NHS Greater Glasgow and Clyde

Board Meeting
Tuesday, 23 October 2007 **Board Paper No. 07/48**

HEAD OF BOARD ADMINISTRATION,
CHIEF OPERATING OFFICER, ACUTE
LEAD DIRECTOR, CHCP (GLASGOW)

QUARTERLY REPORT ON COMPLAINTS :
1 APRIL – 30 JUNE 2007

Recommendations:

The NHS Board is asked to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 April – 30 June 2007.

Introduction

This report provides a commentary and statistics on complaints handling throughout NHS Greater Glasgow and Clyde for the period April - June 2007. It looks at complaints received at Local Resolution and by the Scottish Public Services Ombudsman and identifies areas of service improvements and ongoing developments.

1. Local Resolution : 1 April – 30 June 2007

Table 1 shows the number of complaints received across NHS Greater Glasgow and Clyde between 1 April – 30 June 2007. Thereafter, the statistics relate to those complaints completed in the quarter so that outcomes can be reported.

Table 1

	Partnerships/ MHP/Board (exc FHS)	Acute
(a) Number of complaints **received**	46	350
(b) Number of complaints received and completed within 20 working days *[national target]*	23 (50%)	170 (49%)
(c) Number of complaints **completed**	40	418
(d) Outcome of complaints completed:-		
➢ Upheld	7	91
➢ Upheld in part	15	147
➢ Not Upheld	14	149
➢ Conciliation	0	1
➢ Irresolvable	1	2
(e) Number of complaints withdrawn:-	3	28
(d) Number of complaints declared vexatious	0	0

2. Ombudsman : 1 April – 30 June 2007

Where a complainant remains dissatisfied with a Local Resolution response, they may write to the Ombudsman. Table 2 below reports statistics on the three junctures that we may become aware of the Ombudsman's involvement in a case.

Table 2

	Partnerships/ MHP/Board (NHSGG)	Acute	FHS
(a) Notification received that an investigation is being conducted	1	14	0
(b) Investigations Report received.	0	14	2

In accordance with the Ombudsman's monthly reporting procedure, 16 reports have been laid before the Scottish Parliament concerning NHS Greater Glasgow and Clyde cases; seven of these cases were summarised in the May 2007 commentary and nine in the June 2007 commentary. Due to the election period, no report was submitted to the Parliament in April 2007.

The Ombudsman's office requires the NHS Board to write and confirm the steps taken to implement their actions/recommendations and any other action taken as a result of the Ombudsman's report. In each case it is also necessary to notify the Chief Executive, NHS Scotland, of the actions taken in connection with their possible attendance at the Scottish Parliament Health Committee who scrutinise each Ombudsman's report and seek assurances on the changes that have been brought to the NHS as a result of the Ombudsman's investigations.

In addition, each recommendation made by the Ombudsman is submitted to the Clinical Governance Committee with an Action Plan showing how each has been taken forward or how they will be taken forward. The Clinical Governance Committee has the responsibility, on behalf of the Board, to ensure that each recommendation is implemented in the interests of effective and safe care delivered to the population served. It also ensures that where lessons learned require to be disseminated across the organisation that this is carried out. The Ombudsman's office is also advised on the steps taken in implementing each recommendation.

The 16 NHS Greater Glasgow and Clyde cases for this quarter are described as follows:-

May 2007

1. An Advocacy Worker complained on behalf of the family of an elderly woman who had been a patient at Glasgow Royal Infirmary. She raised a number of concerns about the nursing care provided, communication with the family and procedures for discharge.
   [The Ombudsman fully upheld one element of the complaint, partially upheld one element and did not uphold two elements of the complaint. The Ombudsman recommended that the Board:-

   - *highlight to staff the need to manage the expectations of the families of patients and to be aware of the need to communicate in non-technical language and provide clear explanations;*
   - *undertake an audit of the new care plan documentation and share the results of that audit with the Ombudsman;*
   - *apologise to the family for our failure to carry out our own discharge policy effectively and the inconvenience, distress and concern that this caused; and*
   - *audit our discharge policy to ensure that it is now being fully implemented.*

   The Board has accepted the recommendations and will act on them accordingly].

2. The complainant raised a number of concerns about the treatment his wife, who suffered from liver disease, received at Glasgow Royal Infirmary up to and including March 2003.
[The Ombudsman fully upheld one element of the complaint and the other element was not upheld and had no recommendations to make].

3. The complainant raised concerns about the hernia surgery which he had and about his post-operative nursing care.
[The Ombudsman fully upheld one element of the complaint but did not uphold the other two elements. The Ombudsman recommended that the Board apologise to the complainant for the distress caused with regard to the complaint. She also suggested that relevant staff were reminded of the importance of adequate documentation of the pre-operative consent process.

The Board has accepted the recommendations and will act on them accordingly].

4. The complainant raised a number of concerns about the treatment his wife received at the Vale of Leven Hospital during two admissions in September 2005.
[The Ombudsman fully upheld one element of the complaint but did not uphold the other two elements and had no recommendations to make].

5. The complainant raised a number of concerns about the treatment his late mother received at the Victoria Infirmary in February 2006. These included communication failures between staff and the relatives; inadequate care and treatment; and difficulties in reporting lost property.
[The Ombudsman fully upheld two elements of the complaint and did not uphold one element. The Ombudsman recommended that the Board:-

   - *ensure that the report was shared with the staff involved so that they are reminded of the importance of communication with relatives;*
   - *consider whether our procedure on change over of shifts for passing information to relatives about patients who had recently died was adequate; and*
   - *conduct a review of the availability of claim forms at ward level in the hospital and send the complainant a claim form and consider a request for reimbursement of the lost property should he wish to purse the matter.*

   The Board has accepted the recommendations and will act on them accordingly].

6. The complainant raised concerns about the way in which a dentist had removed her and her children from the practice list.
[The Ombudsman had no finding in this case but recommended that the dentist familiarise himself with the regulations governing the removal of NHS patients from practice lists.

The dentist has accepted the recommendation and will act on it accordingly].

7. The Ombudsman received a number of complaints from parents of patients at a Practice about delayed orthodontic treatment at the practice. The Practice had advised the parents that the delays were not the fault of the Practice but NHS National Health Services Scotland (NHSNSS) which must give the Practice approval to commence orthodontic treatment.
[The Ombudsman did not uphold any aspect of the complaint but recommended that the Practice and NHSNSS continue meaningful discussions to decide the circumstances where radiographs were required in individual cases which required prior approval for the Practice to commence orthodontic treatment.

The Practice and NHSNSS have accepted the recommendation and will act on it accordingly].

June 2007

1. The complainant raised a number of concerns regarding his dental treatment and the preparation and fitment of a dental bridge and a temporary denture.
[The Ombudsman did not uphold any aspect of the complaint and made no recommendations].

2. The complainant raised concerns that her daughter had developed an infection in her leg after receiving her immunisations on 9 February 2006. However doctors at the Practice told her on 20 February 2006 and 21 February 2006 that it was not an infection. The complainant took her daughter back to the Practice on 24 February 2006 and it was then that her daughter was referred to hospital for treatment to the infected wound.
[The Ombudsman did not uphold the complaint and made no recommendations].

3. The complainant raised a number of concerns that doctors at the GP Practice failed to take action when his brother reported headaches following discharge from hospital in April 2005. The complainant's brother died on 9 July 2005 after suffering an aneurysm.
[The Ombudsman did not uphold the complaint but recommended that the Practice take note of the Adviser's comments in regard to record-keeping.

The Practice has accepted the recommendation and will act on it accordingly].

4. The complainant raised a number of concerns about the nursing care afforded to her late father during an admission at the Royal Alexandra Hospital from February 2004 to January 2005.
[The Ombudsman fully upheld one element of the complaint and partially upheld the other and recommended that the Board apologise to the complainant for the failure to chart fluid intake adequately and to consider commencing IV fluids earlier.

The Board has accepted the recommendation and will act on it accordingly].

5. The complainant raised a number of concerns that her ante-natal care had not been properly managed and that in particular the Board had failed to provide adequate monitoring for potential gestational diabetes. The complainant considered that but for this failure her daughter's stillbirth might have been prevented.
[The Ombudsman fully upheld one element of the complaint and partially upheld the other two elements and recommended that the Board advise the complainant of the outcome of their review of the guidance and protocol for management of gestational diabetes].

The Board has accepted the recommendations and will act on them accordingly].

6. The complainant raised a number of concerns about the care and treatment of her late husband at a number of Glasgow hospitals and his death from mesothelioma. The complaint investigated was that the Board failed to provide the patient with timely and appropriate care and treatment.
[The Ombudsman partially upheld the complaint and recommended that the Board:-

   - *apologise to the complainant for communication failures;*
   - *consider using the events of this complaint to inform practise in communicating with patients affected by cancer; particularly when a number of different specialists are involved in care; and*
   - *give consideration to improving written recording of discussions with patients and their relatives especially in situations where there are a number of clinicians involved in delivering care.*

The Board has accepted the recommendations and will act on them accordingly].

7. The complainant raised a number of concerns associated with the removal of two facial lesions.
[The Ombudsman did not uphold eights elements of the complaint but partially upheld one element. The Ombudsman recommended that the Board:-

- *in addition to discussing with the patient any surgical procedure, its possible outcomes and common complications, should consider whether written information, reiterating information given, would enhance informed consent for the patient;*

- *further apologise to the complainant, to acknowledge the initial failure to apologise to him in a timely manner; and*

- *look at reducing the timescales between the dates of dictation, typing and issue of correspondence.*

The Board has accepted the recommendations and will act on them accordingly].

8. The complainant was unhappy about with the information he was given about his spinal angiography (a radiographic technique).
[The Ombudsman fully upheld the complaint and recommended that the Board:-

- *review our current protocols for consent and recording of consent in line with "A good Practice Guide on Consent for Health Professionals in NHS Scotland" issued by the Scottish Executive on 16 June 2006 especially for neurosurgical and radiological interventions*

- *include details of procedures, alternatives and possible complications in leaflets and that these be given to patients as soon as the diagnosis is made;*

- *develop standard letters to be used until the leaflets are available;*

- *ensure that the fact that the relevant leaflet has been given to the patient is recorded in the patient's notes;*

- *include information about embolisation and the possibility of complication occurring in the appropriate leaflet;*

- *ensure that Handbooks for Doctors and protocols on consent include detail on when, where and how to obtain informed consent; and*

- *apologise to the complainant for the failings in giving him information.*

The Board has accepted the recommendations and will act on them accordingly].

9. The complainant had concerns about some aspects of communication at the Western Infirmary and about their decision to transfer her 84 year old husband to a hospital near his home in England. When the complainant's husband was being transferred by ambulance to the English hospital, his condition worsened and the ambulance crew continued the journey, instead of stopping at another hospital on the way. The complainant's husband died in an English hospital a few days later.
[The Ombudsman did not uphold four elements of the complaint but upheld one element. The Ombudsman recommended that:-

- *the Board ensure that, where appropriate "Do Not Attempt Resuscitation" orders (DNARs) are communicated clearly, in writing, for ambulance crews and receiving hospitals;*

- *the Scottish Ambulance Service ensure that, where appropriate, ambulance crews obtain formal written DNAR information from referring hospitals; and*

- *the Scottish Ambulance Service ensure that record-keeping by ambulance crews during journeys is adequate.*

The Board and the Scottish Ambulance have accepted the recommendations and will act on them accordingly].

3. Breakdown of the Three Issues Attracting Most Complaints and the Reasons for this.

The following information provides a breakdown of the issues attracting most complaints:-

Partnerships/ Mental Health Services

Communication (written and oral), clinical treatment and attitude and behaviour are attracting most complaints this quarter.

Annex 1 provides a comprehensive breakdown of the complaint categories for Partnerships/Mental Health Services.

Acute

Clinical treatment, attitude/behaviour and communication (written and oral) are the categories attracting most complaints this quarter.

Annex 2 provides a comprehensive breakdown of the complaint categories for Acute.

4. Service Improvements

Noted below are some examples of service improvements made as a result of complaints completed this quarter:-

Partnerships/Mental Health Services

- As a result of a complaint regarding unmade beds in one area, a supply of quilt covers has been purchased to ensure beds are made up when dirty laundry removed.

- As a result of one complaint in a specific area, a review of a telephone messaging system was undertaken, staff were updated on alternative methods of obtaining necessary information to allow disclosure of test results, and training was given to staff to ensure information was entered correctly on electronic clinical card.

- As a result of a complaint about the delay in an order form being received, the ordering procedure has been discussed with all staff to ensure procedure is being followed correctly.

- As a result of a complaint about physiotherapy waiting times, additional Saturday morning clinics were introduced, a review of admin support staff and permanent physiotherapy staff is to take place, and temporary staff to be employed when suitable experienced physiotherapist becomes available.

- As a result of one complaint, a review will be undertaken to ensure blood test results are available at clinic, and to ensure system indicates to the nurse that blood tests are required.

- In one CHP area, all Health Visitors to be offered refresher training re breast feeding policy.

Acute

- Two particular issues which have arisen from a series of seemingly unconnected complaints have now been raised across the Acute Division:-

    - A review of visiting times has been undertaken to ensure that visiting times meet patients' and visitors' needs;
    - The policy on telephone communication with relatives, particularly where they are at a long distance and cannot visit is being reviewed.

- All wards within Queen Mothers Hospital reviewed to ensure buzzers fully operational.

- Review of appropriate attire being provided for children waiting in Royal Hospital for Sick Children A&E rather than nightgowns.

- Review of recording of special dietary requirements at Southern General Hospital to be carried out to minimise problems with incorrect meals being received.

- Dispensers replaced within Southern General Hospital outpatient department toilets.

- Pre-assessment clinic commenced at Western Infirmary to allow patients to attend 2-3 weeks prior to admission for necessary blood tests in order to minimise waiting times for patients during admission.

- Nursing staff at Western Infirmary reminded of the importance of communicating any incidents to relatives about patients and that documentation is appropriately completed and recorded.

- Medical staff at Western Infirmary reminded formally of the need to complete paperwork timeously for bereaved families. Process has been reviewed and amended to minimise unnecessary delays.

- Staff within Royal Hospital for Sick Children Plaster Room given additional training to make it their normal practice to hold the vibrating edge of the cutting tool against their own skin to demonstrate to patients that it will not cut them and make it a less frightening experience.

5. Ongoing Developments

Partnerships/Mental Health Services

The new complaints posters have now been issued to Partnerships for display within public areas. These allow Partnerships to signpost complainants to a suitable office/telephone number within the Partnership, or to the Clinical Governance Support Unit (CGSU) complaints office. Revised complaints leaflets have also now been issued to Clyde areas, signposting Clyde patients to the correct office, following the transition of complaints support for Clyde CHPs and Mental Health Services to the CGSU. CGSU complaints staff have also undergone awareness training on the use of the telephone interpreting service, and this is now being rolled out to Partnership staff who are likely to be the first point of contact for complainants whose first language is not English. Leaflets on the Independent Advice and Support Service have also been widely distributed to all FHS Practices and Partnerships for display in public areas, with the aim of ensuring patients can access this service for complaints support and a range or other matters relating to health issues.

Acute

The review of complaints handling arrangements has now been concluded and, following discussion with the staff affected, will be implemented over the coming months. The changes proposed should streamline the complaints system for both complainants and staff and will bring a renewed focus on completeness of responses and timescales.

6. Conciliation

There were no requests for conciliation this quarter.

7. Independent Advice and Support Service (IASS)

The Citizens Advice Bureau participated in the Scotland-wide launch of the Independent Advice and Support Service on 10 September 2007.

The library team in Dalian House have now distributed approximately 22,000 copies of the original supply of the IASS leaflets. A covering letter was sent with the leaflets to advise staff about the service and asked them to make the leaflets widely available in patient areas and also gave details of how to order further copies.

The library are about to do another mailing to highlight their new publications catalogue and will send out further information about the IASS service within the catalogue. They are also waiting on a supply of 1000 copies of an A3 poster that the Citizens Advice Bureau (CAB) have produced to promote the service and they will send out copies of the poster to their distribution network along with further copies of the leaflet.

A further 30,000 copies of the leaflet will be supplied to the library to ensure that they have enough in stock to meet future demands and updated leaflets are in the process of being produced specifically for NHSGG&C and more tuned to complaints.

Arrangements have been made for adverts to be placed on buses from October until the end of the year.

It is hoped that this additional publishing and distribution of leaflets and posters will bring about a greater awareness of the new service.

Three case workers have been appointed to support this service and cover the whole NHSGG&C area and are now located in East Dunbartonshire (Kirkintilloch), Glasgow (Bridgeton) and East Renfrewshire (Barrhead).

The Head of Board Administration met with the Scottish Health Council (responsible for monitoring the IASS contract) on 1 October and brought them up-to-date with progress and the early indications of the numbers and users of the new service. A six monthly report on usage will be available by the end of October 2007.

8. ISD Annual Report 2006/07

Information Services Division (ISD) published its Annual Report on NHS Complaints for 2006/07 on 25 September 2007. NHS Boards and other NHS organisations submit summary information about complaints they receive to ISD Scotland. The data covers complaints received by Hospital and Community Services and Family Health Services. The data submitted to ISD includes all formal written complaints.

In 2006/07, for NHS Scotland there were 7,347 complaints received about hospital and community services and 2,984 complaints received about family health services. Putting this into context, however, with the number of contacts with the NHS, this results in approximately 4 complaints per 10,000 patient contacts for Scotland. This compares with 5 complaints per 10,000 contacts in 2005/06. In terms of Family Health Services, this results in approximately 2 complaints per 10,000 GP consultations.

<u>Hospital and Community Health Services</u>

- A total of 7,347 complaints were received by NHSScotland in 2006/07 compared with 7,940 in 2005/06 - a decrease of 7%**.**

- 93.2% of complaints were acknowledged within the national target timescale of three working days of receipt - compared with 93.1% in 05/06.

- 58.6% of complaints were dealt with within 20 working days (the national target), compared with 61.8% in 2005/06 and 62.2% in 2004/05. It should be noted that public holidays have been taken into account in the response times from 2005/06.

- The median time taken to deal with complaints was 19 working days for 2006/07.

- 33% of all issues raised were staffing issues, 27% related to treatment and 11% related to waiting times. Within the broad category off "staff" issues, the attitude/behaviour of staff (14.5% of all issues raised) and aspects of written and oral communication (14.5%) were the most common issues raised.

- In 2006/07, 24.6% of complaints were upheld in full and 38.7% were partly upheld. This compares with 26.2% upheld in full and 36.6% partly upheld in 2005/06.

Family Health Services

Three broad service types are included within the Family Health Services complaints procedure - medical services, dental services and complaints regarding Family Health Services administration. Although information is collected on complaints made about Family Health Services , it is less detailed than that collected on hospital and community health service complaints. As Family Health Services practitioners are independent contractors, it was nationally agreed that information collected would be less detailed.

- A total of 2,984 complaints were received by Family Health Services in 2006/07, an increase of 7% on the previous year's figure of 2,791.

- 85% of Primary Care complaints were regarding the medical service area.

NHSGGC

Taking the above information down into a more local level, the following is noted from ISD's Annual Report:-

- In relation to hospital and community health service complaints, NHSGGC received 1,583 in 2006/07 and responded to 38.7% of these within 20 working days.

- In relation to Family Health Service complaints, NHSGGC received 680 in 06/07 (543 medical and 137 dental).

9. Scottish Public Services Ombudsman Annual Report 2006/07

The Scottish Public Services Ombudsman (SPSO) laid its Annual Report for 2006/07 before the Parliament on 2 October 2007. This report marked five years since the SPSO was established and charted the offices progress from the merger of previous Ombudsman offices through the "one-stop-shop", a modern independent complaint handling system with the complainant at its heart.

In terms of the NHS, the following is reported in the Annual Report:-

- The Ombudsman received 833 enquires and complaints about the NHS in 2006/07. This represented 20% of all enquiries and complaints received by them. Of this, 497 complaints were received.

- Of the 497 NHS complaints received, 282 were about hospital services, 107 about general practitioners and 46 about dental and orthodontic services. The remaining 62 complaints covered the State Hospital, NHS 24, the Scottish Ambulance Service and a wide range of other NHS services. The top twelve categories of complaint were:-

    1. GP Practices – Clinical Treatment/Diagnosis
    2. Hospitals – General Medicine

3. Hospitals – Care of the Elderly
4. Dental and Orthodontic Services – Clinical Treatment/Diagnosis
5. Hospitals/Psychiatry
6. Hospitals – General Surgery
7. Hospitals – Other
8. Hospitals – Accident and Emergency
9. Hospital – Oncology
10. GP and Practices – Policy/Administration
11. Hospitals – Orthopaedics
12. GP and Practices – Communication, Staff Attitude, Dignity, Confidentiality.

- The Ombudsman noted that the number of complaints received about the NHS was tiny in comparison with the number of contacts that people across Scotland had with the health service.

- In 2006, the Scottish Public Services Ombudsman and the Scottish Health Council jointly commissioned research on experience and attitudes in relation to NHS complaints. This found high levels of satisfaction with GP and hospital based services but also that there were many barriers to complaining, including resignation (the most common reason selected from those who were dissatisfied but chose not to complain was "I have come to expect these things"). Additionally, many people felt that there was a lack of information about the NHS complaints process and some did not complain because they were worried about potential repercussions.

- The Ombudsman reached decisions on 435 complaints abut the NHS during 2006/07. 289 of these decisions did not involve investigation. Of these cases, 72 were outside their jurisdiction, 81 were premature – in such cases, the Ombudsman normally advises the complainant to first raise their concerns with the relevant NHS practitioner or organisation, and 58 were closed either because the complaint was withdrawn or because the complainant did not respond to a request for information. In a further 78 cases, after initial consideration of the complaint, the Ombudsman decided that an investigation was not appropriate. In 12 cases, investigations were started but discontinued. In 134 cases, investigations were completed and reports were issued. Of these 134 Investigation Reports, the Ombudsman fully upheld 16 complaints, partially upheld 47, and either did not uphold or made no finding on 71.

- A recurring theme coming out of health complaints investigated was communication in the broadest sense.

- Nursing Care, particularly for vulnerable people, remained a concern.

- It was apparent that problems could also arise when a patient's care transferred within the NHS – for example, from a GP to a hospital (or vice versa), from one specialist to another, or from child to adult services. In these circumstances what was sometimes referred to as the patient's journey could be bumpy and involved delays and blockages.

10. Ombudsman Visit to NHSGGC

The Ombudsman gave a presentation at a recent meeting of the Chief Executives of the NHS in Scotland.

The main points which the Ombudsman drew out from the presentation were as follows:-

- Following the significant increase in NHS cases which arose between 2004/05 and 2005/06, there seemed now to be a more settled position emerging, with both the absolute numbers of complaints, and their relative percentage of all of the complaints made to the Ombudsman, leveling off.

- The Ombudsman highlighted that there were still many "communication and record keeping" issues which lay at the heart of complaints, and concerns about the standards of nursing care in older people's and mental health services.

- Included in the Ombudsman's presentation were examples of good and bad responses sent by Primary Care Practitioners to complainants, following the Ombudsman's involvement. The point was made to the Ombudsman that it was important that NHS Boards' Complaints Managers were sighted on such cases so that they can try to ensure that such unsatisfactory letters were not sent.

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- The Ombudsman commented that the Sutherland Review remained an issue: the 1997 guidance issued by the Health Department about continuing care and free personal care needed to be revisited.

The Ombudsman has arranged to come through and talk with the Chief Executive, Chief Operating Officer (Acute) and the Head of Board Administration on 30 October about some of the issues raised above and policy issues which have arisen in Greater Glasgow and Clyde cases.

11. Conclusion

The NHS Board is asked to note the quarterly complaints report for the period 1 April – 30 June 2007.

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COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**14**
	➢ Medical/Dental	**5**
	➢ Nursing	**7**
	➢ AHPs	**0**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**2**
	➢ Other	**0**
02	Complaint handling	**2**
04	Shortage/availability	**1**
05	Communication (written)	**4**
06	Communication (oral)	**16**
07	Competence	**1**
	Waiting times for	
11	Date for admission/attendance	**0**
12	Date for appointment	**3**
13	Results of tests	**0**
	Delays in/at	
21	Admission/transfer/discharge procedures	**1**
22	Outpatient and other clinics	**0**
	Environmental/domestic	
29	Premises (including access)	**2**
30	Aids & appliances, equipment	**0**
32	Catering	**0**
33	Cleanliness/laundry	**0**
34	Patient privacy/dignity	**1**
35	Patient property/expenses	**0**
36	Patient status/discrimination (eg race, gender, age)	**2**
37	Personal records(including medical, complaints files)	**0**
38	Shortage of beds	**0**
39	Mixed accommodation	**0**
40	Hospital Acquired Infection (MRSA)	**0**
	Procedural issues	
41	Failure to follow agreed procedure	**0**
42	Policy and commercial decisions (of NHS Board)	**1**
43	NHS Board purchasing	**0**
44	Mortuary/post mortem arrangements	**0**
	Treatment	
51	Clinical treatment (all aspects)	**16**
	➢ Medical/Dental	**11**
	➢ Nursing	**3**
	➢ Other Staff	**2**
52	Consent to treatment	**0**
61	**Transport arrangements (including ambulances)**	**0**
71	**Other (where no definition applies)**	**5**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**19**
21	Dental (inc surgical)	**0**
31	Nursing, Midwifery, Health Visiting	**17**
41	Professions allied to medicine	**3**
51	Scientific/technical	**0**
61	Ambulance (inc. paramedics)	**0**
71	Ancillary/works/trades	**1**
81	NHS Board administrative staff/members (exc FHS administrative)	**1**
91	Division/CHP/PCO administrative staff/ members	**9**
01	Other	**0**

	SERVICE AREA	
	Hospital acute services	
11	Inpatient	**0**
12	Day case	**0**
13	Outpatient	**0**
14	Accident & emergency	**0**
15	Delivered in the community	**0**
	Care of the Elderly	
21	Inpatient	**0**
22	Day patient	**0**
23	Outpatient	**0**
24	Community	**0**
	Psychiatric/learning disabilities	
31	Inpatient	**15**
32	Day patient	**0**
33	Outpatient	**1**
34	Community	**3**
41	Maternity	**0**
51	Ambulance	**0**
61	Community hospitals	**0**
65	Community services – not elsewhere specified	**20**
72	Purchasing	**0**
73	Administration	**1**
74	**Unscheduled Health Care (Out of Hours)**	**0**
81	Other	**0**

COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**57**
	➢ Medical/Dental	**23**
	➢ Nursing	**22**
	➢ AHPs	**1**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**2**
	➢ Other	**10**
02	Complaint handling	**0**
04	Shortage/availability	**1**
05	Communication (written)	**11**
06	Communication (oral)	**25**
07	Competence	**1**
	Waiting times for	
11	Date for admission/attendance	**14**
12	Date for appointment	**21**
13	Results of tests	**5**
	Delays in/at	
21	Admission/transfer/discharge procedures	**10**
22	Outpatient and other clinics	**6**
	Environmental/domestic	
29	Premises (including access)	**9**
30	Aids & appliances, equipment	**18**
32	Catering	**4**
33	Cleanliness/laundry	**7**
34	Patient privacy/dignity	**5**
35	Patient property/expenses	**0**
36	Patient status/discrimination (eg race, gender, age)	**0**
37	Personal records(including medical, complaints files)	**8**
38	Shortage of beds	**0**
39	Mixed accommodation	**0**
40	Hospital Acquired Infection (MRSA)	**1**
	Procedural issues	
41	Failure to follow agreed procedure	**1**
42	Policy and commercial decisions (of NHS Board)	**1**
43	NHS Board purchasing	**0**
44	Mortuary/post mortem arrangements	**0**
	Treatment	
51	Clinical treatment (all aspects)	**128**
	➢ Medical/Dental	**90**
	➢ Nursing	**35**
	➢ Other Staff	**3**
52	Consent to treatment	**0**
61	**Transport arrangements (including ambulances)**	**6**
71	**Other (where no definition applies)**	**9**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**179**
21	Dental (inc surgical)	**0**
31	Nursing, Midwifery, Health Visiting	**80**
41	Professions allied to medicine	**8**
51	Scientific/technical	**16**
61	Ambulance (inc. paramedics)	**4**
71	Ancillary/works/trades	**19**
81	NHS Board administrative staff/members (exc FHS administrative)	**9**
91	Division/CHP/PCO administrative staff/ members	**15**
01	Other	**23**

SERVICE AREA

	Hospital acute services	
11	Inpatient	**150**
12	Day case	**7**
13	Outpatient	**137**
14	Accident & emergency	**31**
15	Delivered in the community	**1**
	Care of the Elderly	
21	Inpatient	**7**
22	Day patient	**0**
23	Outpatient	**0**
24	Community	**0**
	Psychiatric/learning disabilities	
31	Inpatient	**0**
32	Day patient	**0**
33	Outpatient	**0**
34	Community	**0**
41	Maternity	**4**
51	Ambulance	**0**
61	Community hospitals	**0**
65	Community services – not elsewhere specified	**0**
72	Purchasing	**0**
73	Administration	**3**
74	**Unscheduled Health Care (Out of Hours)**	**3**
81	Other	**6**