

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.

NHS 24

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 and some of which may not be applicable to your Board. 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. 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 four complaints about your Board in 2009-10, compared to five in the previous year. Taken as a percentage of the total number of complaints we received about the NHS in each year this also shows a very slight drop (from 0.7% of the total complaints received to 0.5%).

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 investigated complaints on which we reported to the Parliament.

After discussion with some NHS 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 relevant premises and places.

Investigated Complaints and Recommendations

We investigated and reported on one complaint about your Board in 2009-10, which we upheld. The attached summary sheet shows this complaint 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@spsso.org.uk .

Statistical reports for all years are available on the SPSO website at:
<http://www.spsso.org.uk/statistics/index.php>

Table 1

Complaints Received by Subject		NHS 24	Complaints as % of total	Sector Total	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0%	15	2%
	Appliances, equipment & premises	0	0%	1	0%
	Appointments/admissions (delay, cancellation, waiting lists)	2	50%	48	6%
	Clinical treatment/diagnosis	2	50%	413	48%
	Communication, staff attitude, dignity, confidentiality	0	0%	91	11%
	Complaints by NHS staff	0	0%	2	0%
	Complaints handling	0	0%	20	2%
	Continuing care	0	0%	1	0%
	Failure to send ambulance/delay in sending ambulance	0	0%	6	1%
	Hygiene, cleanliness & infection control	0	0%	6	1%
	Lists	0	0%	7	1%
	Lists (incl difficulty registering and removal from lists)	0	0%	1	0%
	Nurses/nursing Care	0	0%	10	1%
	Other	0	0%	2	0%
	Policy/administration	0	0%	156	18%
	Record keeping	0	0%	7	1%
	Out of jurisdiction	0	0%	3	0%
	Subject unknown	0	0%	68	8%
	Total	4		857	
2008-09	Admission, discharge & transfer procedures	0	0%	18	3%
	Appliances, equipment & premises	0	0%	1	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	0%	23	3%
	Clinical treatment/diagnosis	3	60%	374	55%
	Communication, staff attitude, dignity, confidentiality	0	0%	62	9%
	Complaints handling	0	0%	22	3%
	Continuing care	0	0%	10	1%
	Failure to send ambulance/delay in sending ambulance	0	0%	3	0%
	Hotel services - food, laundry etc	0	0%	1	0%
	Hygiene, cleanliness & infection control	0	0%	4	1%
	Lists	0	0%	5	1%
	Lists (incl difficulty registering and removal from lists)	0	0%	2	0%
	Nurses/nursing care	0	0%	13	2%
	Other	0	0%	1	0%
	Policy/administration	2	40%	110	16%
	Record keeping	0	0%	12	2%
	Out of jurisdiction	0	0%	6	1%
	Subject unknown	0	0%	17	2%
	Total	5		684	

Table 2

Complaints Determined by Outcome			NHS 24	Sector Total
2009-10	Assessment	Discontinued before investigation	0	160
		Discretionary decision not to pursue	0	1
		Other	0	7
		Out of jurisdiction	0	60
		Premature	4	319
	Total	4	547	
	Examination	Discontinued before investigation	0	16
		Determined after detailed consideration	0	314
		Total	0	330
	Investigation	Report issued: fully upheld	1	33
		Report issued: not upheld	0	9
		Report issued: partially upheld	0	32
		Total	1	74
	Total	5	951	
2008-09	Assessment	Discontinued before investigation	3	132
		Out of jurisdiction	0	52
		Premature	1	182
		Total	4	366
	Examination	Determined after detailed consideration	1	193
		Total	1	193
	Investigation	Discontinued during investigation	0	1
		Report issued: fully upheld	1	26
		Report issued: not upheld	0	27
		Report issued: partially upheld	0	46
	Total	1	100	
	Total	6	659	

NHS 24

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
21/10/2009	200700438 200800535	(a) NHS 24 failed to provide proper care and treatment to Mr C (upheld); and (b) the Board failed to provide proper care and treatment to Mr C (upheld).	upheld	<p>(i) NHS 24 provide an apology to Mrs C and her family for the delay in transferring the necessary clinical details to the correct out-of-hours service;</p> <p>(ii) NHS 24 conduct an evaluation into a review of the improvements introduced by NHS 24 as a result of this complaint;</p> <p>(iii) NHS 24 ensure call handlers' basic training is developed enough to ensure staff are able to determine how to manage information they are given when a call is made from a service user, and the mechanism to transfer vital clinical information between services is reviewed to avoid mistakes in transmission arising;</p> <p>(iv) NHS 24 ensure the algorithms are fit for purpose in so far as they are able to capture the appropriate detailed information to assist the nurses to make the appropriate decisions;</p> <p>(v) the Board provide an apology to Mrs C and her family for the delay in picking up on the clinical symptoms described by Mr C and his family;</p> <p>(vi) the Board undertake a further review of the triage doctor's clinical practice in order to ensure their understanding of the signs and symptoms of a subarachnoid haemorrhage; and</p> <p>(vii) the Board ensure the triage doctor reflects on the lessons of the case, shares it with his appraiser during his next appraisal and is aware of the possibilities of rare diagnoses such as subarachnoid haemorrhage for future work.</p> <p>NHS 24 and the Board have accepted the recommendations and will act on them accordingly.</p>