not identify failings in the care and treatment provided to C. Had it been a more thorough and robust investigation, I consider failings in C's care could have been identified at this stage in the process. This was a missed opportunity to identify learning and improvement at an earlier stage. I am also concerned about the lack of empathy and the tone of the response, given the significant impact of these matters on C.

100. With the above in mind, I consider the Board's complaint handling was unreasonable and I have made an additional complaint handling recommendation.

Recommendations

Learning from complaints

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

What we are asking the Board to do for C:

Rec number	What we found	What the organisation should do	What we need to see
1	The decision to discharge C from hospital in August 2021 was unreasonable and not supported by evidence of repeat tests and appropriate clinical review, in particular before switching to oral antibiotics. There was a failure to document the rationale for discharge and complete the safety checklist which could have prompted a better assessment of C's suitability for discharge. The discharge summary documentation was not completed timeously, including to C's GP and	Apologise to C for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets Given the delays C has experienced the Board should, as a matter of urgency, provide them with a clear treatment plan and timeline for the follow up assessments required including any future surgical treatment that is decided on following assessment.	A copy of the apology letter A copy of the treatment plan By: 15 September 2023

Rec number	What we found	What the organisation should do	What we need to see
	there is no evidence that C was provided with appropriate advice on discharge. There was an unreasonable delay to C being offered a follow-up appointment post-surgery and a subsequent delay in them receiving hernia repair surgery. The Board failed to communicate reasonably with C regarding the possibility of their stoma being reversible. The Board's complaint response was unreasonable.		

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

Rec. number	What we found	Outcome needed	What we need to see
2	The decision to discharge C from hospital in August 2021 was unreasonable and not supported by evidence of repeat tests and appropriate clinical review, in particular before switching to oral antibiotics. There was a failure to document the rationale for discharge and complete the safety checklist which could have prompted a better assessment of C's suitability for discharge. The discharge summary documentation was not completed timeously, including to C's GP and there is no evidence that C was provided with appropriate advice on discharge.	Patients' suitability for discharge should be appropriately assessed and their condition appropriately reviewed, including where appropriate antibiotic therapy regimes, prior to discharge. The rationale for discharge should be properly documented and any relevant documentation completed (for example, safety checklist) timeously. Immediate discharge letters should be issued at the time of discharge and patients should receive appropriate advice on discharge which should be documented.	Evidence that the Board have reviewed their management of complicated diverticular disease with specific reference to: (iv) the assessment and clinical review of patients prior to discharge (including decision-making in relation to antibiotic therapy) (v) ensuring the rationale for discharge is clearly documented and, where appropriate, the safety checklist is completed, and (vi) the provision of discharge information to the patient and their GP on discharge. Confirmation of the action taken and details of any resulting action points or procedural changes Evidence that this decision and findings have been fed back to relevant staff, in a supportive manner, for reflection and learning. By: 16 October 2023

Rec. number	What we found	Outcome needed	What we need to see
3	There was an unreasonable delay to C receiving a follow-up appointment post-surgery and a subsequent delay in them receiving hernia repair surgery.	Patients should receive timely follow up and any subsequent surgery that may be required without delay.	Evidence the Board has in place a robust system to arrange follow-up appointments for emergency admissions that ensures appointments are made and are on the system in a timely manner Evidence that the Board have reviewed their processes for listing patients requiring hernia repair to ensure that cases are expedited appropriately Confirmation of the outcome of the Board's consideration including any resulting action points. By: 16 October 2023
4	The Board failed to communicate reasonably with C regarding the possibility of their stoma being reversible.	Patients should be fully advised of any potential future treatment options to enable them to make an informed choice without delay.	Evidence that this decision and findings have been fed back to relevant staff, in a supportive manner, for reflection and learning. By: 16 October 2023

We are asking The Board to improve their complaints handling:

Rec. number	What we found	Outcome needed	What we need to see
5	The Board's complaint response was unreasonable. There was a failure to investigate and respond to all the concerns raised by C and provide an appropriate response that recognised the significance of the events for C.	The Board's complaint handling monitoring, and governance system should ensure that (iv) complaints are properly investigated and responded to in line with the NHS Scotland Model Complaints Handling Procedure. (v) failings and good practice are identified, and learning from complaints is used to drive service development and improvement. (vi) complaint responses recognise and acknowledge the significance and human impact of the events complained about.	Evidence that the findings on the Board's complaint handling have been fed back in a supportive manner to relevant staff and that they have reflected on the findings of this investigation. (For example, a copy of a meeting note of summary of a discussion.) By: 16 October 2023

Terms used in the report **Annex 1**

A&E	the Emergency Department at Forth Valley Royal Hospital
CRP	C-Reactive Protein: an indicator in blood tests for inflammation
CT scan	computerised tomography scan: an imaging technique used to obtain detailed internal images of the body
diverticular disease	the name for a group of conditions that cause small sacs to form in the large intestine
Hartmann’s procedure	a procedure involving removal of part of the bowel and formation of a stoma
hernia	when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall
IV	intravenous
C	the complainant
NEWS	the National Early Warning Score: a tool for assessing how unwell a patient is.
stoma	an opening in the abdominal wall which has been surgically created to divert the flow of faeces
the Adviser	our medical adviser: a Consultant Colorectal and General Surgeon
the Board	Forth Valley NHS Board
the Consultant	a Consultant Colorectal and General Surgeon for the Board who carried out C's surgery
the Hospital	Forth Valley Royal Hospital

WCC	White blood cell count