Scottish Parliament Region: North East Scotland

Case 200501257: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Complaint handling

Overview

The complainant, Mr C, raised a number of concerns about the care and treatment which he received following his private, triple heart bypass operation at Aberdeen Royal Infirmary in June 2003. He also complained about the way in which his complaint about these events had been handled by Grampian NHS Board (the Board). The bulk of Mr C's complaint was not within the jurisdiction of the Ombudsman's office, as it related to the contract for the private treatment, and it was, therefore, only possible to look at the aspect of the complaint relating to complaint handling.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to deal with Mr C's request to receive minutes of meetings with medical staff at which his complaint was discussed in accordance with procedure (*partially upheld*); and

(b) the Board failed to deal with Mr C's request that his concerns be discussed with the surgeons and medical staff involved in accordance with procedure (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C for failing to deal with his requests to be provided with minutes of the meetings with medical staff in which his complaint was discussed, and his subsequent complaints, in accordance with procedure;

(ii) take steps to ensure that, in future, the Board completes any internal enquiries required to respond to issues raised by complainants;

(iii) take steps to ensure that, in future, any potential Data Protection Act requests are identified as such and dealt with in accordance with procedure;

(iv) apologise to Mr C for failing to deal with his request to have his concerns

discussed with the surgeons and medical staff involved in accordance with procedure; and

(v) take steps to ensure that, in future, all points of complaint are addressed in response letters issued by the Board.

The Board have accepted the recommendations and provided information to show that (i) and (ii) have been implemented. The Board have indicated that they will now act on the remaining recommendations.

Main Investigation Report

Introduction

1. On 21 June 2003 the complainant (Mr C) underwent a private, triple bypass operation at Aberdeen Royal Infirmary (the Hospital) which was performed by a Consultant Cardiothoracic Surgeon (Surgeon 1). Following the operation, Mr C developed abdominal problems which required further surgery. A further operation was performed by a Consultant Surgeon (Surgeon 2) on 1 July 2003. Another Consultant Surgeon (Surgeon 3), who had previously performed bowel surgery on Mr C and had been involved in the decision to perform the second bowel operation, was in attendance.

2. On 13 October 2003 Mr C wrote to the Chief Executive (Officer 1) of Grampian NHS Board (the Board) complaining about the bill for the post-operative care which he had received following his triple bypass operation and the standard of his post-operative care. He indicated that he was not prepared to pay his account as it stood and that he 'would welcome the opportunity to discuss the matter'. Mr C continued to correspond with the Board on these matters over the following 20 months. On 3 July 2005 Mr C wrote to the Ombudsman's office to complain about his care and treatment at the Hospital, the bill for his care and treatment and the Board's handling of his complaint.

3. The complaints from Mr C which I have investigated are that:

(a) the Board failed to deal with Mr C's request to receive minutes of meetings with medical staff at which his complaint was discussed in accordance with procedure; and

(b) the Board failed to deal with Mr C's request that his concerns be discussed with the surgeons and medical staff involved in accordance with procedure.

4. I feel that it is important to note at this point that, although the NHS Complaints Procedure (the procedure) specifically states that it is not possible to complain about private care and treatment through that procedure, in this case, the Board nevertheless took the decision to deal with Mr C's complaints under the procedure. Therefore, on the basis that the Board opted to progress Mr C's complaint in this way, I have chosen to examine Mr C's complaint to this office about the Board's handling of his original complaint.

Investigation

5. My investigation of this complaint has involved reading all the correspondence provided by Mr C, making enquiries of the Board and considering their response, along with documentary evidence provided on Mr C's complaint, and the NHS Complaints Procedure.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

7. The correspondence on file shows that, in his initial letter of complaint to Officer 1, Mr C complained about the bill for his treatment and the 'poor quality of care' and indicated that he 'would welcome the opportunity to discuss the matter'. The records show that Mr C attended a meeting with Surgeon 1 at his out-patients' clinic on 30 October 2003. Both parties agree that the initial purpose of this meeting was as a follow-up review for Mr C's cardiac surgery. However, during the meeting, Surgeon 1 took the opportunity to discuss Mr C's complaint about his post-operative care and the bill for his private cardiac surgery. Mr C stated that Surgeon 1's secretary was present at the meeting and took what Mr C describes as 'minutes'.

8. Mr C said that he telephoned Surgeon 1's secretary the next day and requested a copy of what he describes as the 'minutes' of the meeting with Surgeon 1. He did not receive these.

9. Officer 1 wrote to Mr C on 22 December 2003 stating 'I note that you have discussed the situation with [Surgeon 1]. According to this interview it seems that you are satisfied with the cardiac operation and its outcome. Your dissatisfaction appears to be related to the management of the abdominal problem'.

10. Mr C wrote to Officer 1 on 14 January 2004 indicating that he had yet to receive a copy of the 'minutes' of the meeting with Surgeon 1 and that he felt that his complaint had not been fully addressed.

11. It was not until 1 April 2004 that Officer 1, in his capacity as Chief Operating Officer for the Board, provided a full response to Mr C's letter. The issue of the request for the minutes was not addressed and no minutes were

provided.

12. Mr C was not satisfied with Officer 1's letter and felt that there appeared to be a considerable number of the facts, which, he said, had 'either been glossed over or completely left out'. Mr C wrote to Officer 1 on 19 April 2004 saying that he 'would welcome the opportunity to put these to [him] first hand at [his] earliest convenience'.

13. Officer 1, in his capacity as Interim Chief Operating Officer for the Board, wrote to Mr C three months later on 20 July 2004, offering another meeting with Surgeon 1. In his response, Mr C declined this offer, indicated that he felt it would not be helpful, and requested a meeting with Officer 1. He also pointed out that he was still awaiting the 'minutes' from the previous meeting with Surgeon 1.

14. A meeting between Mr C and Officer 1 took place on 29 September 2004 and Officer 1 sent a letter of outcome to Mr C the next day. In his response, Officer 1 stated 'As I explained, prior to meeting you, I spoke to [Surgeon 1] about your care. He has advised me that abdominal pain can be a side effect of cardiac surgery and that in his opinion, conservative treatment was reasonable. However, you indicated that when [Surgeon 3] examined you, he took a different view. We have not contacted [Surgeon 3] to obtain a formal response from him and I think that it would be helpful for us to do so'. He added 'In the meantime I will speak again to [Surgeon 1]'.

15. In an internal email dated 29 September 2004 from the Complaints Manager to Officer 1 regarding the draft of the above letter, Officer 1 wrote 'I have spoken to [Surgeon 1] and have told him we would approach [Surgeon 3]. He was OK about it'.

16. On 24 March 2005, the new Chief Operating Officer for the Board (Officer 2) wrote to Mr C regarding his complaint. The letter made no reference to any meetings with Surgeon 1 or Surgeon 3.

17. On 27 April 2005 (seven months after Officer 1 wrote to Mr C saying he would seek a response from Surgeon 3 and would speak again to Surgeon 1) Mr C wrote to Officer 2 indicating that he had yet to receive notification that the meeting with Surgeon 3 had taken place. In his response to this letter Officer 2 made no reference to any meeting with Surgeon 3.

18. Mr C wrote to Officer 2 again on 25 May and 8 June 2005. In both letters he stated that it had been agreed that the Complaints Team would discuss his complaint with Surgeon 3 and that this had yet to happen. In his letter of 8 June Mr C also stated 'Despite repeated requests for copies of minutes of the two meetings which I have attended I have not yet received these …'. Mr C concluded his letter by saying 'it would appear that you have little interest in obtaining a mutually satisfactory conclusion. I now have no alternative but to contact the Ombudsman'.

19. In his comments on the draft report on this complaint Mr C said he understood that post-cardiac surgery it was advisable to avoid stressful situations. He said 'I feel the untimely and less than efficient manner with which this complaint has been treated had not helped me in this area either'.

(a) The Board failed to deal with Mr C's request to receive minutes of meetings with medical staff at which his complaint was discussed in accordance with procedure

20. The procedure is silent on the issue of providing complainants with copies of minutes of meetings with staff. However, it does state that a 'record' should be kept of all meetings and discussions and a letter issued setting out the agreements reached and any action to be taken. The procedure indicates that the Board's letters of response to complaints should 'address all the issues raised and show that each element has been fully and fairly investigated'. The procedure also states that patients may use the procedure for complaints arising from rights given by the Data Protection Act and that it is the responsibility of the complaints staff in conjunction with the Data Protection Officer or Data Controller within the Board to take the matter forward.

21. When I asked the Board how they dealt with Mr C's request to be provided with minutes of the meetings of 30 October 2003 and 29 September 2004, they advised that no minutes 'were taken or were retained'. They explained that if minutes of meetings are kept it is standard practice for these to be made available to complainants and that usually the main points from a meeting will be incorporated in a letter issued to the patient. The Board acknowledged '[Mr C] was not advised in writing of this fact as he should have been'.

22. When questioned further on this point, the Board confirmed that no official minutes of the meetings were taken.

23. The documentation provided by the Board in response to my enquiries included a one and a half page letter from Surgeon 1 to the Board's Complaints Manager dated 6 November 2003 which appears to be a summary of the meeting of 30 October 2003 between Mr C and Surgeon 1. The only reference to the content of this meeting in the correspondence sent to Mr C is a brief statement in the letter of 22 December 2003 from Officer 1 (see paragraph 9).

24. When I asked the Board why they did not supply Mr C with a copy of this internal letter in response to his request for a copy of the minutes of the meeting of 30 October 2003, the Board advised that the letter was a report of Surgeon 1's involvement and was used as the basis for Officer 1's letter to Mr C dated 22 December 2003.

25. The documentation provided by the Board, also included handwritten notes which, based on the chronology of the file, appeared to be taken around 29 September 2004. The Board advised that these notes were written by the Complaints Manager during the meeting of 29 September 2004 between Mr C and Officer 1.

(a) Conclusion

26. The procedure makes it clear that a 'record' should be kept of all meetings and does not refer to the need to take 'minutes' or 'formal minutes'. The Board have said that it is normal practice for minutes of meetings to be made available to the patient but have acknowledged that they failed to advise Mr C of this or the fact that no official minutes were taken at the meeting. I am of the opinion that the internal letter of 6 November 2003 could reasonably be classified as a 'record' of the meeting of 30 October 2003 and that, in this respect, the Board complied with the procedure. However, Mr C's request to be provided with the 'minutes' of the meeting should have been identified by the Board as a potential Data Protection Act request and processed under the procedure accordingly. It is clear that the Board failed to do so. Further, it is clear from the correspondence that, in some cases, the Board did not respond at all to Mr C's requests to be provided with a copy of 'the minutes' of this meeting and, therefore, failed to consider Mr C's complaint in the context of the Data Protection provisions within the procedure.

27. It is clear that notes were taken by the Board during the meeting of 29 September 2004 with Mr C and that, in accordance with procedure, these

notes were kept and formed the basis of the letter of outcome dated 30 September. There is only one reference on file to Mr C's request for a copy of 'the minutes' of this meeting which is contained in his letter of 8 June 2005. However, it is noted that, although this letter contains a summary of Mr C's outstanding concerns, Mr C advised the Board that he was referring his complaint to the Ombudsman. It was, therefore, reasonable for the Board not to respond to the comment about the minutes.

28. I am pleased to report that as a result of this investigation and in order to try to resolve matters, the Board agreed for Mr C to be provided with a copy of the letter of 6 November 2003 and the handwritten notes of the meeting of 29 September 2004 (these documents were subsequently sent to Mr C by the Ombudsman's office). In light of the procedural failings by the Board, I, nonetheless, partially uphold this complaint.

(a) Recommendation

29. The Ombudsman recommends that the Board:

(i) apologise to Mr C for failing to deal with his request and subsequent complaints in accordance with procedure; and

(ii) take steps to ensure that, in future, all points of complaint are addressed in response letters issued by the Board and that any potential Data Protection Act requests are identified as such and dealt with in accordance with procedure.

(b) The Board failed to deal with Mr C's request that his concerns be discussed with the surgeons and medical staff involved in accordance with procedure

30. The procedure does not specify exactly who should be consulted when a complaint is investigated, other than the person 'who is identified as the subject of a complaint'. As stated in paragraph 20, the procedure states that a response to a letter of complaint needs to address all the issues raised and show that each element has been fully and fairly investigated.

31. In response to my enquiries, the Board explained that Surgeon 1, as the member of the medical staff who had greatest input to the complaint, was consulted during the investigation. The Board added that Surgeon 1 'also emailed [Surgeon 3] on 29 October 2003 with a copy to [Surgeon 2]'. The Board provided a copy of Surgeon 1's email of 29 October 2003. In it he states 'Although [Mr C] stated that his cardiac surgery went well, he is unhappy about

the treatment of his abdominal condition … I am trying to collect information to respond to [Mr C's] complaint'. He goes on to say 'I will be most grateful if you would let me have your thoughts and comments on how to deal best with this situation'. The copy of the email shows that the request for information was also copied to the Board's Complaints Manager and the Service Manager for Cardiac and Medical Specialties.

32. The Board explained that they were unable to find any response on file from Surgeon 2 or Surgeon 3 to the email and added that it did not appear that Surgeon 3 was formally requested in writing to attend a meeting with Mr C. The documentation on file shows that no-one at the Board made any attempt to ensure that the requested comments from Surgeons 2 and 3 were provided.

33. The handwritten notes taken by the Complaints Manager during the meeting of 29 September 2004 between Mr C and Officer 1 noted the final point as 'Speak to [Surgeon 3] re post-operative care'.

34. A 'post it' on the Board's copy of Officer 1's letter of outcome of the meeting of 29 September 2004 noted action points for the complaint. This included 'Write to [Surgeon 3] asking for comment on the case'. During questioning, the Board advised that this note had been written by the Complaints Manager. When asked who was responsible for ensuring that this action point was carried out, the Board advised that Officer 1 left his post on 30 September 2004 and the Complaints Manager left shortly thereafter. The Board said that the action notes were passed to the new Complaints Manager.

(b) Conclusion

35. In order to 'fully and fairly investigate' Mr C's complaint about post-operative care, it would have been reasonable for the Board to seek the opinions of Surgeons 1, 2 and 3. It is clear that the Board attempted to do so, but that they did not follow this through. Further, the Board advised Mr C that they would discuss his complaint with Surgeon 3 and when Mr C asked for feedback on this point, the Board completely ignored this request. I, therefore, uphold this complaint.

(b) Recommendation

36. The Ombudsman recommends that the Board:

(i) apologise to Mr C for failing to deal with his request in accordance with procedure; and

(ii) take steps to ensure that, in future, they complete any internal enquiries required to respond to issues raised by complainants and ensures that all points raised in complaints are addressed in responses from the Board.

37. The Board have accepted the recommendations and provided information to show that (i) and (ii) have been implemented. The Ombudsman asks the Board to notify her when the remaining recommendations have been implemented.

22 August 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Hospital	Aberdeen Royal Infirmary
Surgeon 1	Consultant Cardiothoracic Surgeon
Surgeon 2	Consultant Surgeon
Surgeon 3	Consultant Surgeon
Officer 1	The Chief Executive/Chief Operating Officer/Interim Chief Operating Officer
The Board	Grampian NHS Board
The procedure	The NHS Complaints Procedure
Officer 2	The new Chief Operating Officer

Annex 2

List of legislation and policies considered

The NHS Complaints Procedure