SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 202105473, Highland NHS Board

Sector: Health

Subject: Hospitals / Appointments / Admissions (delay / cancellation / waiting lists)

Summary

The complainant (C) complained to my office about the care and treatment provided during the period January 2018 to September 2021. In January 2018 C underwent emergency surgery for a perforated sigmoid diverticulum (a complication of diverticulitis, an infection or inflammation of pouches that can form in the intestines). An emergency Hartmann's procedure (a surgical procedure for the removal of a section of the bowel and the formation of a stoma - an opening in the bowel) was performed. In April 2018, C was seen in an outpatient clinic and informed it would be possible to have a stoma reversal.

C complained that the Board had continually delayed the stoma reversal surgery which they required, which as of September 2021 had not taken place. C also complained that COVID-19 could not account for the delays between the Board informing C they were ready for surgery around December 2018 and the start of the pandemic in March 2020. C noted that as a consequence they had developed significant complications: a large hernia. C added that this had severely impacted their personal life and self-esteem, and left them unable to work and reliant on welfare benefits.

The Board apologised that C had experienced delays waiting for their operation. They explained that despite a positive reintroduction of surgery in June 2021, they were required to significantly reduce elective surgical activity as COVID-19 patients again increased. C was said to be at the top of the list for their surgery, however, C would require two consultants to perform a joint procedure. They added that there were limited high dependency beds available, necessary for C's post-operative care, causing further delay. The Board were therefore unable to offer a definitive timescale for C's surgery.

I sought independent advice from a consultant general and colorectal surgeon (the Adviser). The Adviser told me that it was unreasonable for C to have waited eight months between being seen in an outpatient clinic in April 2018 and having a flexible sigmoidoscopy (a non-surgical examination) in December 2018. The Adviser considered that this delay had been due to C having been unnecessarily placed on a 'named person list' requiring a specific consultant to carry out what was a routine

investigation. The Adviser also noted that it was a further year before C was placed on the waiting list for surgery and that it appeared that there was no monitoring of C's timeline during this period. Lastly, the Adviser told me that there appeared to have been insufficient priority given to C's treatment post-pandemic. In conclusion, the Adviser said that the delays were unreasonable and noted that as a consequence C required more complex, demanding, and risky surgery.

In light of the evidence I have seen and the advice received, I found that: the Board unreasonably delayed performing a reversal of Hartmann's procedure. As such, I upheld C's complaint. I was also critical of the Board's own investigation of C's complaint. During the course of my investigation, in June 2022, C underwent surgery to reverse the Hartmann's procedure and repair the hernia.

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:

What we found	What the organisation should do	What we need to see
The length of time C waited for a flexible sigmoidoscopy to be carried out was unreasonable. The use of a 'named person' list led to an unreasonable delay in carrying out a flexible sigmoidoscopy. The length of time C waited to been seen at an outpatient clinic in January 2020 to discuss surgery following a flexible sigmoidoscopy was unreasonable.	Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 23 December 2022

What we found	What the organisation should do	What we need to see
The length of time C waited for their planned surgery was unreasonable. There was a failure in complaint handling by the Board in relation to C's complaint.		

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

What we found	Outcome needed	What we need to see
The length of time C waited for a flexible sigmoidoscopy to be carried out was unreasonable.	Patients awaiting elective surgery, particularly flexible sigmoidoscopy/endoscopy should have treatment carried out as soon as possible and where clinically necessary the patient's care should be prioritised.	Evidence that the Board have reviewed the systems they have in place for the management and prioritisation of patients awaiting elective surgery, particularly in relation to the endoscopy service to ensure that they are both appropriate and effectively managed. By: 23 February 2023
The use of a 'named person' list led to an unreasonable delay in carrying out a flexible sigmoidoscopy.	Patients requiring flexible sigmoidoscopy/endoscopy should be added to the most appropriate waiting list for this type of treatment.	Evidence that the Board have carried out a review of the use of a named person's list in relation to the endoscopy service. By: 23 January 2023

What we found	Outcome needed	What we need to see
		Evidence of any actions or changes taken or planned as a result, with timescales if part of an ongoing action plan. By: 23 February 2023
The length of time C waited to been seen at an outpatient clinic in January 2020 to discuss surgery following a flexible sigmoidoscopy was unreasonable.	Patients should be followed up at outpatient clinic appointments following flexible sigmoidoscopy/endoscopy within a reasonable timeframe.	Evidence that the Board have reviewed their arrangements for administering and monitoring the waiting list for outpatient clinic appointments in particular in relation to the endoscopy service, to ensure future delays such as this are avoided with a note of any actions or changes as a result. By: 23 February 2023
The length of time C waited for their planned surgery was unreasonable.	A clear treatment path should be in place for patients whose surgery is delayed that is based on current recognised prioritisation criteria.	Evidence that my findings have been shared with relevant staff in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one to-one sessions). By: 23 January 2023

We are asking the Board to improve their complaints handling:

What we found	Outcome needed	What we need to see
The Board's own complaint investigation was of poor quality and did not address all of the issues raised by C in their complaint to them. The Board failed to address and acknowledge the significant and unreasonable delays in C's care and treatment, which occurred during the period before the COVID-19 pandemic started.	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement. The Board should comply with their complaint handling guidance when investigating and responding to complaints.	Evidence that these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one to-one sessions). By: 23 January 2023

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are 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. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our 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. The complainant (C) complained to my office about unreasonable delay by Highland NHS Board (the Board) in carrying out their colorectal surgery (surgery involving the colon and rectum). The delayed surgery was for a reversal of Hartmann's procedure (a surgical procedure for the removal of a section of the bowel and the formation of a stoma (an opening in the bowel)).

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

(a) The Board has unreasonably delayed performing a reversal of Hartmann's procedure (*upheld*).

Investigation

3. In order to investigate C's complaint, I and my complaints reviewer requested further information from the Board and took independent advice from a general and colorectal surgeon (the Adviser). In considering the case, the Adviser had sight of C's relevant medical records and the Board's complaint file.

4. I appreciate that at the time of reporting, the NHS is under considerable pressure due to the ongoing impact of COVID-19. 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 for the future.

5. In this case, I have decided to issue a public report on C's complaint because of the significant personal injustice suffered by C; my concerns about the failings I have identified; and the potential for wider learning from the complaint.

6. 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. I and my complaints reviewer have reviewed 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.

a) The Board has unreasonably delayed performing a reversal of Hartmann's procedure

Background

7. This section contains a summarised chronology of C's care and treatment, which is the subject of C's complaint.

8. In January 2018, C underwent emergency surgery for a perforated sigmoid diverticulum (a complication of diverticulitis, an infection or inflammation of pouches that can form in the intestines) when an emergency Hartmann's procedure and Laparotomy were performed.

9. In April 2018, C was seen in an outpatient clinic and informed it was possible to have a stoma reversal. However, prior to this being carried out it was necessary to carry out a flexible sigmoidoscopy (an examination of the bowel with the use of a camera).

10. In December 2018, a flexible sigmoidoscopy was performed. C was told they would have a clinic review by the end of January 2019. However, this appointment did not take place.

11. In December 2019, C's GP made a hospital referral stating that the flexible sigmoidoscopy had been carried out over a year ago and C was still awaiting an appointment for surgery.

12. In January 2020, C was seen in an outpatient clinic. They were given an apology for the length of time they had waited. The reversal of the Hartmann's procedure was discussed and it was noted a hernia resulting from C's current condition was also to be repaired. It was now two years since C's emergency surgery.

13. In July 2020, C was admitted to Raigmore Hospital, Inverness (the Hospital) with pain around the stoma site. The discharge letter stated C was on a waiting list for surgery but there would be delay due to the ongoing COVID-19 pandemic.

14. In May 2021, C was readmitted to the Hospital where they spent a week on emergency standby due to the hernia.

15. By October 2021, C had still not been given a date for surgery. As a result, C's case had become increasingly complicated due to having the stoma and a large hernia.

16. In March 2022, C was given a date for surgery at a hospital in Glasgow. However, the surgery could not proceed as the Hospital were unable to administer the necessary pre-operation injections to the abdominal wall (to help relax the muscles) in time due to staff unavailability.

17. In April 2022, C was offered a subsequent date for the surgery to be carried out at the same Glasgow hospital. Due to issues with C's blood pressure the surgery could not proceed.

18. On 22 June 2022, C underwent surgery to reverse the Hartmann's procedure and repair the hernia.

Concerns raised by C

19. C complained to the Board on 18 June 2021, outlining the following complaints:

20. The Board had continually delayed the surgery which C desperately required.

21. COVID-19 could not account for the unreasonable and lengthy delays between C being ready for surgery around December 2018 and the start of the pandemic in March 2020.

22. As a consequence of the delays in carrying out the surgery and the lack of urgency by the Board post the COVID-19 pandemic, they had developed significant complications: a large hernia. This therefore required more complex, demanding, and risky surgery, including the need for two specialists to perform the surgery and High Dependency care post-surgery.

23. This has severely impacted their personal life and self-esteem, and left them unable to work and reliant on welfare benefits.

The Board's response to C's complaint

24. The Board responded to C's complaint in September 2021.

25. They said that a Consultant Colorectal Surgeon had responded previously to part of C's complaint in August 2021. They explained the current situation regarding the booking of elective operations which had reduced due to the impact of COVID-19.

26. Unfortunately, despite a 'positive reintroduction' of surgery in June 2021, they had required to significantly reduce surgical activity as COVID-19 patients had increased. This had affected their Critical Care areas where they required to

redeploy nurses from theatres to the Intensive Therapy Unit and Surgical High Dependency areas. This had reduced their capacity for elective theatre procedures.

27. They apologised sincerely that C had experienced delays waiting for their operation.

28. C was 'at the top of the list' for their surgery. However, the added complexity of C's case was that C would require a High Dependency bed after their procedure. Due to an increase in critically unwell patients, they had a reduced number of High Dependency beds available and this had caused further delay. In addition to this, the Colorectal Team had said C's operation would require two Consultants to perform the operation which involved abdominal wall reconstruction.

29. They were intending to schedule C's operation as soon as they were able to do so and ideally within the coming six months.

30. Unfortunately, at the time the complaint response was issued they were unable to offer a definitive timescale for C's surgery to take place due to reduced operating and bed capacity.

31. They were very sorry that C's surgery had been affected and would make contact with C as soon as they were able.

The Board's response to SPSO

32. In response to my enquiries the Board said:

33. C's first review post-surgery was carried out in April 2018 when they were listed for a flexible sigmoidoscopy.

34. The flexible sigmoidoscopy was performed in December 2018. An eight-month delay for this procedure on a named person's list was unfortunately a normal waiting time at this stage.

35. In January 2020, C was listed for surgery. There was no opportunity to perform surgery within the two-month period prior to the start of the COVID-19 pandemic in March 2020. At this time, C's priority category on the surgical waiting list was P4 (see note below).

36. They had acknowledged there was a long delay for an unexplained administrative reason and an apology was given to C.

37. In May 2021, C was admitted to the Hospital as an emergency. Consideration was given to C being operated on as an emergency admission but it was not

logistically possible. A decision was made not to operate on C's hernia in isolation but to await performing a combined procedure: the reversal of the Hartmann's procedure and the abdominal wall reconstruction.

38. In the Surgical Unit no one person has the skill set for performing the reversal of the Hartmann's procedure and the abdominal wall reconstruction so this would be planned as a joint procedure. As C was an emergency admission their priority category on the surgical waiting list was moved to the next level, P3 (see note below).

39. From the summer of 2021 until December 2021, the Hospital was providing critical care in two Intensive Care units thus reducing Surgical High Dependency capacity and was running at over 100% capacity for much of that time. Booking in a benign case for a bed in Surgical High Dependency during that time was very difficult to justify.

40. In autumn 2021, the Hospital had no capacity for patients who were priority category (P2) for surgery and there was a lack of critical care capacity. Therefore, C was referred to a Glasgow hospital who may have been able to offer C surgery before the Board were able to undertake the surgery.

41. With regard to the question whether C should have been referred earlier for surgery to another hospital situated out with the Board's area, the Consultant involved in C's care did not think the expertise of another hospital was needed. The reason C had been referred to another hospital situated out with the Board's area was because the Board did not have the capacity to carry out C's surgery with this type of referral not being on offer until recently.

Note

42. The UK Colleges of Surgeons have made recommendations for prioritisation of surgery, termed: P1, P2, P3, and P4, P1 being the most urgent.

a. P1 are for urgent life-threatening cases,

b. P2 for cancers and expected to be performed <1 month,

c. P3 in <3 months, P3, for example, is an emergency admission with hernia complications,

d. P4 being >3 for elective procedures that included reversal of Hartmann's.

Relevant policies and procedures

43. In reviewing this case, the Adviser had sight of relevant guidance:

- Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times Monthly and quarterly data to 30 September 2019 NHS National services Scotland

- Federation of Surgical Speciality Associations (FSSA) Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic

Medical advice

44. The Adviser said:

45. C was seen in an outpatient clinic in April 2018 and informed it was possible to have a stoma reversal but prior to this being carried out they required a flexible sigmoidoscopy.

46. The flexible sigmoidoscopy was not carried out until eight months later, in December 2018. At this time, waiting times for non-urgent investigations were generally in the region of less than three months, and met in over 70% of cases. It was uncommon to wait eight months for this type of basic non-urgent investigation[1].

47. If carrying out a flexible sigmoidoscopy was to exclude other pathology, it was counterproductive to wait eight months. An outpatient rigid sigmoidoscopy (a procedure to examine the insides of the rectum and anus) could have been performed sooner. This would have been expeditious and informative on both counts of pathology and the length of bowel, which was not in question.

48. C was not offered a reasonable opportunity to have a flexible sigmoidoscopy investigation carried out in an expected routine timeframe**.**

49. In their complaint response, the Board stated that a flexible sigmoidoscopy investigation is on a 'named person**'** list. It was unclear why this investigation needed to be performed by a named person since this procedure can be carried out by any competent endoscopist (a clinician who carries out an endoscopy, a non-surgical procedure to examine an internal organ or tissue). This was a very basic examination with an already anticipated outcome. The Board's practice was unusual and it appeared that no efforts were being made by the Board to resolve this, which appeared to have led to delay in C's case. While the use of a 'named person' list can

[1] Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times Monthly and quarterly data to 30 September 2019 – NHS National Services Scotland

have benefits this practice is known to have adverse effects on patients waiting for investigation.

50. The length of time C waited for a flexible sigmoidoscopy was unreasonable. The Board had provided no explanation why C's flexible sigmoidoscopy was not booked in a timely manner and it appeared they had failed to acknowledge or investigate this delay.

51. They noted that C was planned to be seen at an outpatient clinic in January 2019, a month after the flexible sigmoidoscopy took place, with plans for surgery. However, this appointment did not take place. C then waited over a year after the flexible sigmoidoscopy for a discussion regarding surgery. This was after C's GP wrote a referral in December 2019 inquiring why C still did not have their surgery nearly one year after the decision to proceed.

52. The surgeon's note on the GP referral indicated that C's surgery was not booked (or overlooked). It appeared that C was either not on the waiting list for surgery or if they were on the list, there was no apparent monitoring of the timeline while C was waiting.

53. Reversal of a Hartmann's procedure is commonly viewed as a routine case although the intention to reverse is effectively a two-stage operation. The importance to patients in reversal cannot be underestimated since managing a stoma has significant impact on patients and therefore carries an expectation that it should be performed in an optimal time rather than being placed at the back of a surgical queue as has occurred in C's case. Once the decision is made to reverse it should be performed in a timely manner on a routine basis.

54. While C has waited for surgery, they have developed a large hernia due to the lengthy delays which have occurred. Delays over a year have consequences for patients resulting in hernia(s) requiring abdominal wall reconstruction which is a very complex procedure.

55. It was reasonable not to complete the reversal of the Hartmann's procedure when C was admitted to hospital in May 2021, because it is best performed under elective circumstances as performing both the reversal and the hernia repair at the same time is complex. Nevertheless, the Board did not appear to have significantly prioritised C's case to alleviate their situation.

56. There appears to have been no sense of urgency by the Board to ensure that C was seen and managed in a timely manner. The expectation would have been given the complexity of C's case that their surgery should be performed within at least a

three to four month time frame post pandemic and after the development of C's hernia complications. Non-cancer cases during the current pandemic period can be given prioritisation, a period shorter than six months and C reasonably fitted into that category.

57. As a result of the delays, C required more complex and demanding surgery resulting in an increased clinical risk, from both the surgery and the risk of developing complications. The Board had acknowledged that C required two specialists to perform the surgery and High Dependency care post-surgery, all of which are a consequence of the delays.

58. The length of time C waited for their planned surgery was unreasonable.

59. The Board has acknowledged delays caused due to the COVID-19 pandemic and their complaint response has had a focus on the delays to C's surgery being caused by the pandemic. While it was reasonable to expect some delay, the pandemic started over a year after C's flexible sigmoidoscopy and over two years since their emergency surgery.

60. The Board's response does not appear to have related to a reasonable investigation on why C was waiting for surgery since 2018. There were clearly administrative issues that led to significant delays for C's proposed surgery. The Board have provided no explanation why C's proposed surgery was not booked in a timely manner. The Board have failed to acknowledge the delays in C's case which were unreasonable or offer an apology to C for this.

61. The Board have also failed to fully acknowledge the consequences of the delays upon C and the suffering C underwent as a result.

62. C's case has strong indications that there is no actual monitoring by the Board to ensure administratively that patients are investigated and treated in a timely manner to meet national guidance on treatment. C's case was prior to the COVID-19 pandemic. Further, there appears to be a lack of orderly prioritisation or an action plan in the current situation to ensure that non-cancer elective cases, such as C's case, are appropriately prioritised.

63. In order to address what has occurred the Adviser considered the Board should:

a. review the management of the investigation and treatment of patients in cases such as C's, including the administration of the relevant waiting list, to ensure that as far as possible they are treated in a timely manner including those who have ongoing care needs

b. review the prioritisation of these patients and ensure they make reasonable efforts to meet their clinical needs

c. investigate the waiting times variation between a standard 'pooled' list and a 'named person' list, and

d. seek to ensure parity or at least offer patients the opportunity to be treated in a timelier manner.

Comments

64. In commenting on the proposed report, the Board noted that:

i. C was not placed on a waiting list for their procedure until January 2020, by which time they had already developed the hernia.

ii. The Board acknowledged that C's wait for a sigmoidoscopy was longer than expected, and that this was likely due to C being on a 'specific Consultant list'. The Board explained that there can be a need for specific individuals to carry out this procedure on occasion, in order to make clinical decisions, especially during periods where there are locum and independent sector lists running.

iii. The Board accepted that there was a significant delay between the flexible sigmoidoscopy in December 2018 and the outpatient appointment in January 2020. They told us that they had been unable to identify the cause for this, but also said that if the patient had concerns about this delay any contact with the service would have prompted an appointment.

iv. With respect to the urgency and priority given to C after January 2020, the Board commented that they were unable to deliver care to any patient with a significant hernia during the pandemic waves due to limitations in operating theatre access. They explained that they referred the patient to a hospital out with the Board area as soon as this became a possibility.

v. In summary, the Board said they did not agree with the overall suggestion that, other than the delay between the flexible sigmoidoscopy in December 2018 and the outpatient appointment in January 2020, they should have done something differently in this case. They noted that NHS Highland have not fitted in a single reversal of Hartmann's procedure during the pandemic nor a large incisional hernia. They felt that it is therefore difficult to say that this one patient should have been treated differently to all the other patients still awaiting these procedures.

65. C noted that they were happy with the proposed report and did not provide any further comments.

Further medical advice

65. I asked the adviser whether or not the Board's comments affected the advice they had previously provided. They responded as follows:

i. That C was not on the waiting list until January 2020 was not relevant. C had emergency treatment in January 2018. The expected completion of that treatment was by reversal of the stoma. The consequences of a temporary stoma are significant, and the delay in being placed on the waiting list for this was unreasonable.

ii. The waiting time for C's flexible sigmoidoscopy was, by any standard along the treatment pathway, unacceptably long. This led to significant delays in C being placed on the waiting list amongst other issues. They did not accept that in C's case it was necessary to be on an individual list. Flexible sigmoidoscopy is not a demanding procedure and employment of a locum should not be considered as a factor as they should be competent to carry out such a procedure.

iii. It is the Board's responsibility to ensure timely care and the patient should not be expected to chase this.

iv. While there was a focus on the pandemic as a cause of delay, C's care commenced in January 2018, well before the pandemic and should have been completed before the pandemic. The delays in the flexible sigmoidoscopy as well as clinics were significant. There was an apparent lack of prioritisation of C's case following the reintroduction of surgery, given that the pre-pandemic delays were the Board's responsibility. The Board should examine and improve their clinical pathways for their endoscopy service to ensure more effective management of the patient journey.

(a) Decision

66. C complained to my office that the Board had unreasonably delayed performing a reversal of Hartmann's procedure. I recognise and acknowledge at the outset the significant impact of these delays on C.

67. In investigating C's concerns, I have obtained professional advice from the Adviser (as outlined above). I have carefully considered this advice, which I accept.

68. C waited eight months for a flexible sigmoidoscopy to be carried out. While the Board have indicated this was a normal waiting time, the advice I have received is that it was uncommon to wait this length of time for this type of investigation and the delay was unreasonable.

69. While I am acutely aware of, and appreciate the ongoing significant challenges for the NHS in terms of waiting times, I am also mindful that this delay occurred pre-pandemic. It appears to have been due, at least in part, to the Board's use of a named person waiting list and their failure to consider any alternative procedures such as a rigid sigmoidoscopy that may have provided the relevant information sooner. I am critical of the delay in this case. I am also troubled by the Board's explanation that this was a normal time to wait given the advice I have received that this is a basic investigation procedure and, at that time, the average waiting times were far shorter.

70. Of particular concern to me is the Board's practice of using a named person list for this type of procedure given the advice I have accepted that the procedure can be carried out by any competent endoscopist. I recognise that use of a named person list may have benefits in certain situations nevertheless, given the significant delay experienced by C and the potential impact for other patients requiring this type of procedure, the Board should urgently review their use of named person waiting lists to ensure they are being appropriately utilised and managed.

71. My investigation has also established that no reasonable explanation has been offered by the Board as to why C's clinic review did not take place in January 2019 and why this was not identified until December 2019 as a result of C's GP raising that C was still awaiting an appointment for their surgery. Such a significant delay together with no valid explanation is wholly unreasonable.

72. C was then seen at an outpatient clinic in January 2020 which was now two years after their emergency surgery. By this time C had developed a large hernia, which the Adviser has said was owing to the unreasonable time that C had been waiting for their surgery and was a recognised complication of such a lengthy delay. Despite the gravity of C's situation, there appears to have been no sense of urgency by the Board to ensure that C was managed and treated in a timely manner.

73. In addition, the Board do not appear to have significantly prioritised C's case and made adequate effort to promptly treat C. I have seen no evidence in C's case of active monitoring and planning by the Board to ensure that administratively C was investigated and treated in a timely manner.

74. As noted above, while I recognise the current challenges for the NHS in relation to waiting times and accept that there will likely be unavoidable delay, I do not accept that this should always be the case. It is of vital importance that elective cases such as C are appropriately monitored and managed to ensure patient safety and confidence in the prioritisation and waiting list systems being used.

75. As a result of the delays C has experienced they needed more complex, demanding and risky surgery requiring two Consultants to perform the operation which involved complex abdominal wall reconstruction. It is of significant concern to me that the Board has failed to fully acknowledge the consequences of the delays and the adverse effects upon C's physical and mental health as a result. The consequences for C of these delays cannot and should not be underestimated. I am extremely critical of the failure by the Board to acknowledge this during the handling of C's complaint and my investigation. I am particularly concerned that the Board do not consider, other than the delay between the flexible sigmoidoscopy in December 2018 and the outpatient appointment in January 2020, they should have done anything differently in this case. I have addressed the Board's complaint handling more fully below

76. Taking account of all of the evidence and the advice I have received from the adviser, I consider the Board unreasonably delayed performing a reversal of Hartmann's procedure.

77. As such, I uphold the complaint.

78. I welcome the fact that C has now undergone surgery. Nevertheless my investigation has established that C should have received surgery far earlier. I have made a number of recommendations to address the issues identified and these are set out at the end of this report. The Board have accepted the recommendations and will act on them accordingly. My complaints reviewer and I will follow up on these recommendations. I expect evidence to demonstrate that appropriate action has been taken before I can confirm that the recommendations have been met.

Complaints handling issues

79. C complained to the Board in July 2021. The Board has acknowledged that while a Consultant sent an update letter to C, and that their Feedback Team also sent an email update following a phone call from C in August 2021, no other update letters were sent to C prior to the issue of their final complaint response in September 2021.

80. As a result of the learning from this case, the Board have said a revised process has recently been introduced to provide a report to the Feedback Team of all 20, 40, 60, 80 day holding letters due for complaints that week. I am satisfied with the action the Board have taken to address this, and their willingness to act on learning.

81. The Board's complaint response focused on the delays to C's surgery being caused by the COVID-19 pandemic. I accept that by that time it was reasonable to expect some delay. I do not accept that the pandemic is the only cause of delay, noting that it started over a year after C's flexible sigmoidoscopy and over two years since their emergency surgery. I find it concerning that the Board's complaint response does not appear to have addressed why C has been waiting for surgery since 2018 either in their investigation of C's complaint or in their complaint response. The Board has also failed to acknowledge these delays were unreasonable or offer an apology to C for this. Given these issues, I consider the Board's complaint handling was unreasonable.

82. Under section 16G of the SPSO Act 2002, the Ombudsman is required to monitor and promote best practice in relation to complaints handling. In view of this, I have made a recommendation in relation to the Board's handling of C's complaint.

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:

What we found	What the organisation should do	What we need to see
The length of time C waited for a flexible sigmoidoscopy to be carried out was unreasonable. The use of a 'named person' list led to an unreasonable delay in carrying out a flexible sigmoidoscopy. The length of time C waited to been seen at an outpatient clinic in January 2020 to discuss surgery following a flexible sigmoidoscopy was unreasonable.	Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 23 December 2022

What we found	What the organisation should do	What we need to see
The length of time C waited for their planned surgery was unreasonable. There was a failure in complaint handling by the Board in relation to C's complaint.		

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

What we found	Outcome needed	What we need to see
The length of time C waited for a flexible sigmoidoscopy to be carried out was unreasonable.	Patients awaiting elective surgery, particularly flexible sigmoidoscopy/endoscopy should have treatment carried out as soon as possible and where clinically necessary the patient's care should be prioritised.	Evidence that the Board have reviewed the systems they have in place for the management and prioritisation of patients awaiting elective surgery, particularly in relation to the endoscopy service to ensure that they are both appropriate and effectively managed. By: 23 February 2023

What we found	Outcome needed	What we need to see
The use of a 'named person' list led to an unreasonable delay in carrying out a flexible sigmoidoscopy.	Patients requiring flexible sigmoidoscopy/endoscopy should be added to the most appropriate waiting list for this type of treatment.	Evidence that the Board have carried out a review of the use of a named person's list in relation to the endoscopy service. By: 23 January 2023 Evidence of any actions or changes taken or planned as a result, with timescales if part of an ongoing action plan. By: 23 February 2023
The length of time C waited to been seen at an outpatient clinic in January 2020 to discuss surgery following a flexible sigmoidoscopy was unreasonable.	Patients should be followed up at outpatient clinic appointments following flexible sigmoidoscopy/endoscopy within a reasonable timeframe.	Evidence that the Board have reviewed their arrangements for administering and monitoring the waiting list for outpatient clinic appointments, particularly in relation to the endoscopy service, to ensure future delays such as this are avoided with a note of any actions or changes as a result. By: 23 February 2023
The length of time C waited for their planned surgery was unreasonable.	A clear treatment path should be in place for patients whose surgery is	Evidence that my findings have been shared with relevant staff in a supportive manner that encourages learning,

What we found	Outcome needed	What we need to see
	delayed that is based on current recognised prioritisation criteria.	including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one to-one sessions). By: 23 January 2023

We are asking the Board to improve their complaints handling:

What we found	Outcome needed	What we need to see
The Board's own complaint investigation was of poor quality and did not address all of the issues raised by C in their complaint to them. The Board failed to address and acknowledge the significant and unreasonable delays in C's care and treatment, which occurred during the period before the COVID-19 pandemic started.	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement. The Board should comply with their complaint handling guidance when investigating and responding to complaints.	Evidence that these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one to-one sessions). By: 23 January 2023

Terms used in the report **Annex 1**

C	the complainant
colorectal	impacting the colon or rectum
endoscopist	a clinician who carries out an endoscopy, a non-surgical procedure to examine an internal organ or tissue
flexible sigmoidoscopy	an examination of the bowel with the use of a camera
Hartmann's procedure	a surgical procedure for the removal of a section of the bowel and the formation of a stoma (an opening in the bowel)
hernia	where an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall
stoma	an opening in the bowel
the Adviser	a consultant general and colorectal surgeon
the Board	Highland NHS Board
the Hospital	Raigmore Hospital, Inverness

Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times Monthly and quarterly data to 30 September 2019 NHS National services Scotland

Federation of Surgical Speciality Associations (FSSA) Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic