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.

Lothian 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 131 complaints about your Board in 2009-10, compared to 119 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 drop of just over two per cent (from 17.4% of the total complaints received to 15.3%).

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 a total of 13 complaints about your Board in 2009-10. We upheld eight and partially upheld another five, and reported on these in 12 reports. 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.
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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

		Lothian NHS Board Area												
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Service	A Pharmacist or Pharmacy	Lothian NHS Board	Lothian NHS Board - Acute Division	Lothian NHS Board - Lothian University Hospitals Division	Lothian NHS Board - Royal Edinburgh and Associated Services Division	Lothian NHS Board - University Hospitals Division	**Lothian NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	0	0	1	0	0	0	0	**1**	1%	**15**	2%
	Appliances, equipment & premises	0	0	0	0	0	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	1	1	0	0	10	0	0	0	0	**12**	9%	**48**	6%
	Clinical treatment/diagnosis	9	14	0	1	36	10	5	1	1	**77**	59%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	1	7	0	0	7	2	0	0	0	**17**	13%	**91**	11%
	Complaints by NHS staff	0	0	0	0	0	0	1	0	0	**1**	1%	**2**	0%
	Complaints handling	0	0	0	0	0	0	0	0	0	**0**	0%	**20**	2%
	Continuing care	0	0	0	0	1	0	0	0	0	**1**	1%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	0	0	0	0	0	0	0	**0**	0%	**6**	1%
	Lists	0	2	0	0	0	0	0	0	0	**2**	2%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	0	0	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	0	0	0	0	0	0	0	0	**0**	0%	**10**	1%
	Other	0	0	0	0	1	0	0	0	0	**1**	1%	**2**	0%
	Policy/administration	0	2	0	0	12	2	0	0	0	**16**	12%	**156**	18%
	Record keeping	0	0	0	0	0	0	0	0	0	**0**	0%	**7**	1%
	Out of jurisdiction	0	0	0	0	0	0	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	0	0	0	2	1	0	0	0	**3**	2%	**68**	8%
	Total	**11**	**26**	**0**	**1**	**70**	**15**	**6**	**1**	**1**	**131**		**857**	
2008-09	Admission, discharge & transfer procedures	0	3	0	0	1	0	0	0	0	**4**	3%	**18**	3%
	Appliances, equipment & premises	0	0	0	0	0	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	1	0	0	7	0	0	0	0	**8**	7%	**23**	3%
	Clinical treatment/diagnosis	2	11	0	0	43	0	0	0	0	**56**	47%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	5	0	0	9	0	0	0	0	**14**	12%	**62**	9%
	Complaints handling	0	1	0	0	2	0	0	0	0	**3**	3%	**22**	3%
	Continuing care	0	0	0	0	1	0	0	0	0	**1**	1%	**10**	1%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	0	0	0	**0**	0%	**3**	0%
	Hotel services - food, laundry etc	0	0	0	0	0	0	0	0	0	**0**	0%	**1**	0%
	Hygiene, cleanliness & infection control	0	0	0	0	0	0	0	0	0	**0**	0%	**4**	1%
	Lists	0	0	0	0	0	0	0	0	0	**0**	0%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	1	0	0	0	0	0	0	0	0	**1**	1%	**2**	0%
	Nurses/nursing care	0	0	0	0	4	0	0	0	0	**4**	3%	**13**	2%
	Other	0	0	0	0	0	0	0	0	0	**0**	0%	**1**	0%
	Policy/administration	2	5	1	0	13	0	0	0	0	**21**	18%	**110**	16%
	Record keeping	1	0	0	0	0	0	0	0	0	**1**	1%	**12**	2%
	Out of jurisdiction	1	0	0	0	0	0	0	0	0	**1**	1%	**6**	1%
	Subject unknown	0	1	0	0	4	0	0	0	0	**5**	4%	**17**	2%
	Total	**7**	**27**	**1**	**0**	**84**	**0**	**0**	**0**	**0**	**119**		**684**	

Table 2

			Lothian NHS Board Area								
	Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Services	A Pharmacy or Pharmacist	Lothian NHS Board	Lothian NHS Board - Acute Division	Lothian NHS Board - Lothian University Hospitals Division	**Lothian NHS Board Area Total**	**Sector Total**
2009-10	Assessment	Discontinued before investigation	2	4	0	0	17	2	0	**25**	**160**
		Discretionary decision not to pursue	0	0	0	0	0	0	0	**0**	**1**
		Other	0	0	0	0	0	0	0	**0**	**7**
		Out of jurisdiction	1	2	0	0	6	1	0	**10**	**60**
		Premature	3	5	0	0	20	9	1	**38**	**319**
		Total	**6**	**11**	**0**	**0**	**43**	**12**	**1**	**73**	**547**
	Examination	Discontinued before investigation	0	0	0	1	1	0	0	**2**	**16**
		Determined after detailed consideration	4	20	0	0	29	0	0	**53**	**314**
		Total	**4**	**20**	**0**	**1**	**30**	**0**	**0**	**55**	**330**
	Investigation	Report issued: fully upheld	1	0	1	0	6	0	0	**8**	**33**
		Report issued: not upheld	0	0	0	0	0	0	0	**0**	**9**
		Report issued: partially upheld	0	1	0	0	4	0	0	**5**	**32**
		Total	**1**	**1**	**1**	**0**	**10**	**0**	**0**	**13**	**74**
	Total		**11**	**32**	**1**	**1**	**83**	**12**	**1**	**141**	**951**
2008-09	Assessment	Discontinued before investigation	0	4	0	0	19	0	0	23	**132**
		Out of jurisdiction	1	1	0	0	5	0	0	**7**	**52**
		Premature	2	6	0	0	24	0	0	**32**	**182**
		Total	**3**	**11**	**0**	**0**	**48**	**0**	**0**	**62**	**366**
	Examination	Determined after detailed consideration	1	10	0	1	26	0	0	**38**	**193**
		Total	**1**	**10**	**0**	**1**	**26**	**0**	**0**	**38**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	0	0	0	0	**1**
		Report issued: fully upheld	0	1	0	0	4	0	0	**5**	**26**
		Report issued: not upheld	0	2	0	0	2	0	0	**4**	**27**
		Report issued: partially upheld	0	0	0	0	4	0	0	**4**	**46**
		Total	**0**	**3**	**0**	**0**	**10**	**0**	**0**	**13**	**100**
	Total		**4**	**24**	**0**	**1**	**84**	**0**	**0**	**113**	**659**

Lothian NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
17/06/2009	200700789	informed consent to the operation was not properly sought (upheld).	upheld	(i) apologise to Mrs C for the failure to seek informed consent; (ii) satisfy themselves that relevant administrators and healthcare professionals at the Board have an appropriate knowledge and understanding of the Adults with Incapacity (Scotland) Act 2000, its Code of Practice and other relevant guidance; (iii) share lessons learnt from this case across their hospitals and disciplines; (iv) use the events of this case as part of their induction and other training programmes about consent and about communication with carers etc who have a legal say in decisions about the medical treatment of an adult with incapacity; (v) ensure that the Board's Consent Policy, in relation to obtaining consent in writing, is followed; (vi) advise clinicians across the Board's hospitals that recording only key points of consent discussions will not be sufficient in some cases; and (vii) consider revising their consent form in respect of adults with incapacity.
17/06/2009	200800963	on 25 January 2008, the Dentist provided Mrs C with an inadequate level of treatment (upheld).	upheld	(i) apologises to Mrs C for the failings identified in this report; and (ii) reflects on the Adviser's comments in regard to the standard of radiographs, working length calculation and record-keeping. The Dentist has accepted the recommendations and will act on them accordingly.
23/09/2009	200800296	Optometrist 1 failed to provide reasonable care and treatment to Mr C at his visit of 8 January 2008 (upheld).	upheld	(i) provide patients with a warning (which should be recorded on their record cards) that a reduced power prescription may require some adjustment; (ii) review the way he communicates the possible implications of reducing a myopic prescription with a patient and records this communication in the clinical records; and (iii) review the way he operates his formal complaints procedure when providing NHS services to ensure that complaints are considered in line with the NHS complaints guidance. Optometrist 1 has viewed a draft of this report. He has made clear that he does not accept the conclusion in the report but has accepted the recommendations and will act on them.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
21/10/2009	200703108	(a) Mr C and his family were given conflicting reasons by nursing staff for Mrs A's move to a two bedded room in the Ward (upheld); (b) the language used by nursing staff about Mrs A was inappropriate (upheld); (c) the attitude of a staff nurse on the Ward was unacceptable (no finding); (d) the attitude of nursing staff towards mobilising Mrs A was reprimanding in manner and unreasonable (not upheld); (e) the temperature in the Ward was high and uncomfortable (upheld); (f) the conditions in the two bedded room contributed to the speed of Mrs A's decline in the final days of her life (not upheld); and (g) the Board failed to handle the complaint from Mr C and his family appropriately (partially upheld).	partially upheld	(i) issue Mr C, Mrs D and their family with a formal written apology for the failings identified in heads of complaint (a), (b), (e) and (g) of this report; and (ii) audit and update the Action Plan in one year and share the findings with the Ombudsman's office. The Board have accepted the recommendations and will act on them accordingly.
18/11/2009	200800148	(a) the plaster cast that was applied to Mrs C's left leg was not appropriate treatment given Mrs C's other medical conditions (not upheld); (b) Mrs C contracted a MRSA infection whilst a patient in Hospital 1 (not upheld); (c) the standard of nursing care which Mrs C received was inadequate (not upheld); and (d) the standard of record-keeping in respect of Mrs C's medical notes was inadequate (upheld).	partially upheld	(i) undertake a review of the policy for reviewing plaster casts and in particular referral to senior medical staff; (ii) encourage the doctor concerned to reflect on the case at their next appraisal; (iii) apologise to Mrs C and her family for the failing to review Mrs C's plaster cast which has been identified in head of complaint (a) of this report; (iv) provide the Ombudsman with copies of the next Scottish Patient Safety Programme audit documentation in relation to all patient records within the orthopaedics department of Hospital 1; and (v) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in head of complaint (d) of this report. The Board have accepted the recommendations and will act on them accordingly.
23/12/2009	200801134	(a) the consent process was not properly carried out and there was insufficient communication with regard to operative risks (partially upheld to the extent that the doctor obtaining consent did not have the appropriate level of seniority and experience); (b) the surgical decision-making process was inappropriate (upheld); (c) the surgical complications were not dealt with appropriately (upheld); and (d) Mrs A was discharged prematurely from the Hospital (not upheld).	partially upheld	(i) review their procedures to ensure that the process of obtaining patient consent is carried out by a clinician with an appropriate level of seniority and experience, ideally the doctor who will be carrying out the surgery; (ii) review their procedures to ensure that there is consultant involvement in decisions to proceed to surgery and in decisions regarding the type of surgery to be carried out; (iii) reflect on the delay in identifying Mrs A's intra-abdominal bleed and implement an action to prevent similar future failures; (iv) ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective; and (v) apologise to Mr C for the failings identified in this report.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
23/12/2009	200800557 200800997	(a) the Board did not provide reasonable care and treatment to Mrs A between May 2007 and February 2008 (partially upheld to the extent that the investigation, diagnosis, care and treatment of Mrs A from November 2007 to February 2008 was not reasonable); (b) the actions taken by the Board in response to Mrs C's complaints about the care and treatment of Mrs A were not reasonable (upheld); (c) Mrs A did not receive adequate care and treatment from the Practice between November 2007 and February 2008 (partially upheld to the extent that the Practice did not reasonably address or follow-up the symptoms that Mrs A displayed which can be linked to cancer, that the Practice's prescription of pills rather than other forms of treatment to Mrs A was not reasonable, that the Practice did not reasonably take into account changes in Mrs A's condition and that the level of information recorded in Mrs A's notes was not comprehensive); and (d) the Practice's responses to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing (partially upheld to the extent that, although the Practice appropriately responded to some of Mrs C's enquiries and complaints, some of the Practice's responses, or lack of responses, to Mrs C's enquiries and complaints were inappropriate and unnecessarily distressing).	both complaints partially upheld	The Ombudsman recommends that the Board: (i) apologise to Mrs A's family that the chest x-ray of 26 November 2007 was mis-reported and that this led to a delay in the diagnosis of Mrs A's cancer; (ii) remind medical staff that letters to GPs should be dictated immediately after consultations with patients; (iii) encourage the practice of discussing patients with atypical clinical features at multi-disciplinary meetings; (iv) take steps to assure themselves of the quality of their chest x-ray reporting service; (v) apologise to Mrs C that the investigation of her complaints did not uncover the mis-reporting of the chest x-ray of 26 November 2007; and (vi) ensure that investigations of similar complaints in the future consider the possibility that x-rays, scans, test results or similar may have been mis-reported. The Ombudsman recommends that the Practice: (i) apologise to Mrs A's family for those aspects of her care and treatment that were not reasonable; (ii) produce a plan for reviewing their adherence to national guidelines. This plan should be minuted and form part of the Practice's clinical governance meetings. The minutes should be inspected by the Board's clinical governance lead to ensure that the Practice have identified areas for improvement and taken action to address these issues; (iii) ensure that national guidelines are readily available to all practitioners; (iv) undertake a review of clinical record-keeping using the Royal College of General Practitioners (Scotland) template on section 3D (2) of the Revalidation Toolkit. The review should be discussed with the Board's clinical governance lead to ensure that the Practice have identified areas for improvement and taken action to address these areas; (v) apologise to Mrs C that their responses to her enquiries and complaints were inappropriate and unnecessarily distressing; and (vi) review their complaints handling procedure to ensure that complainants are given direct answers to reasonable direct questions, that individual circumstances, distress and stated preferences are reasonably taken into account when suggesting meetings with correspondents and complainants, that it is made clear to correspondents how to set in motion the Practice's complaints procedure and that avoidable errors are reasonably eliminated, taking into account the individual circumstances of a complaint. The Board and the Practice have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
20/01/2010	200801828	(a) the Centre failed to detect problems with Ms A's pregnancy and failed to carry out appropriate tests when she attended the Centre on 15 and 16 June 2008 (upheld); (b) the Centre failed to take Mr C and Ms A's concerns and questions into account on 15 and 16 June 2008 (upheld); (c) the Centre failed to give Mr C and Ms A correct advice on 15 and 16 June 2008 or to ensure that adequate follow-up support was in place and offered to Mr C and Ms A on 16 June 2008 (upheld); and (d) on 23 June 2008 there was a time lapse of more than 30 minutes (the recommended practice) from the decision to perform an emergency lower uterine caesarean section to the start of this procedure (upheld).	upheld	(i) inform him of the measures being undertaken to address the issues raised within paragraphs 26, 27 and 28; (ii) inform him of the measures being undertaken to address the inadequate level of staff interface and communication with Mr C and Ms A at the Centre; (iii) inform him of the measures they take to ensure that the practice (when presented with a patient with reduced foetal movement) is adhered to, with reference to NICE Antenatal Guidelines 2008; (iv) inform him of the measures undertaken to ensure that the delay which occurred in this case, from decision to 'knife to skin', does not recur in a similar situation; and (v) issue Mr C and Ms A with a formal written apology for the inadequate standard of care and treatment Mr C and Ms A received on 15, 16 and 23 June 2008, prior to the birth of Baby A, as identified in heads of complaint (a), (b), (c) and (d). The Board have accepted the recommendations and will act on them accordingly.
20/01/2010	200802225	the Board did not provide reasonable care and treatment to Mr C during and following his operation for carpal tunnel syndrome (upheld).	upheld	(i) reinforce with staff the importance of referring patients back for a consultant review as soon as possible if there are complications or adverse symptoms which need attention; and (ii) apologise to Mr C for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
20/01/2010	200800801	the Board did not act reasonably in failing to re-test Mr C for HD following the introduction of more accurate tests (upheld).	upheld	(i) remind clinicians of the importance of open discussions of available new genetic tests with affected patients in order to enable them to make informed choices; and (ii) remind clinicians of the importance of recording such discussions, including relevant information given to patients. The Board have accepted the recommendations and will act upon them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
20/01/2010	200801582 200801583	Ms A was not investigated properly and that the diagnosis could have been made sooner by the NHS (upheld).	upheld	Board 1 (i) review their procedures for monitoring and auditing the referral process in light of the problems identified; (ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process; (iii) consider the best practice advice made by the Adviser to the Ombudsman; and (iv) provide him with reassurance that there has been an improvement in the time taken to review CT scans and discuss them with patients. He also asks that Board 1 notify him when the recommendations have been implemented. Board 2: (i) review their procedures for monitoring and auditing the referral process in light of the problems identified; (ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process; (iii) consider the best practice advice made by the Adviser to the Ombudsman; (iv) undertake a short, focussed audit of record-keeping in the Ear Nose and Throat clinic and the Dental Institute and put in place an action plan to deal with any problems identified; and (v) reimburse Ms A for the costs of the private treatment required to identify her condition. Board 1 have accepted the recommendations and will act on them accordingly.
24/03/2010	200901408	the Board failed to: (a) provide appropriate treatment to Mrs C (upheld); (b) provide the correct course of antibiotics to Mrs C (upheld); and (c) communicate effectively with Mr C (upheld).	upheld	(i) ensure that their transfer protocol includes a requirement to consult with appropriate available relatives prior to transfer, when a patient is unable to give consent; (ii) provide guidance on documentation to all relevant staff at induction; (iii) adhere to their Incident Management Policy when a significant adverse event review is initiated, by ensuring that consideration is given to the inclusion of members with appropriate objectivity to the event; (iv) remind staff in Hospital 2 of the importance of assessing the competency of patients to make decisions to refuse treatment or medication where appropriate; (v) undertake an external peer review of the nursing care in Ward 1 in Hospital 2; (vi) provide him with details of the findings and action plan created as a result of the above recommendation and provide updates where relevant; (vii) ensure that the findings in this report are communicated to the staff involved in Mrs C's care and treatment; and (viii) issue an apology to Mr C for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.