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.

Shetland 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 two complaints about your Board in 2009-10, compared to three in the previous year. Taken as a percentage of the total number of complaints we received about the NHS in each year, this shows a slight drop (from 0.4% of the total complaints received to 0.2%).

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 determined some NHS complaints as 'premature' during the year, although none related to your Board. 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 two complaints about your Board in 2009-10, of which we upheld one and partially upheld the other. 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

		Shetland NHS Board Area						
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	Shetland NHS Board	**Shetland 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%	**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	0	0	1	**1**	50%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	0	0	**0**	0%	**91**	11%
	Complaints by NHS staff	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	0	0	**0**	0%	**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	0	**0**	0%	**6**	1%
	Lists	0	0	0	**0**	0%	**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	1	0	**1**	50%	**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	0	**0**	0%	**68**	8%
	Total	**0**	**1**	**1**	**2**		**857**	
2008-09	Admission, discharge & transfer procedures	0	0	0	**0**	0%	**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	0	1	**2**	67%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	0	0	**0**	0%	**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)	0	0	0	**0**	0%	**2**	0%
	Nurses/nursing care	0	0	0	**0**	0%	**13**	2%
	Other	0	0	0	**0**	0%	**1**	0%
	Policy/administration	0	1	0	**1**	33%	**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	0	**0**	0%	**17**	2%
	Total	**1**	**1**	**1**	**3**		**684**	

Table 2

Shetland NHS Board Area

	Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	Shetland NHS Board	**Shetland NHS Board Area Total**	**Sector Total**
2009-10	Assessment	Discontinued before investigation	0	0	0	**0**	**160**
		Discretionary decision not to pursue	0	0	0	**0**	**1**
		Other	0	0	0	**0**	**7**
		Out of jurisdiction	0	0	0	**0**	**60**
		Premature	0	0	0	**0**	**319**
		Total	**0**	**0**	**0**	**0**	**547**
	Examination	Discontinued before investigation	0	0	0	**0**	**16**
		Determined after detailed consideration	0	1	0	**1**	**314**
		Total	**0**	**1**	**0**	**1**	**330**
	Investigation	Report issued: fully upheld	0	0	1	**1**	**33**
		Report issued: not upheld	0	0	0	**0**	**9**
		Report issued: partially upheld	0	0	1	**1**	**32**
		Total	**0**	**0**	**2**	**2**	**74**
	Total		**0**	**1**	**2**	**3**	**951**
2008-09	Assessment	Discontinued before investigation	0	0	1	1	**132**
		Out of jurisdiction	0	0	0	**0**	**52**
		Premature	0	1	0	**1**	**182**
		Total	**0**	**1**	**1**	**2**	**366**
	Examination	Determined after detailed consideration	1	0	0	**1**	**193**
		Total	**1**	**0**	**0**	**1**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	**1**
		Report issued: fully upheld	0	0	0	**0**	**26**
		Report issued: not upheld	0	0	0	**0**	**27**
		Report issued: partially upheld	0	0	0	**0**	**46**
		Total	**0**	**0**	**0**	**0**	**100**
	Total		**1**	**1**	**1**	**3**	**659**

Shetland NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
22/04/2009	200601436 200800094	(a) there was a delay in the arrival of the ambulance and when it arrived it could not take Mrs C in a powered wheelchair (upheld to the extent that the ambulance could have been dispatched more quickly and the delay avoided had the crew been advised when the request for the ambulance arrived); (b) no arrangements were made to take Mrs C home after her attendance at Accident and Emergency at Hospital 1 (upheld); (c) Mrs C had no nutrition or fluids for 20 hours (upheld); (d) Mrs C was sent to the wrong address in a taxi (upheld); and (e) the initial travel arrangements made for Mrs C to attend a hospital outwith the Shetland NHS Board area were unreasonable (upheld).	upheld	Scottish Ambulance Service: (i) apologise to Mr C for the failings identified in this paragraphs 5 to 12 of this report; and (ii) demonstrate that, through providing more tailored options for requesting physicians, the response and appropriateness of that response has improved. The Ombudsman recommends that Shetland NHS Board: (iii) apologise to Mr C for the failings identified in paragraphs 18 to 29 of this report; (iv) send him a copy of the results of the audit of record keeping in the Accident and Emergency department and any action taken to improve practice; and (v) audit the Patient Travel Service to ensure that they are now requesting sufficient information to allow them to make appropriate arrangements for all patients in the Board area who require to travel. Both the Scottish Ambulance Service and Shetland NHS Board have accepted the recommendations and will act on them accordingly.
19/08/2009	200603164	(a) the reasons for medication, prescribed for Mrs A's suspected clinical condition at the time, were unclear (partially upheld, to the extent that the reason why medication was prescribed in the community for Mrs A's suspected condition was clear and appropriate but the reasons for the prescribing decisions made following admission to the Hospital were not clear and appropriate); (b) medical and nursing staff failed to assess and record the treatment and care requirements adequately throughout this particular episode of care (partially upheld, in relation to the actions of the Hospital); (c) Mrs A was not provided with an acceptable level of fluids during her stay in the Hospital (upheld); and (d) Mrs A should have remained in the Hospital longer (upheld).	Partially Upheld	(i) share this report with the staff involved in Mrs A's care, so they can reflect on the findings relevant to the prescription of medication when Mrs A was admitted to the Hospital and identify clear and explicit indications for the use of prescribed and administered medication; (ii) ensure thorough assessment, recording and treatment is undertaken for the ongoing care of a patient when health remains compromised and discharge is being considered; (iii) ensure nursing staff are appropriately trained to record baseline observations and understand the reasons for recording them; (iv) ensure a fluid intake and output record is kept for an unwell patient, where feeding and drinking assistance is required; and explanations are recorded when there is a delay in supporting the early, prompt intake of fluids; (v) remind staff of the importance of encouraging fluid intake, when a patient is unable to attend to that aspect of care independently; (vi) ensure full consideration is given to any potential discharge plan, when observations continue to indicate a level of patient distress or compromise; (vii) ensure appropriate family members are given an opportunity to contribute to the discharge planning process of an unwell relative; and (viii) provide Mr C with a full formal apology for the failures in care identified in this report.