# SPSO decision report

SPSO Scottish Public Services Ombudsman

**Case:** **201300298, Greater Glasgow and Clyde NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations

## Summary

Mrs C, who is an advice worker, complained to us on behalf of her client (Mrs A). Mrs A was referred to a gynaecology clinic, as she had been experiencing some loss of bladder control. It was agreed that Mrs A would have an operation to try to resolve this. However, after the operation Mrs A was left in pain, and with a feeling of great urgency to pass urine at times. Mrs C complained that Mrs A was not reasonably informed of the risks before the operation and that it had worsened her situation.

After considering Mrs A's clinical records and taking independent advice from one of our medical advisers, we found that Mrs A had been counselled appropriately about the risks and benefits of the operation. She signed a consent form that identified the risks and was given a patient information leaflet about the operation, which was clear and informative. This included information about the risk of long-term pain and the risk of developing irritable bladder symptoms.

Although it was clear that the operation had not been successful, we found that that it was reasonable for the board to carry out the procedure, which was performed appropriately and by surgeons with adequate training and expertise. We did not identify any failings by the board that led to the problems Mrs A experienced.

Mrs C also complained about the care provided to Mrs A after the operation. We found that her initial post-operative care was reasonable and appropriate. However, Mrs A had to wait too long for appointments and we found that the aftercare should have been provided in a more timely fashion. It was only when Mrs C complained on her behalf that an appointment with a consultant was brought forward, a complication was recognised and Mrs A was then referred to the pain clinic. Even then, the appointment with the pain clinic initially given to Mrs A was more than three months later.

## Recommendations

We recommended that the board:

- issue a written apology to Mrs A for the delays in providing appointments once the complication had been recognised; and
- confirm to the Ombudsman that they have learned lessons from this case and will ensure that, in future, patients who suffer complications after having this type of surgery do not face similar delays in getting appointments.