SPSO decision report

Case: **201103844, Lothian NHS Board - Acute Division**
Sector: health
Subject: policy/administration
Outcome: some upheld, recommendations

Summary

Mr C complained about the admisitration processes for outpatient appointments and complaint handling.

The SPSO investigation found that there had been a delay in Mr C being allocated his original outpatient appointment and the board acknowledged this. However, our investigation did not find that the system was 'chaotic' as Mr C claimed. To the extent identified, that is the delayed initial appointment, this complaint was upheld.

On the matter of a verbal complaint made when Mr C attended for an appointment on the wrong day due to a failure to confirm a re-arranged appointment in writing, The investigation could not establish why he was told that a person whom the board have been unable to identify would come to speak to him. No one came to speak to Mr C within 10 minutes at which point Mr C began to suffer chest pains and was taken to the accident and emergency. He was then admitted to a ward for observation for 24 hours. He asked the ward staff to pass a message to Mr A to ask him to come to speak to Mr C on the ward. This did not happen before Mr C was discharged.

Our investigation could not establish who Mr A was. The board told us that there were no male members of the complaints team in the hospital that Mr C had attended. The board tried to establish who Mr A was but no one of that name could be found on the staff lists at the time of the incident.

On the matter of the complaints handling, our investigation found that although some of Mr C's complaints had been responded to in a comprehensive and timely manner there had been some matters that were not addressed. Mr C had also asked to be reassured that the issues he had raIsed had been brought to the attention of senior managers and/or the chief executive of the board. Our investigation established that although the complaints were brought to the attention of the chief executive, Mr C was not informed of this fact. Therefore, to the extent of the failings identified, this complaint was upheld.

Recommendations

We recommended that the board:

- apolgise for the delay in providing the inital outpatient appointment; and
- apologise for the failings identified in the complaints handling.