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.

Tayside 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 90 complaints about your Board in 2009-10, compared to 85 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 (from 12.4% of the total complaints received to 10.5%).

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 nine complaints about your Board in 2009-10, of which we upheld four, partially upheld four and did not uphold one. The attached summary sheet shows these complaints and summarises the recommendations made. As you are no doubt aware, in appropriate cases the Ombudsman may make recommendations where a complaint is not upheld, if he believes that there are lessons that may be learned. You will also be aware that SPSO complaints reviewers follow up to find out what changes have been made as a result of our recommendations.

We discontinued one complaint about your Board at the investigation stage, and did not report on it.

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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 Dentist or Dental Practice	A GP or General Medical Practice	A Pharmacy or Pharmacist	Tayside NHS Board	**Tayside NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
		Tayside NHS Board Area							
2009-10	Admission, discharge & transfer procedures	0	0	0	1	**1**	1%	**15**	2%
	Appliances, equipment & premises	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	1	0	3	**4**	4%	**48**	6%
	Clinical treatment/diagnosis	0	6	0	38	**44**	49%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	2	0	5	**7**	8%	**91**	11%
	Complaints by NHS staff	0	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	1	0	0	**1**	1%	**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	3	**3**	3%	**6**	1%
	Lists	0	1	0	0	**1**	1%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	1	0	1	**2**	2%	**10**	1%
	Other	0	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	3	0	12	**15**	17%	**156**	18%
	Record keeping	0	1	0	1	**2**	2%	**7**	1%
	Out of jurisdiction	0	0	0	2	**2**	2%	**3**	0%
	Subject unknown	0	0	0	8	**8**	9%	**68**	8%
	Total	**0**	**16**	**0**	**74**	**90**		**857**	
2008-09	Admission, discharge & transfer procedures	0	0	0	3	**3**	4%	**18**	3%
	Appliances, equipment & premises	0	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0	0	2	**2**	2%	**23**	3%
	Clinical treatment/diagnosis	2	8	0	37	**47**	55%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	0	0	0	4	**4**	5%	**62**	9%
	Complaints handling	1	0	0	4	**5**	6%	**22**	3%
	Continuing care	0	0	0	1	**1**	1%	**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	2	**2**	2%	**4**	1%
	Lists	0	0	0	0	**0**	0%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	**0**	0%	**2**	0%
	Nurses/nursing care	0	0	0	3	**3**	4%	**13**	2%
	Other	0	0	0	0	**0**	0%	**1**	0%
	Policy/administration	0	1	1	11	**13**	15%	**110**	16%
	Record keeping	0	0	0	5	**5**	6%	**12**	2%
	Out of jurisdiction	0	0	0	0	**0**	0%	**6**	1%
	Subject unknown	0	0	0	0	**0**	0%	**17**	2%
	Total	**3**	**9**	**1**	**72**	**85**		**684**	

Table 2

Tayside NHS Board Area

Complaints Determined by Outcome

			A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Service	Tayside NHS Board	**Tayside NHS Board Area Total**	**Sector Total**
2009-10	Assessment	Discontinued before investigation	0	2	0	21	**23**	**160**
		Discretionary decision not to pursue	0	0	0	0	**0**	**1**
		Other	0	0	0	0	**0**	**7**
		Out of jurisdiction	0	3	0	7	**10**	**60**
		Premature	0	1	0	27	**28**	**319**
		Total	**0**	**6**	**0**	**55**	**61**	**547**
	Examination	Discontinued before investigation	0	0	0	1	**1**	**16**
		Determined after detailed consideration	0	14	0	23	**37**	**314**
		Total	**0**	**14**	**0**	**24**	**38**	**330**
	Investigation	Report issued: fully upheld	0	0	0	4	**4**	**33**
		Report issued: not upheld	0	0	0	1	**1**	**9**
		Report issued: partially upheld	0	0	0	4	**4**	**32**
		Total	**0**	**0**	**0**	**9**	**9**	**74**
	Total		**0**	**20**	**0**	**88**	**108**	**951**
2008-09	Assessment	Discontinued before investigation	2	3	0	20	25	**132**
		Out of jurisdiction	0	1	0	3	**4**	**52**
		Premature	0	3	0	20	**23**	**182**
		Total	**2**	**7**	**0**	**43**	**52**	**366**
	Examination	Determined after detailed consideration	0	1	0	16	**17**	**193**
		Total	**0**	**1**	**0**	**16**	**17**	**193**
	Investigation	Discontinued during investigation	0	0	0	1	1	**1**
		Report issued: fully upheld	0	0	0	4	**4**	**26**
		Report issued: not upheld	0	2	0	4	**6**	**27**
		Report issued: partially upheld	0	0	0	5	**5**	**46**
		Total	**0**	**2**	**0**	**14**	**16**	**100**
	Total		**2**	**10**	**0**	**73**	**85**	**659**

Tayside NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
22/07/2009	200800181	the Board: (a) incorrectly assumed that Mr A had dementia (not upheld); (b) failed to treat Mr A appropriately for a five day period following his admission to the Hospital (upheld); and (c) failed to appropriately monitor Mr A's fluid intake (upheld).	partially upheld	The Ombudsman recommends that the Board: (i) review their progress against the action plan and provide an updated version of the document; (ii) provide details of the steps that they have taken to implement the Scottish Government's new Food, Fluid and Nutrition programme; (iii) provide details of the steps that they have taken to achieve the Scottish Government's new Clinical Quality Indicators for Food, Fluid and Nutrition; and (iv) formally apologise to Mrs C and her family for the distress and anxiety caused to them and Mr A during his stay at the Hospital. The Board have accepted the recommendations and will act on them accordingly.
19/08/2009	200800508	the Board: (a) delayed in diagnosing Mr A (upheld); (b) failed to provide timely treatment following diagnosis (not upheld); (c) did not provide adequate care to Mr A in the respiratory ward (the Ward) of Ninewells Hospital, Dundee (upheld); and (d) failed to handle Mr C's complaint appropriately (not upheld).	Partially Upheld	(i) ask the consultant responsible for Mr A's care in the Ward to apologise to Mr C for any contribution he may have made to the misunderstanding with Mr A about visiting him on 28 September 2007; (ii) apologise to Mr C for the failure to provide adequate care to Mr A as identified in this report; and (iii) review the current arrangements for selecting patients for consultant out of hours review, including processes for communication and handover between doctors. The Board have accepted the recommendations and will act on them accordingly.
23/09/2009	200800374	(a) cleanliness standards at the Hospital were poor (no finding); (b) staff at the Hospital failed to adhere to the Board's hygiene policies (no finding); (c) the Board's procedures for monitoring cleanliness were ineffective (not upheld); and (d) the Board failed to securely store patient records (upheld).	partially upheld	(i) invite Mr C to a meeting at the Hospital to discuss his concerns about cleanliness and infection control; and (ii) instruct their Caldecott Guardian to review the procedures for transferring clinical records between the Orthopaedic Out-patient Clinic reception area and clinical staff to ensure the security of clinical records at all times. The Board have accepted the recommendations and will act upon them accordingly.
18/11/2009	200802345	the Board: (a) failed to treat Mr A with all appropriate medical, nursing and personal care and dignity (upheld); (b) failed to communicate adequately with Mr A or his family (upheld); and (c) failed to deal with Mrs A's complaint in a timely or appropriate manner (upheld).	upheld	(i) apologise to Mrs A and Miss C for the failings identified in this report; (ii) review their administrative policy for the documentation of the administration of controlled drugs; documentation of patient symptom control; and support to foundation level doctors in the management of terminal patients; (iii) review their policy for the insertion of chest drains to include the reporting of chest x-rays following drain insertion and the management and investigation of pain following drain insertion; and (iv) review their approach to the documentation of complications of procedures such as chest drains including; i) decisions relating to best management of the complications; and ii) information given to the injured party or their relatives. The Ombudsman also asks that the Board keep him appraised of progress towards achieving the goals of the Action Plan. The Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
23/12/2009	200701716	the care and treatment Ms C received from the Board, following the delivery of her first child, was inappropriate (not upheld).	not upheld	ensure that, in future, good contemporaneous notes are made following delivery by caesarean section. The Board have accepted the recommendation and will act on it accordingly.
23/12/2009	200702821	(a) the Board did not appropriately examine, diagnose and treat Child C at four attendances in July and August 2007 (partially upheld to the extent that further investigations of Child C's condition should have been undertaken in August 2007 and she should have been admitted on 16 August 2007); (b) the Board did not respond appropriately to Mr and Mrs C's complaint of 24 August 2007 (partially upheld to the extent that the Board's conclusion that there had been a change in Child C's clinical condition, following her final attendance at Hospital 1, was not supported by the available written evidence); and (c) the Board's letter of 3 September 2007 to Child C's GP was inappropriate in the circumstances (not upheld).	partially upheld	(i) apologise to Mr and Mrs C that further investigations of Child C's condition were not undertaken and that she was not admitted on 16 August 2007; (ii) review the decision-making in this case with the appropriate Board staff at their next appraisals; and (iii) apologise to Mr and Mrs C that the conclusion that Child C's clinical condition had changed between 16 August 2007 and 17 August 2007 was not supported by the available written evidence. The Board have accepted the recommendations and will act on them accordingly.
23/12/2009	200803057	(a) there was a delay in testing CK level (upheld); and (b) the Board failed to treat Mr A's elevated potassium levels appropriately (upheld).	upheld	(i) ensures patients with new and significant muscular weakness, as was found in this case, who are taking statins, should have their CK level checked on admission; (ii) the Board issue an apology to the family of Mr A and accept that there was a failure to provide urgent medical treatment; (iii) the Board evaluate existing policy in relation to the usage of 12 lead electrocardiograms when determining cardiac risks and provide Mr C and the Ombudsman with the evidence and outcome of this review; and (iv) the Board apologise to the complainant and review the way this complaint was handled to see if there are any lessons to be learned for the future handling of complaints.
23/12/2009	200702047	the Board failed to: (a) provide Miss A with access to appropriate psychology services (upheld); (b) provide Miss A with access to appropriate eating disorder services (upheld); and (c) handle Mrs C's complaint in a timely and appropriate manner (upheld).	upheld	(i) apologise in writing to Mrs C for all the failures identified in this report; (ii) review the current service provision of family therapy to adolescents with eating disorders; and (iii) consider the introduction of an Integrated Care Pathway designed around the NHS Quality Improvement Scotland and NICE guidelines on the management of anorexia.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
24/03/2010	200802400	(a) Miss C was not properly assessed at a formal pre-operative clinic prior to her surgery (upheld); (b) the care and treatment Miss C received post-operatively was inadequate (upheld); and (c) communications with Miss C's family were not appropriate (upheld).	upheld	(i) review the current interface arrangements in place between the ENT and Anaesthesia departments, to gain assurance that adequate communication, planning and multi team working arrangements are now in place with regard to pre-operative admissions; and advise him of the outcome of this review; (ii) provide a copy of the appropriate action plans which specifically contain details of how the Board will implement and meet the relevant policies, including: • NHS QIS quality indicators for people with learning difficulties (NHS QIS report 'Learning Disabilities' Quality Indicators February 2004) • NHS QIS report 'Tackling Indifference', (Healthcare Services for People with Learning Disabilities. National Overview Report. December 2009); (iii) provide a copy of their education and training strategy, including the specific requirement relating to patients with learning disabilities; (iv) review and evaluate the current arrangements for pre-operative admission for people with learning disabilities and provide him with a report of the findings; (v) confirm the specific action taken to clarify the terms 'special nursing' and 'routine monitoring' to avoid ambiguity over what level of nursing support is required when caring for people with learning difficulties; (vi) provide assurance that policies and procedures are in place to ensure that the Nursing and Midwifery Council Code of Conduct and in particular the 'Guidance for record keeping' (2009) is implemented so that communication with patients' families is clear and unambiguous; and (vii) provide an explicit, unambiguous and meaningful apology to Miss C's family for all the failings identified in this report, detailing the steps they have put into place to ensure that a similar occurrence is not repeated. The Board have accepted the recommendations and will act on them accordingly.