2009-10 Statistics Tables – Explanatory Notes and Commentary

After local authorities, the NHS is traditionally the sector about which we receive the next highest number of complaints in a year. As we say in our Annual Report, this is to be expected, given the way in which both sectors touch the lives of so many of Scotland's citizens. And we also know that each year authorities satisfactorily resolve many more complaints directly with members of the public.

The information provided consists of the statistics we recorded for 2008-09 and 2009-10, plus these explanatory notes and commentary. We'd encourage you to take time to review these and consider how you might use the information in taking forward your service improvement work.

Ayrshire and Arran NHS Board

Complaints received
Table 1 details in bold the number of complaints we received for your Board for 2008-09 and 2009-10, alongside the total of complaints about the NHS for these years. The complaints are categorised by subject area, some of which are fairly broad. The subjects shown are confined to the main issue that the complainant raised with us, and many of the complaints will also have had other issues involved. The table also shows whether the complaint was about an FHS provider, the Board itself etc. In the majority of Boards the main area of complaint was, unsurprisingly, about clinical treatment/diagnosis. Rates of complaint about this subject ranged from 40 to 60 per cent across the larger regional Boards.

We recorded 52 complaints about your Board in 2009-10, compared to 47 in the previous year. Although we received more complaints about the Board in 2009-10, when taken as a percentage of the total number of complaints we received about the NHS in each year it shows a slight drop (from 6.9% of the total complaints received to 6.1%).

Complaints determined
Table 2 shows the outcomes of complaints that the SPSO determined about your Board in 2009-10 - i.e. it shows what we did with them. In most of the cases, we will have written and told you that we had received a complaint, and what our decision on it was. Normally we will also have sent you a copy of our decision letter to the complainant. We may not, however, have told you about all of the cases that we determined as premature, depending on the circumstances of the case. (There is an explanation of this in the FAQs on the Statistics page of our website.) The final section of these explanatory notes deals with the investigated complaints on which we reported to the Parliament.

The table also shows whether the complaint was about an FHS provider, the Board itself etc. After discussion with some Board representatives last year we agreed that it would not be helpful to break these down further by subject matter, given that our subject codes differ from those used by the NHS.

Please note that received and determined numbers do not normally tally exactly, and it is normal for us to carry some cases forward. This is because our work on a complaint received in one business year may not be completed until the following year. This is particularly relevant to health cases - for example we may find we need to obtain clinical advice, and this can take time.

Complaints determined as 'premature'

We determine some complaints as 'premature'. We consider a complaint to be premature when it reaches us before it has completed the NHS complaints process. There may be a number of reasons that people send us complaints too early – sometimes they have not tried to make the complaint to the NHS at all, sometimes they have made the complaint but come to us before they receive a final response. When we receive a premature complaint, we normally return it to the complainant and ask them to make the complaint directly to the relevant authority, or to contact the authority about it again. If it returns to us after that we will reopen the case. We may, however, accept a complaint before it has completed the process if it is clear that there has been significant delay by the authority in sending a response.

The number of premature complaints that we receive about the NHS is in fact very low compared to other sectors. This may reflect the fact that there is only a single-stage process involved. However, it may be worth considering whether there is any more that you can do to ensure that staff are aware of the process and can tell people how to access it and that members of the public have easy access to NHS complaints leaflets in premises within your Board area.

Investigated Complaints and Recommendations

We investigated and reported on six complaints about your Board in 2009-10, of which we upheld one, partially upheld three and did not uphold two. The summary sheet shows these complaints and the recommendations made. You will be aware that SPSO complaints reviewers follow up to find out what changes have been made as a result of our recommendations.

……..

We hope that you find this summary useful. We are aware from our consultation that the way in which we categorise complaints does not mirror the NHS way of doing so, and it would be useful to know if any further explanation of our categories is required. We'd also welcome any other thoughts you may have on the information presented and ways in which we can further improve this feedback to you, which we plan to provide annually in future if Health Boards find it useful.

If you have any comments about this or enquiries about the statistics provided, please contact Annie White, SPSO Casework Knowledge Manager, on 0131 240 8843 or email awhite@spso.org.uk .

Statistical reports for all years are available on the SPSO website at:
http://www.spso.org.uk/statistics/index.php

Table 1

		Ayrshire & Arran NHS Board Area								
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Service	Ayrshire & Arran NHS Board	Ayrshire & Arran NHS Board - Patient Services	**Ayrshire & Arran NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	0	0	0	**0**	0%	**15**	2%
	Appliances, equipment & premises	0	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	1	0	1	0	**2**	4%	**48**	6%
	Clinical treatment/diagnosis	0	4	0	24	1	**29**	56%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	1	0	4	0	**5**	10%	**91**	11%
	Complaints by NHS staff	0	0	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	0	0	1	0	**1**	2%	**20**	2%
	Continuing care	0	0	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	0	0	0	**0**	0%	**6**	1%
	Lists	0	0	0	0	0	**0**	0%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	0	0	1	1	**2**	4%	**10**	1%
	Other	0	0	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	0	0	7	0	**7**	13%	**156**	18%
	Record keeping	0	0	0	0	0	**0**	0%	**7**	1%
	Out of jurisdiction	0	0	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	0	0	6	0	**6**	12%	**68**	8%
	Total	**0**	**6**	**0**	**44**	**2**	**52**		**857**	
2008-09	Admission, discharge & transfer procedures	1	1	0	0	0	**2**	4%	**18**	3%
	Appliances, equipment & premises	0	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	1	0	**1**	2%	**23**	3%
	Clinical treatment/diagnosis	0	5	1	22	0	**28**	60%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	2	0	1	0	**3**	6%	**62**	9%
	Complaints handling	0	0	0	0	0	**0**	0%	**22**	3%
	Continuing care	0	0	0	2	0	**2**	4%	**10**	1%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	**0**	0%	**3**	0%
	Hotel services - food, laundry etc	0	0	0	0	0	**0**	0%	**1**	0%
	Hygiene, cleanliness & infection control	0	0	0	0	0	**0**	0%	**4**	1%
	Lists	0	0	0	0	0	**0**	0%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	0	**0**	0%	**2**	0%
	Nurses/nursing care	0	0	0	1	0	**1**	2%	**13**	2%
	Other	0	0	0	0	0	**0**	0%	**1**	0%
	Policy/administration	1	2	0	5	0	**8**	17%	**110**	16%
	Record keeping	0	0	0	1	0	**1**	2%	**12**	2%
	Out of jurisdiction	0	0	0	0	0	**0**	0%	**6**	1%
	Subject unknown	0	0	0	1	0	**1**	2%	**17**	2%
	Total	**2**	**10**	**1**	**34**	**0**	**47**		**684**	

Table 2

Ayrshire & Arran NHS Board Area

	Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Service	Ayrshire & Arran NHS Board	Ayrshire & Arran NHS Board - Patient Services	**Ayrshire & Arran NHS Board Area Total**	**Sector Total**
2009-10	Assessment	Discontinued before investigation	0	0	0	10	1	**11**	**160**
		Discretionary decision not to pursue	0	0	0	0	0	**0**	**1**
		Other	0	0	0	0	0	**0**	**7**
		Out of jurisdiction	0	0	0	4	0	**4**	**60**
		Premature	0	2	0	13	0	**15**	**319**
		Total	**0**	**2**	**0**	**27**	**1**	**30**	**547**
	Examination	Discontinued before investigation	0	0	0	1	0	**1**	**16**
		Determined after detailed consideration	1	5	0	16	1	**23**	**314**
		Total	**1**	**5**	**0**	**17**	**1**	**24**	**330**
	Investigation	Report issued: fully upheld	0	0	0	1	0	**1**	**33**
		Report issued: not upheld	0	0	0	2	0	**2**	**9**
		Report issued: partially upheld	0	0	0	3	0	**3**	**32**
		Total	**0**	**0**	**0**	**6**	**0**	**6**	**74**
	Total		**1**	**7**	**0**	**50**	**2**	**60**	**951**
2008-09	Assessment	Discontinued before investigation	0	0	0	7	0	7	**132**
		Out of jurisdiction	0	2	1	5	0	**8**	**52**
		Premature	0	3	0	8	0	**11**	**182**
		Total	**0**	**5**	**1**	**20**	**0**	**26**	**366**
	Examination	Determined after detailed consideration	1	3	0	5	0	**9**	**193**
		Total	**1**	**3**	**0**	**5**	**0**	**9**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	0	0	**1**
		Report issued: fully upheld	0	0	0	0	0	**0**	**26**
		Report issued: not upheld	0	1	0	2	0	**3**	**27**
		Report issued: partially upheld	0	0	0	2	0	**2**	**46**
		Total	**0**	**1**	**0**	**4**	**0**	**5**	**100**
	Total		**1**	**9**	**1**	**29**	**0**	**40**	**659**

Ayrshire and Arran NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
17/06/2009	200800078	(a) the assessment on 15 October 2007 was inadequate (not upheld); (b) the Board discounted the benefit of Mrs A's move to be closer to her family (not upheld); and (c) the Board failed to explain properly the decision not to award continuing care funding (upheld).	partially upheld	(i) apologise to Mr C for failing to explain the decision properly; (ii) undertake a retrospective assessment of Mrs A's eligibility for NHS Continuing Care from the point of her transfer to Scotland; (iii) consider whether they now have a preferred or standardised format for decisions relating to and documentation of assessments for NHS Continuing Care; (iv) consider what procedures they have in place to assess cross border transfers where there is no request or need for NHS Continuing Care; (v) consider what procedures they now have in place to ensure that all care home residents are routinely assessed at the point of entry and thereafter, with regard to their eligibility for NHS Continuing Care; (vi) consider under what circumstances they will consider retrospective requests for NHS Continuing Care; and (vii) review the instructions they give to their staff on the handling of assessments relating to extraordinary issues such as cross border patient movement. The Board have accepted the recommendations and will act on them accordingly.
22/07/2009	200600199	(a) Ms A's treatment at Hospital 1 during January and February 2006 was ineffective and she was discharged inappropriately (not upheld); and (b) Ms A was treated and discharged inappropriately from Hospital 2 following her attendances at the Accident and Emergency Department on 10 and 13 February 2006 (not upheld).	not upheld	The Ombudsman has no recommendations to make.
22/07/2009	200800173	the Board's care and treatment of Mrs A in the final hours of her life was not reasonable (partially upheld to the extent that some aspects of Mrs A's care and treatment were not reasonable).	partially upheld	(i) encourage Doctor 1 to reflect on the case at their next appraisal, with particular reference to: assessment of unfamiliar patients as part of the Ayrshire Doctors On Call team; the factors to be considered in reaching a decision on the admission to hospital of frail elderly patients; the discussion and recording of admission criteria with carers and relatives; and the dosage of antibiotics in relation to Scottish Intercollegiate Guidance Network guidance; and (ii) encourage Doctor 2 to reflect on the case at their next appraisal, with particular reference to: the discussion and recording of terminal diagnoses with carers and relatives; andthe use of symptomatic measures in terminal care. The Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
18/11/2009	200801379	(a) there had been an error in the diagnosis of cancer, which led to an unnecessary operation (upheld); (b) there were problems with the communication to Mr C about the new diagnosis and the response to his questions about this (upheld); (c) there had been an unreasonable delay in ensuring Mr C was put back on the kidney transplant list (upheld); and (d) the responses to Mr C's complaints were inadequate (upheld).	upheld	(i) undertake a short, focussed audit of lung fine needle aspirations (FNA)s carried out by the department; (ii) review, as a matter of urgency, the clinical use of such FNAs by Hospital 1; (iii) emphasise to clinical staff involved the importance of taking and documenting a full clinical history; this matter should be confirmed with Consultant 1 as part of his annual appraisal; (iv) emphasise to staff involved the importance of timely and open communication; (v) alert staff to the need to ensure appropriate communication with patients and file management, in an effort to prevent the situation recurring, where a patient could be concerned about information placed in his/her file which has not been discussed with him/her; (vi) undertake a full review of the operation of their complaints process and the relationship of this to clinical governance, as a matter of urgency; (vii) establish why an incident review was not considered and this matter not re considered by the lung cancer multi-disciplinary team and take appropriate steps to ensure that their own policies and procedures are followed by clinical and complaints handling staff; and (viii) make a full apology to Mr C for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
18/11/2009	200801457	(a) when Ms A was admitted as an emergency to Hospital 2 on 17 December 2007, there was a delay in performing surgery to remove a dermoid ovarian cyst (upheld); (b) there was a failure to inform Ms A of the removal of her right ovary and tube until 20 December 2007 – the day after her surgery (upheld); (c) there was a failure to take into account Ms A's description of the pain she was suffering while she was an out-patient (not upheld); and (d) when Ms A was a patient in Ward 6 of Hospital 2 she was sometimes forgotten about (not upheld).	partially upheld	the Board: (i) apologise to Ms A for the delay in undertaking her surgery and take steps to ensure that such delays do not recur; (ii) inform the Ombudsman of the measures being undertaken to address the issues raised; and (iii) take steps to ensure delays in communicating the results of surgery to patients do not recur. The Board have accepted the recommendations and will act on them accordingly.
23/12/2009	200701747 200800670	(a) during the period May 2006 to September 2007 the Board failed to provide appropriate care to address Mr C and his family's deteriorating health, resulting from the Council's alleged failure to fulfil their duties towards Mr C and his family (not upheld); (b) during the period May 2006 to September 2007 the Board failed to put in place a programme of intervention to meet Child C's needs (not upheld); and (c) during the period May 2006 to September 2007 the Board failed to provide proper care to alleviate the distress caused to Mr C and his family from the effects of his son's disability (not upheld). (d) from March 2005 to May 2008, the Council failed to properly assess Mr C and his family's needs for support from social work services and subsequently provide this support, in accordance with procedure (not upheld); (e) the Council failed to inform Mr C that from 6 April 2008 Child C would lose his right to all his 'banked hours' (upheld); and (f) the Council failed to allocate Child C a new social worker, after the previous one left in December 2007 (not upheld).	partially upheld	(i) re-instate Child C's unused hours of support for the period 25 October 2005 to 25 April 2008; and (ii) take note of both the Ombudsman's Mental Health Adviser (Adviser 1)'s and the Ombudsman's Psychiatric Adviser's comments on multi-agency working in this case, and seek to implement Adviser 1's suggestions at paragraph 128, in particular, the suggestion that stakeholders 'regroup' to re-establish and commit to effective future collaborative working arrangements, including a set of principles upon which future care should be based. The Ombudsman recommends that the Board take note of both the Ombudsman's Mental Health Adviser (Adviser 1)'s and the Ombudsman's Psychiatric Adviser's comments on multi-agency working in this case, and seek to implement Adviser 1's suggestions at paragraph 128, in particular, the suggestion that stakeholders 'regroup' to re-establish and commit to effective future collaborative working arrangements, including a set of principles upon which future care should be based. The Board and the Council have accepted the recommendations and will act on them accordingly.