

Ombudsman's Commentary

SPSO Scottish Public Services Ombudsman

April 2012

The SPSO laid six investigation reports before the Scottish Parliament today, all relating to health boards. We also laid a report on 47 decisions about health and other sectors under our remit. All of the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in March) in addition to the four full reports laid before the Parliament we determined 384 complaints and handled 38 enquiries. Taking complaints alone, we:

- gave advice on 258 complaints
- resolved 88 in our early resolution team
- resolved 38 by detailed consideration
- made a total of 29 recommendations in decision letters.

In line with other public sector organisations, we follow Scottish Government guidelines on publishing before elections. Local government elections take place on Thursday 3 May 2012. This means that, while we continue to work as normal, we generally try not to publish reports in the immediate run up to an election and therefore we are not publishing reports about local government in April. We will resume publishing after the election.

Ombudsman's Overview

Health reports

This month's investigation reports make for harrowing reading. An elderly patient left in a hospital corridor for an entire day and later discharged in a taxi wearing only his pyjamas and a thin housecoat, in winter. A wife having to empty her husband's urine bottle, another finding medicine in her husband's hospital bed and on the floor. Basic aspects of nursing care fell well below an acceptable standard, including nutritional management and problems stemming from the lack of an assessment of cognitive function. In particular, I highlight serious shortcomings in care in relation to patients with dementia and I make recommendations about respecting dignity, improving communication with patients and their families and improving understanding about dementia.

Two other cases highlight the devastating impact on the health and quality of life of people whose clinical care fell short of what they might reasonably have expected. I upheld the complaints of a woman who was very unhappy with the outcome of reconstructive breast surgery and I also upheld the complaint about a board where failures in care meant that a man with kidney cancer was unable to reach an informed decision about his condition or prognosis.

Complaints Standards Authority (CSA) Update

Model complaints handling procedures (CHPs) published

I am pleased to report that in March and April we published our first two model CHPs, for the local authority and RSL sectors. These documents mark two major milestones in the journey to improve complaints procedures in the public sector, and put into practice the principles of simplification and standardisation called for in the Crerar and Sinclair Reports.

We developed the procedures through a process of consultation and partnership, and I would like to take this opportunity to thank the staff of the CSA and the representatives of the local authorities and housing bodies and other key stakeholders who worked with us to develop the procedures. I believe that adopting the model CHPs will bring about tangible benefits to the public and also to service providers, by encouraging authorities to value the learning from complaints and to empower and train their staff to deal with complaints early and robustly.



Care of the elderly; clinical treatment; nursing care; communication

Lanarkshire NHS Board
(201004658)

Care of the elderly; hospital discharge; clinical treatment; complaints handling

Greater Glasgow and Clyde NHS Board – Acute Services Division (201101255)

Care of the elderly; clinical treatment; nursing care; communication; hospital discharge

Fife NHS Board (201100109)

Delay in diagnosis; complaints handling

Highland NHS Board
(201004742)

Clinical treatment; consent; communication

Grampian NHS Board
(201101426)

Clinical treatment; nursing care; consent; communication

The Golden Jubilee National Hospital (200904100)

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Ombudsman's Commentary

April 2012

Valuing Complaints website

Background information, the model CHPs and details about implementation, compliance and performance monitoring are available on the CSA's Valuing Complaints website (www.valuingcomplaints.org.uk). We have redesigned the website and will re-launch it later this month. In addition to information about the model CHPs and CSA guidance and best practice, the site will host a new community forum which aims to generate online discussion amongst complaints handlers from all sectors.

For further information, please contact the CSA on CSA@spsso.org.uk.

E-learning training

We are in the final stages of developing e-learning training modules for local authority frontline staff. We expect to launch the training programmes later this month on a learning portal via a link on the Valuing Complaints website. Our aim is to review demand after the initial phase to assess whether we can continue to maintain our commitment of providing these free of charge. E-learning training programmes for housing and other sectors are scheduled to follow in due course. For further information about the training please contact our Training Coordinator Kerry Barker on kbarker@spsso.org.uk or 0131 240 2967.

Social work

As I indicated we would in my January Commentary, we responded to the Scottish Government's consultation on the Review of Social Work Complaints which closed last month. Our response supported the option which would see local authority internal processes streamlined and aligned with the local authority model CHP and the option of providing SPSO with the remit to undertake the external review role currently undertaken by Complaints Review Committees. Our response makes it clear that this would require changes to the SPSO Act 2002 and additional resources for the SPSO. To read the response in full, please visit: www.spsso.org.uk/media-centre/inquiries-and-consultations.

Case Summaries

Health

Care of the elderly; clinical treatment; nursing care; communication

Lanarkshire NHS Board (201004658)

Mr C, who suffered from dementia, was admitted to hospital after he became unwell with shortness of breath. He was diagnosed with pneumonia and given antibiotics, and later tested positive for MRSA for which he was prescribed different antibiotics. However, his wife (Mrs C) felt the hospital were not caring for him adequately. In particular, she felt that staff did not properly recognise his needs, particularly in respect of his dementia. She said that she had found medication in Mr C's bed and on the floor and that he had not been kept adequately warm while on the ward nor had he been adequately fed. Mr C discharged himself against medical advice and was nursed at home for just over a week, until he died. Mrs C then raised a number of concerns about Mr C's care and treatment while he was in hospital. She met with staff and also raised the issue of communication about Mr C's treatment plan with her and her family, which she felt was inadequate. When she remained dissatisfied with the board's responses she complained to me.

I agreed with Mrs C that there were unreasonable failings in Mr C's medical and nursing care and treatment. I took advice from two of my professional medical advisers, one a consultant physician and the other my nursing adviser. In their investigation into her complaint, the board had identified some failings in Mr C's care and treatment for which they had already apologised to Mrs C. These included the issues about untaken medication, nutrition and nursing care. Although my medical advisers did not take the view that failings in care caused Mr C to contract pneumonia, after

studying Mr C's medical records my nursing adviser found a number of other areas of concern. In particular she said that the evidence suggested that nursing staff did not take reasonable steps to ensure that Mr C's medication was competently administered. She also noted that the family were not asked to assist with his care, which might have encouraged him to eat and drink, or to discuss his personal likes, dislikes and normal behaviours, which would have given staff a better idea of Mr C's needs. As nutritional charts were inadequately completed, my adviser concluded that aspects of Mr C's nutritional care were poor as she could not be confident that there was a system in place to make sure that Mr C was prompted to eat and drink. Mrs C and her family's needs had not been met by the level of communication provided.

My investigation found that several aspects of Mr C's care, all in relation to nursing care, fell well below an acceptable standard. I was concerned that the standard of care was such that Mrs C lost confidence in the board's ability to care for Mr C and decided he would be better cared for at home. All of the areas where I identified failings were basic aspects of nursing care, and I have criticised the board for demonstrating failings in these areas. I note that the board have already taken significant steps to implement a range of initiatives to inform and support nursing staff in the care of older people and people with dementia, and I expect the board to further develop these through the learning identified from Mr C's case. I upheld Mrs C's complaint. I also recommended that the board provide me with a copy of their implementation plan in relation to Scotland's National Dementia Strategy (with particular reference to the issues identified in Mr C's case) as well as evidence that future relevant record keeping complies with the Nursing and Midwifery Council's Standards for Medicine Management.

Ombudsman's Commentary

April 2012

Case Summaries

Health

Care of the elderly; hospital discharge; clinical treatment; complaints handling

Greater Glasgow and Clyde NHS Board
– Acute Services Division (201101255)

Mr A, who was 85 years old, lived alone and had a number of health difficulties. When he fell at home and broke his hip, he was admitted to hospital for a hip replacement operation. He was discharged from hospital two weeks later, but two days later he fell again and was readmitted to hospital, where his condition gradually deteriorated and he died. His son (Mr C) complained about the care that Mr A received in hospital. Mr C was concerned that the staff involved in Mr A's care and treatment had failed to consider and assess his cognitive function, or communicate directly with Mr C about the plans for discharge, resulting in Mr A being inappropriately discharged from hospital. Mr C said that when his father returned home, he was cold and was not dressed in the outdoor clothes that the family had provided for his journey home. Mr C also complained about the board's handling of his complaint, which he said was unreasonable.

I obtained advice on Mr A's clinical treatment and nursing care from one of my medical advisers and my nursing adviser. Having taken and accepted their advice I upheld all of Mr C's complaints, and noted that this case raised some particularly difficult issues. My medical adviser said that it was not possible to decide from the records whether Mr A's care and treatment had been reasonable. This was mainly because there was no evidence that staff had formally assessed Mr A's cognitive function at any time, despite some evidence that he might have been suffering short-term memory loss. This assessment was needed to see whether Mr A had the capacity to make decisions about his own welfare. This led my medical adviser to express concern about some of the decisions that staff had taken about Mr A's care and discharge (although he said that staff had acted appropriately if they believed Mr A had capacity). However, the fact that no assessment took place is of concern to me, especially as I found that there were a number of factors in Mr A's case that could have alerted staff to the need for this. My medical adviser said that on balance it would have been preferable if Mr C

had been involved directly in communication, given the doubts about Mr A's capacity. All the problems that occurred stemmed from the lack of assessment. I recommended that the board send me evidence that they have implemented a policy to assess the cognitive function of elderly patients, including whether a patient has capacity to participate in decision-making. I also noted that there is new government policy on this issue, and expect the board to give it detailed consideration.

Although my nursing adviser said that the preparation for discharge was well documented and staff had ensured that an appropriate package of care for Mr A was in place, there were other issues relating to Mr A's discharge that were unsatisfactory. This included limited evidence of any medical input into the discharge decision-making process, and lack of assessment of Mr A's ability to dress himself. Again, these problems stemmed from the lack of assessment of Mr A's cognitive function. It was not clear whether such an assessment would have resulted in a different course of care, or if medical input would have changed anything. However, I noted Mr C's concerns about his father's welfare, particularly given what happened after Mr A returned home. I also noted that Mr A was inappropriately dressed on the journey home, and found that this could have been avoided had staff checked his belongings properly, as his family had provided outdoor clothing. I found this unacceptable and recommended that the board provide a copy of their new discharge policy to show that it says that relatives and carers must be engaged with during discharge planning, and that it features a reminder that patients are appropriately clothed on discharge.

Finally, although in some respects the board's response to Mr C's complaints was comprehensive, their investigation also failed to recognise the need for assessment and a couple of aspects were unclear including their policy about reviews of hip fractures by the Department of Medicine for the Elderly. I recommended that they clarify this policy and apologise fully to Mr C for all the failings identified in the report.

Ombudsman's Commentary

April 2012

Case Summaries

Health

Care of the elderly; clinical treatment; nursing care; communication; hospital discharge

Fife NHS Board (201100109)

Mr C is 73 years old and has dementia and a history of strokes. He was admitted to a hospital A&E department at 07.25 in pain and with blurred vision. He was assessed as needing to be admitted to a ward, but as there were no beds available he was moved on a trolley to a corridor in the department. He became more unwell and was in more pain. Mr C's wife (Mrs C) raised her concerns about this with staff, and Mr C was taken to a cubicle and examined. However he was then placed back in the corridor to wait for a bed. He did not reach a ward until 22.00. While he was in the corridor, Mrs C had to go home to take her own medication. She called the hospital a number of times to find out how Mr C was. As staff eventually blocked her calls, Mrs C called the police to help her, at about the same time that staff were contacting them to go to her house and ask her to stop calling. (The board told us that this was because Mrs C called the department so many times, and they said this blocked the single phone line.) Mr C was able to leave hospital the next day. Mrs C asked if she could collect him in the afternoon, but he was sent home in a taxi in the morning, dressed only in pyjamas and a thin housecoat.

Mrs C raised a number of concerns about Mr C's care, treatment and subsequent discharge. She was concerned that his care and treatment were unreasonable, as was the time taken to admit him to a ward. She also considered that arrangements to deal with Mr C's personal hygiene while he was waiting and the A&E department's responses to her telephone calls were unreasonable. She was also unhappy about the way in which he was discharged and that his mental health condition and her role in his care as a decision maker were not properly taken into account.

The board explained that when Mr C was admitted the hospital was experiencing particularly difficult pressures due to a combination of bad winter weather (which meant patients could not be moved out of hospital) and increased attendances at hospital because of the winter vomiting noro-virus. I acknowledged this but note the comments of my nursing adviser, who said that the documented evidence of care given in the department was very poor, and did not even contain notes about what happened when Mr C felt more unwell and was returned to a cubicle for re-assessment. There was no record of medication given or of any personal care. I found that the lack of records showed a failing in care while he was waiting in the corridor, which my adviser said was in itself undignified, regardless of the exceptional circumstances in terms of pressure on beds. She also said that the government had introduced four hour waiting times for A&E departments, which were clearly breached in this case. While recognising the pressures on staff at the time, I found that the standard of care that Mr C received fell well below an acceptable level. I upheld these complaints.

I also upheld all Mrs C's other complaints. She had to empty Mr C's urine bottle herself, which my adviser said was unacceptable, especially as this is a basic aspect of care with which staff would be expected to assist. I also found the staff's response to Mrs C's telephone calls unacceptable. She said she called the police as staff had not told her about his condition and she was very concerned about him. Although the board said that staff had reassured Mrs C, the records contained no evidence of this. My adviser said that Mrs C was entitled to be kept fully informed, and that it was understandable that she was very anxious and distressed, given the situation. My adviser felt that there was a lack of engagement with or compassion for Mrs C, and that staff should have referred their concerns about her calls to a more senior member of staff. She said it was unprofessional and contrary to the Nursing and Midwifery Code for the nursing staff to have instead contacted the police, and that this caused Mrs C more distress. I also criticised the board as they did not, even with hindsight, consider the staff response to have been inappropriate.

I upheld the complaint about Mr C's discharge, which my adviser said was not in keeping with the board's policy which should have ensured that Mrs C, as his main carer, was involved in the arrangements. This included a failure to advise Mrs C about Mr C's medication; although there had not been any change to his Warfarin dosage, the board did not make this clear and did not provide Mr C with a discharge letter detailing his medication, which they should have done. Finally I upheld the complaint that Mr C's mental health condition and Mrs C's role in his care were not taken into account. This was important as Mrs C was concerned what might happen if Mr C needed to be admitted to the hospital again. I found that there was minimal evidence to suggest that staff communicated with Mrs C during Mr C's admission and on his discharge. Her role and the fact that she had power of attorney for him, which meant she should be involved in any process involving consent, was not appropriately recognised at any stage.

Mr C's case identified some serious shortcomings in the hospital in relation to the care of patients with dementia and their families, particularly with regard to anyone with guardianship of the patient. The board have apologised to Mr and Mrs C but I consider that they need to demonstrate improvement across their service in this respect. I made a number of recommendations to the board. These included recommendations about respecting dignity, improving communication and improving understanding about patients with dementia, and their families. I also recommended that the board provide a full apology to Mr and Mrs C for the failings identified. All these recommendations can be read in full in my report.

Ombudsman's Commentary

April 2012

Case Summaries

Health

Delay in diagnosis; complaints handling

Highland NHS Board (201004742)

Mr C was admitted to hospital in December 2005 with severe chest pain. While he was there an ultrasound scan detected a small mass on the outside of his left kidney, which was diagnosed as a benign fatty tumour. About three and a half years later he was admitted again, where an ultrasound scan found a mass had grown. He was diagnosed with renal cancer and had to have the tumour and part of his left kidney removed. Mr C felt that if the mass had been regularly and appropriately checked, the delay in diagnosing the cancer could have been prevented. He said that as a result his health and quality of life have been severely affected. Mr C also complained that the board did not deal with his complaint adequately.

I upheld both of Mr C's complaints. Although the board said that they sent Mr C an appointment and a request for a further scan, he said he did not receive them. The board, in responding to his complaint, said that as he did not attend a clinic and ultrasound appointment, this impacted on Mr C's subsequent care (Mr C did attend for other appointments). My adviser said that Mr C's medical records did not make it clear if these two appointments were actually sent or received. The adviser noted, however, that Mr C did not appear to have been provided with direct information about why follow-up was required and that Mr C's GP was not made sufficiently aware of the importance of follow-up. My adviser felt that the board did not do enough to ensure that follow-up took place. He also said that there was no evidence of shared decision-making (such as case reviews or discussions), and nothing was documented to indicate whether certain staff crucial in Mr C's care were aware of the critical recommendation made in a radiology report dated December 2005 for a CT scan. I found that this contributed to systemic failures in Mr C's care that did not allow him to reach an informed decision about his condition or prognosis. I recommended that the board conduct a Significant Event Review of Mr C's case, feed back the learning from the case to staff to try to avoid this happening again, and review how they ensure that the result of patient investigations received after discharge are read and acted upon.

In his complaint, Mr C asked questions about his care and treatment, including why a particular kind of scan was preferred rather than one that might have detected the cancer sooner. In their response, the board did not address all of the issues Mr C raised. I asked my adviser to review the medical aspects of their response. He said that the response contained contradictions; he also considered that it was incomplete and inaccurate. Mr C's complaint was about a very serious matter, which had significant consequences for his health, and I took the view that the board's response

lacked details and explanation. It was also inadequate in both tone and content, provided misleading information and appeared to consider what had happened to have been Mr C's sole responsibility. I recommended that the board review their complaints management procedures to ensure that they are complied with.

Clinical treatment; consent; communication

Grampian NHS Board (201101426)

Mrs C, who had a history of breast cancer, underwent reconstructive breast surgery. However, on the day of the surgery, Mrs C was advised that the consultant surgeon with whom she had had her consultation was on leave. She was told that a registrar (a more junior member of surgical staff) would carry out the operation. She met him on the morning of the operation and he said that he proposed to carry out a different procedure to that originally planned by the consultant. Although Mrs C was concerned about this, and felt 'rushed' into giving her consent, she went ahead with the surgery as she felt she it was not appropriate for her to cancel it at that late stage. Afterwards, she was very unhappy with the outcome of the surgery, which she said had a devastating physical and psychological impact on her. Mrs C complained to the board that the surgeon and the surgical procedure were both changed at short notice. She said she had not had sufficient time to consider the changes prior to undergoing the surgery. She also complained that the outcome of the surgery was unacceptable.

I took advice from one of my medical advisers, who is a consultant surgeon. My adviser was surprised that the registrar decided to change the procedure already agreed by a more senior colleague, and could find no satisfactory explanation in the records for why this happened. He acknowledged that surgeons may have different views on the surgery that is appropriate, but said the reasons should have been clearly explained in Mrs C's records. He pointed out that the board's position on this was not reasonable or clear, and said it was difficult to tell whether the registrar was competent to perform the procedure originally proposed by the consultant. For a number of reasons, he also had concerns about how the board obtained Mrs C's consent for this complex and significant surgical procedure. I was, therefore, critical of the board for failing to address Mrs C's concerns about the registrar in a meaningful way, and do not accept the reasons he gave for changing the procedure agreed by his more senior colleague.

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Ombudsman's Commentary

April 2012

Case Summaries

Health

I am also concerned about the 'rushed' way in which consent was obtained and that there is no evidence that Mrs C was given a clear explanation of the surgical procedures she was about to undergo. I was also of the view that, among other things, Mrs C should have been given the opportunity to have the procedure deferred until the consultant returned. Mrs C instead suffered an upsetting and difficult experience, and I considered that the standard of care was unacceptable. I upheld the complaint and recommended that the board discuss this case with the registrar at his next appraisal, provide me with evidence that staff are following the appropriate guidelines for obtaining consent, and ensure that a similar situation does not occur when cases are re-assigned amongst surgical staff in future.

I also upheld Mrs C's complaint about the outcome of the surgery, of which the long term impact upon her cannot be underestimated. My adviser said that breast reconstruction cannot be expected to achieve perfect symmetry, but that this should be clearly explained to a patient in advance. There was no evidence that this was discussed with Mrs C. However, having seen photographs of the surgical results, he said that overall the operative outcome was not reasonable. Mrs C was extremely distressed by the results, to the extent that she has sought an opinion about further treatment and surgical options from another board. He also noted that the board's responses were contradictory with regard to the registrar's involvement with Mrs C after the operation. I cannot say if the outcome would have been different had the original consultant carried out the operation. I was, however, dissatisfied with the care Mrs C received, and that there is no evidence that some issues relevant to the possible outcome were discussed with her before surgery. I was also extremely critical of the board for providing conflicting information about the registrar in their responses to her and my office. I recommended that the board apologise fully to Mrs C for the failures identified in my report and bring the report to the attention of all staff involved in Mrs C's care, to prevent this type of incident happening again.

Clinical treatment; nursing care; consent; communication

The Golden Jubilee National Hospital (200904100)

Mr A was diagnosed with lung cancer and was admitted to hospital, where he was operated on. At first the operation appeared to have been successful, but four days after surgery, Mr A's condition began to deteriorate and he died just under two weeks after admission. His daughter (Mrs C) raised a number of concerns on behalf of her mother (Mrs A) about the care and treatment that Mr A received. These included that there was a lack of proper supervision and care by medical staff, delay in moving Mr A to a high dependency unit; failure or delay to carry out certain treatments and procedures; and failure by staff to communicate with the family. The family believed that Mr A was suffering from an underlying condition

that medical staff did not detect, although his family repeatedly expressed their concerns to staff. Mrs C also felt that the hospital had not clearly explained why Mr A died.

I obtained advice from two of my advisers – a consultant thoracic surgeon (my medical adviser) and a senior nurse working in cardiothoracic surgery (my nursing adviser), both of whom looked at Mr A's medical records. My medical adviser said that the operation was properly performed and that post-operative medical care was satisfactory. However, he said that the clinical/physiological assessment of Mr A appeared to have been based on unsatisfactory data and his postoperative nutritional management was inadequate. There was a lack of evidence that treatment options were fully discussed with Mr A. While my medical adviser considered that the lack of evidence did not mean that the doctor treating Mr A did not discuss these matters with Mr A, he considered that if these discussions, which were important, took place then there should have been a written record made of these. I also found that the consent form he signed was poorly designed. He may therefore not have given fully informed consent to the treatment he received. My nursing adviser was concerned that there was a failure to address Mrs C's concerns about her father and to escalate them to the medical team, and that the reasons for not doing this were not recorded. My adviser concluded that a number of issues raised by Mrs C and her family were dismissed by nursing staff. There was also a lack of fluid balance monitoring and indications that, when Mr A's condition was deteriorating, an escalation plan to pick up problems was not robust. My adviser said that the nursing plan that the board produced as a result of the complaint did not adequately address these issues.

Mr A's death was reported to the Procurator Fiscal because Mrs C and her family were unhappy with the care he had received and because, at the time he died, the exact cause of his death was not known. I accept that Mr A's sudden deterioration meant that medical staff were not at first in a position to say exactly why he had died. My medical adviser, however, has said that he would have expected them to have explained this to Mr A's family at the time. Lack of information in the medical records means that it is not clear what was in fact said to the family members. My adviser said that the final cause of Mr A's death was quite clear, but took the view, with which I agree, that clinicians should have obtained the post mortem report to inform themselves about what had happened and to check if Mr A's family wished to discuss the findings. I upheld this complaint because there was an unreasonable lack of clarity in telling Mr A's family why he died.

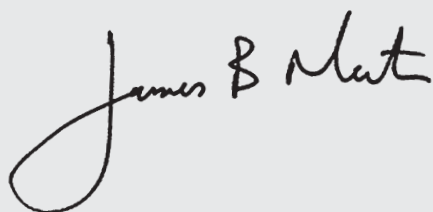
I made a number of recommendations to the board. These included recommendations about rewording their consent form; reflecting on the medical adviser's comments in my report; in future obtaining a copy of a post mortem report, and revising their nursing action plan. All these recommendations can be read in full in my report.

Ombudsman's Commentary

April 2012

Compliance and follow-up

In line with SPSO practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



Jim Martin, Ombudsman, 25 April 2012

The compendium of reports can be found on our website **www.spsso.org.uk**

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Ombudsman's Commentary

April 2012

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage for handling complaints about councils, housing associations, the National Health Service, 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 formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

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. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: **www.spsso.org.uk**

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