NHS Greater Glasgow and Clyde

Board Meeting
Tuesday, 18 December 2007 **Board Paper No. 07/69**

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

QUARTERLY REPORT ON COMPLAINTS : 1 JULY – 30 SEPTEMBER 2007

Recommendations:

The NHS Board is asked to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 July - 30 September 2007.

Introduction

This report provides a commentary and statistics on complaints handling throughout NHS Greater Glasgow and Clyde for the period July - September 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 July – 30 September 2007

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

Table 1

	1 July – 30 September 07		1 April – 30 June 2007	
	Partnerships/ MHP/Board (exc FHS)	Acute	Partnerships/ MHP/Board (exc FHS)	Acute
(a) Number of complaints **received**	55	354	46	350
(b) Number of complaints received and completed within 20 working days *[national target]*	29 (53%)	177 (50%)	23 (50%)	170 (49%)
(c) Number of complaints **completed**	73	352	40	418
(d) Outcome of complaints completed:-				
➢ Upheld	12	105	7	91
➢ Upheld in part	15	106	15	147
➢ Not Upheld	19	115	14	149
➢ Conciliation	0	0	0	1
➢ Irresolvable	3	1	1	2
(e) Number of complaints withdrawn	4	25	3	28
(f) Number of complaints declared vexatious	0	0	0	0

2. Ombudsman : 1 July – 30 September 2007

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

Table 2

	Partnerships/ MHP/Board (NHSGGC)	Acute	FHS
(a) Notification received that an investigation is being conducted	1	12	0
(b) Investigations Report received.	1	13	1

In accordance with the Ombudsman's monthly reporting procedure, 15 reports have been laid before the Scottish Parliament concerning NHS Greater Glasgow and Clyde cases; three of these cases were summarised in the July 2007 commentary, seven in the August 2007 commentary and five in the September 2007 commentary.

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

July 2007

1. The complainant complained about the Board's delay in dealing with her complaint concerning the circumstances pertaining when she required to view her son's body in the Royal Alexandra Hospital's mortuary.
   [The Ombudsman upheld the complaint and recommended that the Board re-emphasise to staff the importance of following the stated complaints procedure and that, in the event of investigations overrunning target dates, the complainant must be contacted on day 20 and fully advised. Further that complainants' agreement to an extension should be sought and, after 40 days, where they do not agree, complainants should be advised of their right to raise the matter with the Ombudsman.

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

2. The complainants raised a number of concerns that their relative had suffered as a result of a break in the skin of her left heel not being adequately monitored and treated. They also raised concerns regarding a potential communication breakdown between two hospitals when the relative was transferred from one hospital to another.
   [The Ombudsman fully upheld one element of the complaint, had no finding on one element and the other two elements were not upheld. The Ombudsman recommended that the Board reiterate to the staff involved the importance of making clear notes after assessments.

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

3. The complainant raised a complaint that the Board had failed to provide her with an appropriate level of care during her stay in the Southern General Hospital.
[The Ombudsman fully upheld two elements of the complaint but did not uphold the other element. The Ombudsman recommended that the Board:-

- *apologise to the complainant for failing to take sufficient account of her needs when considering her care provision; and*

- *ensure that appropriate training is now in place to ensure staff are aware of the potential issues which may arise when treating patients who have communication difficulties.*

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

August 2007

1. The complainant raised a number of concerns about the treatment her late mother received at the Southern General Hospital in November and December 2005. Her concerns included that her mother should have been treated in a High Dependency Unit, nursing staff failed to maintain her mother's oral and personal hygiene, staff failed to react when her mother's condition deteriorated and poor communication.
[The Ombudsman did not uphold any aspect of the complaint and made no recommendations].

2. The complainant was concerned about the care and treatment provided to his late wife. He said that a delay in the initial diagnosis of her cancer meant she had to attend the hospital daily for injections for suspected deep vein thrombosis. He was also unhappy about the care and treatment his late wife had received following her admission to Inverclyde Royal Hospital and felt that the communication both to his late wife, her family and between the hospital staff had been inadequate.
[The Ombudsman fully upheld two elements of the complaint and partially upheld one element. The Ombudsman recommended that the Board:-

- *apologise to the complainant and his family for the delay in diagnosis and share the Ombudsman's report with the clinical staff responsible for his late wife's care;*

- *review our pain assessment and management procedures and ensure that these include a full explanation of the role and involvement of specialist or palliative care teams in the care of patients with non-surgical pain;*

- *apologise to the complainant and his family for not fully explaining his late wife's pain management regime and for any unnecessary pain that she suffered as a result of this;*

- *review our policies and procedures to ensure that there is suitable monitoring of nutritional care and management;*

- *provide evidence that standards of communication have improved and, in particular, that there are policies and procedures in place to ensure that patients who are terminally ill and their families are fully supported and treated with appropriate dignity;*

- *emphasise to staff responsible for responding to complaints the importance of doing so in a non-defensive and open manner; and*

- *apologise to the complainant and his family for all the failures identified in record keeping and communication; for failing to provide adequate support to them and his late wife during her final illness; for the confusion about the circumstances surrounding her death; and for failing to respond with appropriate care and sensitivity to the concerns raised by the complainant's daughter.*

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

3. The complainant raised a number of concerns about the treatment his mother received at the Royal Alexandra Hospital and also about the delay by the Board in dealing with his complaint.
[The Ombudsman fully upheld three elements of the complaint and partially upheld one element. The Ombudsman recommended that:-

- *the Board issues the complainant and his family with a full formal apology for the failures identified in two elements of the complaint;*
- *the Board audit our care planning document in one year and share the findings with the Ombudsman's office;*
- *when a hospital patient was being transferred internally or externally, a "tick list" of what needs to go with that patient should be completed before the patient leaves the ward;*
- *when a hospital patient is being transferred externally, staff transporting the patient should also check that all the items contained on the "tick list" accompany the patient;*
- *the "tick list" should then be immediately checked by the receiving ward or hospital when the patient arrives there;*
- *the Board issue the complainant with a formal apology for the errors contained in their letter of 21 January 2005; and*
- *the apology should be in accordance with the Ombudsman's guidance note on "apology" (which sets out what was meant and what was required for a meaningful apology).*

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

4. The complainant raised a number of concerns about surgery she underwent for the removal of a breast tumour at the Western Infirmary and about the subsequent radiotherapy treatment at the Beatson Oncology Centre. She believed that both had been more extensive than she had been advised and that, as a result, she was at a greater risk of developing lymphoedema.
[The Ombudsman partially upheld one element of the complaint and did not uphold one element. The Ombudsman recommended that:-

- *when launching a new policy on consent, the Board arrange appropriate training for staff to ensure it is fully implemented and audit its implementation to confirm that it was being followed consistently; and;*
- *the Board ensure that all staff are aware of the need to provide full explanations when responding to complaints and that staff dealing with complaints contact all appropriate staff for comment when doing so.*

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

5. The complainant raised a number of concerns about clinical treatment and delays in appointments and results.
[The Ombudsman fully upheld the complaint and recommended that the Board make a written apology to the complainant for all the identified failures.

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

6. The complainant raised concerns that, following the withdrawal of part of his medication by the manufacturer, clinical staff failed to adequately assess his condition and provide him with suitable alternative medication or check his blood pressure.
[The Ombudsman did not uphold any aspect of the complaint and had no recommendations to make].

7. The complainant complained that administrative and complaint handling errors by the Board had resulted in an unreasonable delay in her referral for treatment from the NHS and that consequently she felt it necessary to obtain the treatment privately. She sought reimbursement of the costs directly incurred by her in having her surgery performed outwith the NHS.
[The Ombudsman fully upheld the complaint and recommended that the Board reimburse the complainant's invoiced treatment costs.

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

September 2007

1. The complainant complained that the GP Practice's late diagnosis of her mother's colon cancer could have been avoided by their greater consideration of her symptoms. The complainant's mother died in hospital about a month after diagnosis.
[The Ombudsman fully upheld the complaint and recommended that the GPs in question:-

   - *apologise in writing to the complainant, acknowledging that further investigation should have been done in mid 2002; and*

   - *inform the Ombudsman what steps they have taken and/or are taking to learn from, and try to avoid a recurrence of, this serious case, for example, by discussing it at the general practitioner appraisals and discussing other relevant cases with the clinical governance lead of the appropriate Community Health Partnership.*

   The Ombudsman was pleased that the Practice had accepted the recommendations and were taking action on them].

2. The complainant's representative raised a complaint against the Board on behalf of the complainant about the treatment she received at the Royal Alexandra Hospital in respect of a top-up epidural to allow for the surgical removal of the retained placenta after the birth of her son in August 2004.
[The Ombudsman did not uphold any aspect of the complaint but recommended that the Board:-

   - *consider whether it needs to review when clinical risk reviews of incidents such as these are carried out; and*

   - *ensures that clinical staff are reminded of their responsibility to maintain detailed records, in particular, in respect of anaesthetic procedures.*

   The Board has accepted the recommendation and will act on it accordingly. The Ombudsman asked that the Board notify her when the recommendations have been implemented].

3. The complainant raised a number of concerns about the care and treatment of his late sister by the Board. In particular he complained that his sister had an operation to fuse her ankle joint which left her in considerable pain when it would have been clinically more appropriate to have amputated the foot; and also that on her final admission on 25 July 2005 to hospital she had been inappropriately admitted to orthopaedics which delayed diagnosis of the septicaemia which caused her death on 6 August 2005.
[The Ombudsman did not uphold one aspect of the complaint and partially upheld one aspect and recommended that the Board review our procedures for ensuring an overall treatment plan with ongoing input from all the relevant specialisms where a patient has a number of underlying medical problems.

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

4. The complainant raised a number of concerns about aspects of the care and treatment of his mother by the Board from May 2005 until her death in October 2005.
[The Ombudsman fully upheld two elements of the complaint and did not uphold the other two elements. The Ombudsman recommended that the Board:-

- *reflect on the lessons that emerge from the record-keeping issues in this case, consider whether the documentation should be changed or if the issue was rather abut staff induction/training and advise the Ombudsman of the outcome of this consideration;*

- *complete the work on a Bed Alarm Policy and submit a copy to the Scottish Public Services Ombudsman when this was issued;*

- *arrange for staff to reflect on the importance of good communication and involvement of patients and relatives in decisions about care and treatment and advise the Ombudsman of the steps taken to achieve this; and*

- *consider how to address the needs of longer term patients for mental stimulation to enhance their quality of life and advise the Ombudsman of the outcome of this consideration.*

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

5. The complainant raised a number of concerns about the care and treatment provided to her by the Board following a labyrinthectomy on 22 August 2006. She also complained about the attitude of a doctor during an eye examination.
[The Ombudsman did not uphold any aspect of the complaint and had no recommendations to make].

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), attitude/behaviour and clinical treatment are the categories attracting most complaints this quarter.

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

Acute

Clinical treatment, waiting times, communication (written and oral) an attitude/behaviour 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

- To prevent unnecessary delay when a patient is referred to Clinical Psychology, information will be given to patients regarding referrals. All patients will also receive a letter from Psychology confirming that the referral has been received.

- Within community and mental health services, a review is to take place to ensure patients have a full explanation of their discharge from any element of the service and what follow up arrangements have been put in place.

- In one area a review of procedures to support the management of patients' valuables will be undertaken.

- In one area, when a clinic is cancelled, patients will now be offered another appointment within two weeks to ensure no excessive gaps in patients being seen by consultants.

- As a result of a complaint where ward and fire safety procedures had not been explained to a patient, this information will now be included in new patient information booklet and as part of the admission procedures.

- In one CHP guidelines are to be developed on the restrictions of nursing equipment given to patients attending the treatment room.

- As a result of a complaint in one CHP a local system will be implemented to ensure that patients on priority referral list are contacted within 16 days by physiotherapy department.

Acute

- Inverclyde Royal Hospital - Current process for handling internal IRH referrals being reviewed as a result of a complaint within Surgical & Anaesthetics

- Review of sanitary provision at Vale of Leven following complaints within Facilities.

- Following complaints re Smoking Policy on several sites, staff to continue to discourage smoking in grounds along with a review of cleaning frequencies at the front of hospitals within Facilities.

- Following complaint regarding pre-admission clinic for surgery, Royal Alexandra Hospital to review the process for sending letters for pre-admission within Surgical & Anaesthetics.

- Following complaint within the Royal Alexandra Hospital, staff within Medicine reminded of the importance of assessments when reviewing the needs of patients to ensure that we continue to meet the needs of all patients, particularly those who are elderly or with special needs.

- Concerns raised over clothing for elderly patient within Drumchapel, review of the handling of patient clothing being undertaken to minimise distress caused to patients when their clothing is lost.

- Review of protocol for dealing with discharged patients who have positive MRSA results to be undertaken within Southern General Hospital – within Surgical and Anaesthetics.

- Policy for laundering long-stay patients' clothing within the Southern General Hospital to be reviewed to be consistent and sensitive to the needs of patients who have no family to assist with the cleaning of dirty clothing – Facilities.

- Due to lack of over-bed tables, a supply of new tables and chairs have been ordered within the Victoria Infirmary medical wards – Medicine.

- Staff advised around the need for sensitivity and acceptance of the wearing of religious items such as the Kirpan (religious knife).

- Freephone numbers have been added to referral letters to reduce any costs to patients needing to contact the hospital. Medical Records / Information & Technology Directorate.

5. Ongoing Developments

Partnerships/Mental Health Services

- Two training sessions on the use of the telephone interpreting service for Partnership staff have now taken place. Several Partnerships had no representation at the sessions and these areas will be identified and briefed on an individual basis in order that the appropriate identification code may allocated to allow them to access the service.

- The Clinical Governance Support Unit is currently working with the Mental Health Partnership to develop and implement an appropriate complaints handling protocol/process within the Partnership.

- The Clinical Governance Support Unit has continued to provide awareness raising and training sessions with a variety of staff groups throughout the CH(C)Ps and Mental Health Partnership. Requests for training are being received on a regular basis and are currently being provided on an ad hoc basis.

Acute

Work continues with staff in partnership to implement the revised complaints handling arrangements within the Division with a view to increasing performance in responding to complaints.

6. Conciliation

There were no requests for conciliation this quarter.

7. Conclusion

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

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COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**14**
	➢ Medical/Dental	**6**
	➢ Nursing	**5**
	➢ AHPs	**0**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**3**
	➢ Other	**0**
02	Complaint handling	**1**
04	Shortage/availability	**1**
05	Communication (written)	**11**
06	Communication (oral)	**13**
07	Competence	**4**
	Waiting times for	
11	Date for admission/attendance	**0**
12	Date for appointment	**4**
13	Results of tests	**0**
	Delays in/at	
21	Admission/transfer/discharge procedures	**0**
22	Outpatient and other clinics	**0**
	Environmental/domestic	
29	Premises (including access)	**0**
30	Aids & appliances, equipment	**1**
32	Catering	**1**
33	Cleanliness/laundry	**1**
34	Patient privacy/dignity	**4**
35	Patient property/expenses	**3**
36	Patient status/discrimination (eg race, gender, age)	**0**
37	Personal records(including medical, complaints files)	**1**
38	Shortage of beds	**0**
39	Mixed accommodation	**0**
40	Hospital Acquired Infection (MRSA)	**0**
	Procedural issues	
41	Failure to follow agreed procedure	**2**
42	Policy and commercial decisions (of NHS Board)	**0**
43	NHS Board purchasing	**0**
44	Mortuary/post mortem arrangements	**0**
	Treatment	
51	Clinical treatment (all aspects)	**29**
	➢ Medical/Dental	**24**
	➢ Nursing	**3**
	➢ Other Staff	**2**
52	Consent to treatment	**1**
61	**Transport arrangements (including ambulances)**	**0**
71	**Other (where no definition applies)**	**6**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**32**
21	Dental (inc surgical)	**0**
31	Nursing, Midwifery, Health Visiting	**17**
41	Professions allied to medicine	**6**
51	Scientific/technical	**0**
61	Ambulance (inc. paramedics)	**0**
71	Ancillary/works/trades	**0**
81	NHS Board administrative staff/members (exc FHS administrative)	**0**
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	**19**
32	Day patient	**0**
33	Outpatient	**3**
34	Community	**14**
41	Maternity	**0**
51	Ambulance	**0**
61	Community hospitals	**0**
65	Community services – not elsewhere specified	**17**
72	Purchasing	**0**
73	Administration	**0**
74	**Unscheduled Health Care (Out of Hours)**	**0**
81	Other	**0**

COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**46**
	➢ Medical/Dental	**21**
	➢ Nursing	**17**
	➢ AHPs	**0**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**5**
	➢ Other	**3**
02	Complaint handling	**0**
04	Shortage/availability	**4**
05	Communication (written)	**18**
06	Communication (oral)	**28**
07	Competence	**2**
	Waiting times for	
11	Date for admission/attendance	**15**
12	Date for appointment	**30**
13	Results of tests	**5**
	Delays in/at	
21	Admission/transfer/discharge procedures	**8**
22	Outpatient and other clinics	**8**
	Environmental/domestic	
29	Premises (including access)	**7**
30	Aids & appliances, equipment	**15**
32	Catering	**1**
33	Cleanliness/laundry	**7**
34	Patient privacy/dignity	**9**
35	Patient property/expenses	**2**
36	Patient status/discrimination (eg race, gender, age)	**1**
37	Personal records(including medical, complaints files)	**7**
38	Shortage of beds	**4**
39	Mixed accommodation	**0**
40	Hospital Acquired Infection (MRSA)	**3**
	Procedural issues	
41	Failure to follow agreed procedure	**1**
42	Policy and commercial decisions (of NHS Board)	**2**
43	NHS Board purchasing	**0**
44	Mortuary/post mortem arrangements	**0**
	Treatment	
51	Clinical treatment (all aspects)	**121**
	➢ Medical/Dental	**89**
	➢ Nursing	**28**
	➢ Other Staff	**4**
52	Consent to treatment	**0**
61	**Transport arrangements (including ambulances)**	**2**
71	**Other (where no definition applies)**	**6**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**192**
21	Dental (inc surgical)	**5**
31	Nursing, Midwifery, Health Visiting	**70**
41	Professions allied to medicine	**12**
51	Scientific/technical	**12**
61	Ambulance (inc. paramedics)	**1**
71	Ancillary/works/trades	**11**
81	NHS Board administrative staff/members (exc FHS administrative)	**4**
91	Division/CHP/PCO administrative staff/ members	**31**
01	Other	**16**

SERVICE AREA

	Hospital acute services	
11	Inpatient	**128**
12	Day case	**10**
13	Outpatient	**143**
14	Accident & emergency	**37**
15	Delivered in the community	**0**
	Care of the Elderly	
21	Inpatient	**13**
22	Day patient	**0**
23	Outpatient	**0**
24	Community	**1**
	Psychiatric/learning disabilities	
31	Inpatient	**0**
32	Day patient	**0**
33	Outpatient	**0**
34	Community	**0**
41	Maternity	**10**
51	Ambulance	**0**
61	Community hospitals	**0**
65	Community services – not elsewhere specified	**0** **0**
72	Purchasing	**2**
73	Administration	**2**
74	**Unscheduled Health Care (Out of Hours)**	**6**
81	Other	**2**