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.

Fife 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 43 complaints about your Board in 2009-10, compared to 34 in the previous year. When taken as a percentage of the total number of complaints we received about the NHS in each year, however, this shows only a very slight rise (from 4.97% of the total complaints received to 5.02%).

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 three complaints about your Board in 2009-10, of which we upheld one, and partially upheld the other two. We reported on these three complaints in two reports. The attached summary sheet shows the 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.
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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

		Fife NHS Board Area						
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	Fife NHS Board	**Fife NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	1	**1**	2%	**15**	2%
	Appliances, equipment & premises	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	**0**	0%	**48**	6%
	Clinical treatment/diagnosis	3	6	15	**24**	56%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	2	3	**5**	12%	**91**	11%
	Complaints by NHS staff	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	0	1	**1**	2%	**20**	2%
	Continuing care	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	1	**1**	2%	**6**	1%
	Lists	0	1	1	**2**	5%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	0	0	**0**	0%	**10**	1%
	Other	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	0	5	**5**	12%	**156**	18%
	Record keeping	0	0	0	**0**	0%	**7**	1%
	Out of jurisdiction	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	0	4	**4**	9%	**68**	8%
	Total	**3**	**9**	**31**	**43**		**857**	
2008-09	Admission, discharge & transfer procedures	0	0	1	**1**	3%	**18**	3%
	Appliances, equipment & premises	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	**0**	0%	**23**	3%
	Clinical treatment/diagnosis	1	3	14	**18**	53%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	2	3	**5**	15%	**62**	9%
	Complaints handling	0	0	0	**0**	0%	**22**	3%
	Continuing care	0	0	0	**0**	0%	**10**	1%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**3**	0%
	Hotel services - food, laundry etc	0	0	0	**0**	0%	**1**	0%
	Hygiene, cleanliness & infection control	0	0	0	**0**	0%	**4**	1%
	Lists	0	0	0	**0**	0%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	1	0	0	**1**	3%	**2**	0%
	Nurses/nursing care	0	0	0	**0**	0%	**13**	2%
	Other	0	0	0	**0**	0%	**1**	0%
	Policy/administration	0	1	6	**7**	21%	**110**	16%
	Record keeping	0	0	0	**0**	0%	**12**	2%
	Out of jurisdiction	0	0	0	**0**	0%	**6**	1%
	Subject unknown	0	0	2	**2**	6%	**17**	2%
	Total	**2**	**6**	**26**	**34**		**684**	

Table 2

			Fife NHS Board Area					
			A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Services	Fife NHS Board	**Fife NHS Board Area**	**Sector Total**
	Complaints Determined by Outcome							
2009-10	Assessment	Discontinued before investigation	0	3	0	5	**8**	**160**
		Discretionary decision not to pursue	0	0	0	0	**0**	**1**
		Other	0	0	0	0	**0**	**7**
		Out of jurisdiction	0	0	0	1	**1**	**60**
		Premature	0	3	1	10	**14**	**319**
		Total	**0**	**6**	**1**	**16**	**23**	**547**
	Examination	Discontinued before investigation	0	0	0	1	**1**	**16**
		Determined after detailed consideration	2	4	1	12	**19**	**314**
		Total	**2**	**4**	**1**	**13**	**20**	**330**
	Investigation	Report issued: fully upheld	0	0	0	1	**1**	**33**
		Report issued: not upheld	0	0	0	0	**0**	**9**
		Report issued: partially upheld	0	1	0	1	**2**	**32**
		Total	**0**	**1**	**0**	**2**	**3**	**74**
	Total		**2**	**11**	**2**	**31**	**46**	**951**
2008-09	Assessment	Discontinued before investigation	0	0	0	2	2	**132**
		Out of jurisdiction	0	0	0	1	**1**	**52**
		Premature	0	0	0	9	**9**	**182**
		Total	**0**	**0**	**0**	**12**	**12**	**366**
	Examination	Determined after detailed consideration	1	3	0	9	**13**	**193**
		Total	**1**	**3**	**0**	**9**	**13**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	0	**1**
		Report issued: fully upheld	0	2	0	2	**4**	**26**
		Report issued: not upheld	1	2	0	1	**4**	**27**
		Report issued: partially upheld	0	0	0	4	**4**	**46**
		Total	**1**	**4**	**0**	**7**	**12**	**100**
	Total		**2**	**7**	**0**	**28**	**37**	**659**

Fife NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
22/07/2009	200801921	the Board failed to: (a) communicate adequately with Mrs C and in particular failed to follow the procedure for instituting and implementing a DNR order (upheld); and (b) keep Mr C safe using appropriate restraint (partially upheld).	partially upheld	(i) review the DNR policy, the use, and value added by the use of, the resuscitation box in the Unitary Patient Record; followed by an ongoing audit (or similar improvement methodology) to ensure that there is clarity about when the policy applies and whether it is sustained in practice. The audit should measure the completion of the DNR form and associated documentation in the patient record; (ii) review how Cardio Pulmonary Resuscitation status is communicated at ward level, to ensure nursing staff are aware of the importance of robust communication at handover and transfer. The national 'Leading Better Care' policy may be helpful here; (iii) consider including DNR orders in both induction and Basic Life Support staff training. This is already done in some parts of NHS Scotland and is endorsed by the Scottish Palliative Care Society; (iv) review the mechanisms in place to ensure that communication between patients, their relatives and carers and staff is recognised as an important part of the patient experience; and (v) develop a specific policy for the WanderGuard bracelet to ensure that its use complies with the Adults with Incapacity (Scotland) Act 2000 to ensure patients are treated with dignity and respect. The Board have accepted the recommendations and will act on them accordingly.
18/11/2009	200802262 200900284	(a) the Practice unreasonably prescribed anti-depressants to Mrs A based on information from a third party (not upheld); (b) the Practice unreasonably changed a routine psychiatric referral to an urgent referral based on information from a third party (not upheld); (c) the Practice failed to refer the actions of another health professional, which they knew had given rise to professional concern, to the appropriate authority (upheld); (d) the Board unreasonably prescribed medication to Mrs A based on information from a third party (not upheld); and (e) the Board failed to refer the actions of a health professional, which had given rise to professional concern, to the appropriate authority (upheld).	partially upheld	There are no recommendations in respect of the Practice. The Ombudsman recommends that the Board take steps to remind all clinical staff, including Primary Care staff and Family Health Service providers in the Board area, of their professional duty to act when they have a concern about the fitness to practise of a health professional. The Board have accepted the recommendation and will act on it accordingly.