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. I'd encourage you to take time to review these and consider how you might use the information in taking forward your service improvement work.

Grampian 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 50 complaints about your Board in 2009-10, compared to 38 in the previous year. When taken as a percentage of the total number of complaints we received about the NHS in each year this shows a very slight rise (from 5.5% of the total complaints received to 5.8%).

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 four complaints about your Board in 2009-10, of which we upheld two and partially upheld another two. The attached 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.

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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

	Complaints Received by Subject	A Body Not Known	A Dentist or Dental Practice	A GP or General Medical Practice	Grampian NHS Board	**Grampian NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
		Grampian NHS Board Area							
2009-10	Admission, discharge & transfer procedures	0	0	1	1	**2**	4%	**15**	2%
	Appliances, equipment & premises	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	5	**5**	10%	**48**	6%
	Clinical treatment/diagnosis	0	0	1	23	**24**	48%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	0	0	5	**5**	10%	**91**	11%
	Complaints by NHS staff	0	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	0	0	3	**3**	6%	**20**	2%
	Continuing care	0	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	0	1	**1**	2%	**6**	1%
	Lists	0	0	0	0	**0**	0%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	0	0	0	**0**	0%	**10**	1%
	Other	0	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	0	1	8	**9**	18%	**156**	18%
	Record keeping	0	0	0	0	**0**	0%	**7**	1%
	Out of jurisdiction	0	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	0	0	1	**1**	2%	**68**	8%
	Total	**0**	**0**	**3**	**47**	**50**		**857**	
2008-09	Admission, discharge & transfer procedures	0	0	0	0	**0**	0%	**18**	3%
	Appliances, equipment & premises	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	1	**1**	3%	**23**	3%
	Clinical treatment/diagnosis	1	0	6	19	**26**	68%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	0	0	0	**0**	0%	**62**	9%
	Complaints handling	0	0	0	4	**4**	11%	**22**	3%
	Continuing care	0	0	0	0	**0**	0%	**10**	1%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	**0**	0%	**3**	0%
	Hotel services - food, laundry etc	0	0	0	0	**0**	0%	**1**	0%
	Hygiene, cleanliness & infection control	0	0	0	0	**0**	0%	**4**	1%
	Lists	0	2	0	0	**2**	5%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	**0**	0%	**2**	0%
	Nurses/nursing care	0	0	0	1	**1**	3%	**13**	2%
	Other	0	0	0	0	**0**	0%	**1**	0%
	Policy/administration	0	0	1	3	**4**	11%	**110**	16%
	Record keeping	0	0	0	0	**0**	0%	**12**	2%
	Out of jurisdiction	0	0	0	0	**0**	0%	**6**	1%
	Subject unknown	0	0	0	0	**0**	0%	**17**	2%
	Total	**1**	**2**	**7**	**28**	**38**		**684**	

Table 2

Grampian NHS Board Area

Complaints Determined by Outcome

Year	Stage	Outcome	A Body Not Known	A Dentist or Dental Practice	A GP or General Medical Practice	Grampian NHS Board	**Grampian NHS Board Area**	**Sector Total**
2009-10	Assessment	Discontinued before investigation	0	0	0	4	**4**	**160**
		Discretionary decision not to pursue	0	0	0	0	**0**	**1**
		Other	0	0	0	1	**1**	**7**
		Out of jurisdiction	0	0	0	5	**5**	**60**
		Premature	0	0	0	22	**22**	**319**
		Total	**0**	**0**	**0**	**32**	**32**	**547**
	Examination	Discontinued before investigation	0	0	0	1	**1**	**16**
		Determined after detailed consideration	0	1	2	16	**19**	**314**
		Total	**0**	**1**	**2**	**17**	**20**	**330**
	Investigation	Report issued: fully upheld	0	0	0	2	**2**	**33**
		Report issued: not upheld	0	0	0	0	**0**	**9**
		Report issued: partially upheld	0	0	0	2	**2**	**32**
		Total	**0**	**0**	**0**	**4**	**4**	**74**
	Total		**0**	**1**	**2**	**53**	**56**	**951**
2008-09	Assessment	Discontinued before investigation	1	0	0	1	2	**132**
		Out of jurisdiction	0	0	2	3	**5**	**52**
		Premature	0	0	1	7	**8**	**182**
		Total	**1**	**0**	**3**	**11**	**15**	**366**
	Examination	Determined after detailed consideration	0	2	4	10	**16**	**193**
		Total	**0**	**2**	**4**	**10**	**16**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	0	**1**
		Report issued: fully upheld	0	0	1	1	**2**	**26**
		Report issued: not upheld	0	0	0	0	**0**	**27**
		Report issued: partially upheld	0	0	0	0	**0**	**46**
		Total	**0**	**0**	**1**	**1**	**2**	**100**
	Total		**1**	**2**	**8**	**22**	**33**	**659**

Grampian NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
20/05/2009	200801545	the Board did not provide reasonable care and treatment to Mr A in relation to a referral from his GP for hoarseness (upheld).	upheld	(i) ensure that all clinical staff are aware that persistent hoarseness should be taken to be a symptom of cancer of the larynx unless proved otherwise; (ii) ensure that such cases are dealt with urgently; (iii) ensure that endoscopies undertaken to exclude cancer have the direct involvement of a senior trained practitioner; (iv) ensure that any junior staff involved in such procedures are adequately trained and supervised and that this is recorded; (v) review the way in which the laryngoscopy performed on Mr A in 2005 was carried out to establish if there are any lessons that can be learned and whether further guidelines in relation to such procedures are required; (vi) consider further investigation where a laryngoscopy shows no evidence of malignancy, but the patient continues to display laryngeal symptoms; and (vii) apologise to Miss C for the failings identified in this report.
20/05/2009	200802067	following her admission to A and E on the morning of 11 January 2008 Grampian NHS Board failed to: (a) properly monitor and record Mrs C's condition (upheld); (b) supervise the actions of junior staff (upheld); and (c) provide Mrs C with appropriate transport at discharge (not upheld).	partiallly upheld	(i) undertake an audit (or provide evidence of a recent audit) of the quality of clinical documentation in A and E, with particular reference to discharge documentation; (ii) review their practice in relation to patient call buzzers being removed and consider how patients can summon assistance from staff when required; (iii) use events of this case to remind frontline staff of the importance of early diagnosis of meningitis and use in teaching for new junior doctors and nursing staff; and (iv) stress the importance of documenting consultation outcomes and requests for senior review to all grades of staff in the A and E department.
17/06/2009	200700577	(a) the facilities at Hospital 1 were unsuitable and did not meet minimum standards (not upheld); (b) Mr C was not tested for MRSA before discharge and there were no facilities for quickly diagnosing MRSA and isolating MRSA positive patients (not upheld); (c) there was a lack of cleanliness, no control over the numbers of visitors and handwashing advice was ignored (not upheld); and (d) Mr C's complaints were not handled appropriately (upheld).	partially upheld	remind staff dealing with complaints of the need to have regard to the NHS complaints procedure timescales.
17/06/2009	200702838	(a) some aspects of the care and treatment were inadequate (upheld); and (b) communication with the family was inadequate (no finding).	upheld	(i) apologise direct to Ms C for the shortcomings identified in this report; (ii) reflect on the medical lessons to be learnt from this case and consider appropriate action; (iii) ensure that, in future, they are able to evidence patients' fluid levels, by retaining, for example, a record of daily fluid totals for a year after the event, in case needed; (iv) consider how to improve the record-keeping, including notes of discussions with patients and families, of medical staff in the ward in question, and take action accordingly; (v) consider any need for a wider audit of medical record-keeping; and (vi) reflect on the criticisms about complaint handling and consider appropriate action.