NHS Greater Glasgow and Clyde

Board Meeting
Tuesday, 15 April 2008 **Board Paper No. 08/22**

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

QUARTERLY REPORT ON COMPLAINTS :
1 OCTOBER – 31 DECEMBER 2007

Recommendations:

The NHS Board is asked to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 October – 31 December 2007.

Introduction

This report provides a commentary and statistics on complaints handling throughout NHS Greater Glasgow and Clyde for the period October - December 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 October – 31 December 2007

Table 1 shows the number of complaints received across NHS Greater Glasgow and Clyde between 1 October – 31 December 2007 and for comparison 1 July – 30 September 2007. Thereafter, the statistics relate to those complaints completed in the quarter so that outcomes can be reported.

Table 1

	1 Oct – 31 December 07		1 July – 30 September 07	
	Partnerships/ MHP/Board (exc FHS)	Acute	Partnerships/ MHP/Board (exc FHS)	Acute
(a) Number of complaints **received**	48	313	55	354
(b) Number of complaints received and completed within 20 working days *[national target]*	25 (52%)	158 (50%)	29 (53%)	177 (50%)
(c) Number of complaints **completed**	50	300	73	352
(d) Outcome of complaints completed:-				
➢ Upheld	15	73	12	105
➢ Upheld in part	15	92	15	106
➢ Not Upheld	17	107	19	115
➢ Conciliation	0	0	0	0
➢ Irresolvable	0	0	3	1
(e) Number of complaints withdrawn	3	28	4	25
(f) Number of complaints declared vexatious	0	0	0	0

There was discussion at the recent Performance Review Group meeting about the continued poor performance in responding to complaints within the national target of 70% of complaints responded to within 20 working days. It was reported that the Acute Services Division had recently undertaken a full review of how they handled complaints and identified a number of operational issues in which they believe they will be able to improve on through co-location of the complaints staff and the introduction of the new arrangements to align the complaints staff to the way in which services are now delivered.

The process with staff was currently underway and it was hoped that once completed there would be an improvement on the performance indicator of completing closer to the 70% of complaints within 20 working days.

2. Ombudsman : 1 October – 31 December 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	0	4	0
(b) Investigations Report received.	2	8	3

In accordance with the Ombudsman's monthly reporting procedure, 13 reports have been laid before the Scottish Parliament concerning NHS Greater Glasgow and Clyde cases; five of these cases were summarised in the October 2007 commentary, four in the November 2007 commentary and four in the December 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 13 NHS Greater Glasgow and Clyde cases for this quarter are described as follows:-

October 2007

1. The complainant, a patient at Dykebar, Hospital, raised a number of issues concerning the conduct and behaviour of two of the hospital's staff toward her and the manner in which the Board dealt with her complaint.
   [The Ombudsman upheld the complaint and recommended that the Board:-

   - *ensure that they have in place a system for handling complaints that can demonstrate to a complainant that their complaint has been fairly, impartially and thoroughly investigated;*

- *ensure that, in particular, they have in place a system for handling complaints in circumstances where serious allegations are made by a patient about a member of staff;*

- *ensure that they and their employees understand their responsibilities in relation to protecting staff and patients, particularly in mental health settings;*

- *ensure that current arrangements for separating the complaints process from the disciplinary process meet the requirements of the current NHS complaints guidance; and*

- *issue the complainant with a full formal apology for the failures identified. The apology should be in accordance with the Ombudsman's guidance note on "apology" (which sets out what is meant and what is required for a meaningful apology).*

The Board has accepted the recommendations].

2. The complainant raised a complaint regarding the length of time he had been advised he would have to wait to see a Neurologist within the Board after his GP had requested a routine referral on his behalf when he presented with a clinical picture of a six to eight month history of a constant ache in his arm.
[The Ombudsman upheld the complaint and recommended that:-

   - *the Board ensure that GPs and potential referrers are reminded how to find up to date local waiting times for out-patient services they are referring to within the Board so that, as referrers, they may prioritise their patients accordingly. The Ombudsman asked that the Board advise her of the measures that are put in place, or have been introduced, to facilitate this; and*

   - *as one of several factors, some formal consideration should be given to the age of the patient being referred to a lengthy waiting list, where a list is unavoidably long. The Ombudsman asked that the Board inform her what they have implemented.*

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

3. The complainant considered that his GP Practice failed to diagnose and treat his illness and he was unhappy that the Practice decided to no longer provide medical treatment to him, his brother and his father.
[The Ombudsman upheld one element of the complaint and did not uphold one element. The Ombudsman recommended that the Practice:-

   - *apologise in writing to the complainant, his brother and his father for the failure to follow the appropriate procedures when taking the decision to remove them from the Practice list; and*

   - *review how it takes such decisions in light of The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, and ensure that Practice policy and actions are compliant with this Statutory Instrument.*

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

4. The complainant raised concerns about her care and treatment by a consultant, information that was included in a letter and subsequent effect on her medical care as a result.
[The Ombudsman upheld one element of the complaint and did not uphold two elements and had no recommendations to make].

5. The complainant complained about various aspects of the treatment of his brother, prior to his death in the Southern General Hospital. In particular he complained that the GP failed to diagnose his brother's brain tumour and that the care and treatment received by his brother in the Southern General Hospital was inadequate.
[The Ombudsman did not uphold any aspect of the complaint and made no recommendations].

November 2007

1. The complainant raised a number of concerns about the care and treatment she received from her dentist, and about his attitude in handling her complaint.
[The Ombudsman did not uphold two elements of the complaint and had no finding on one element and recommended that the dentist ensures that appropriate records are kept, including x-ray, in respect of root canal treatment].

2. The complainant raised a number of concerns about the care and treatment his late mother received from her GP during 2006. These included issues such as a failure by the GP to action treatment for his mother's reported concerns of nausea and weight loss and a failure to diagnose that she was suffering from fluid on her lungs. In addition the complainant complained that the GP failed to call an ambulance when his mother took ill at the Practice on 29 September 2006. She was taken to hospital later the same day by ambulance from her home but sadly did not recover from a coma and died two weeks later.
[The Ombudsman did not uphold any aspect of the complaint and made no recommendations].

3. The complainant's father died on 28 December 2004 following treatment in Gartnavel General Hospital. She was concerned that there was an unreasonable delay in diagnosing his cancer and that he was not provided with adequate treatment on admission to the hospital. The complainant also felt that there were unreasonable delays in the handling of her complaint by the Board.
[The Ombudsman fully upheld three elements of the complaint and did not uphold one element. The Ombudsman recommended that the Board, reflecting on this case:-

   - *review their guidelines to ensure that in cases similar to this one, staff understand the need for the appropriate multi-disciplinary team to meet at the earliest possible opportunity to discuss all options for investigation, treatment or non-treatment; and also that options are discussed in detail with patients and/or with the family in such circumstances;*

   - *review the circumstances in which it may be appropriate to provide palliative treatment prior to firm diagnosis, and that they include their findings in revised clinical guidelines for staff. The Ombudsman asks that the Board inform her of the outcome of this review and the actions taken; and*

   - *review their methods of obtaining information from internal sources with a view to ensuring that there are no resultant avoidable delays in responding to complaints.*

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

4. The complainant was concerned her son had suffered from a deterioration in his mental illness in 2005 but that this had not been recognised by mental health professionals in his care. As a result, his condition had not been correctly managed. She believed that, if appropriate care and treatment had been provided, an alleged incident in June 2005 involving her son would not have occurred. She was further unhappy that this contact with the Community Psychiatric Nurses was reduced in July 2005 in response to a perceived risk to them. The complainant was also unhappy about the response she had received from the Board following her complaints about this.
[The Ombudsman upheld one element of the complaint and did not uphold one element and recommended that the Board apologise to the complainant for the failures identified in responding to her complaint.

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

December 2007

1. The complainant raised a complaint about a delay in a referral for a urodynamics study at the Department of Urology in the Southern General Hospital. He had not received an appointment after he had cancelled three previous opportunities to attend the Department. He also complained that he had been told his name had been taken off the waiting list at his request. Additionally he was unhappy that the complaint response from the Chief Executive of the South Glasgow Division wrongly referred to his original out-patient referral as having come from his GP rather than the Gastrointestinal Clinic at the hospital.
   [The Ombudsman fully upheld the complaint and recommended that:-

   - *the Board apologise to the complainant for their error in saying the referral was from his GP;*

   - *staff members are reminded of the importance of keeping accurate and contemporaneous records to verify their understanding of all patient information; and*

   - *the Department staff are reminded of the value of alerting patients' GPs to the changes in the clinical care of patients on their Practice list.*

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

2. The complainant raised a number of concerns about the care her late brother received in the days before he died.
   [The Ombudsman upheld one element of the complaint and did not uphold three elements. The Ombudsman recommended that the Board:-

   - *apologise to the complainant for shortcomings in communications about her late brother's condition;*

   - *take further action to ensure that a proactive approach is taken to establishing good communication with relatives;*

   - *use this complaint as a case study to illustrate the importance of good communication with relatives, especially when the hospital are aware that the patient is unlikely to survive; and*

   - *apologise to the complainant formally for the conduct of a member of nursing staff and also give consideration to providing to staff dealing with patients and their families a more focussed reinforcement of the importance of good customer care through, for example, appropriate training.*

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

3. The complainant raised a complaint about the treatment he received when he was a patient in Glasgow Royal Infirmary. In particular, he said that his condition was misdiagnosed and, therefore, he did not receive appropriate, timely treatment.
   [The Ombudsman partially upheld one element of the complaint but did not uphold two elements and recommended that the Board emphasise to staff that extreme care should be taken when drugs are being administered and recorded.

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

4. The complainant raised a number of concerns about the care and treatment he received from two NHS Boards (one being Greater Glasgow and Clyde) following a sudden onset of severe leg pain in November 2005. He also complained about the handling of his complaints by both Boards.
   [The Ombudsman did not uphold any aspect of the complaint and made no recommendations].

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

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

- As a result of an incorrect prescription form being issued to a discharged patient requiring methadone, Hospital Manager and Community Addiction Team will review existing agreements to ensure correct procedures are followed.

- In one area the process for storage of personal belongings was subject to a review.

- In one CHP area, a review and redesign of Physiotherapy services to be undertaken over next 12 to 18 months.

- As a result of a complaint in one area, issues in relation to consent/informed consent will be addressed through training and the production of an appropriate information leaflet.

- To reduce waiting time for assessments for autism, a review of systems and processes is being carried out.

- Staff in another area have been advised of the process for accessing social care support to ensure there are no delays when referring clients for support.

- In one CHP area a Communication Group for carers has been set up to ensure clear communication links.

Acute

- In light of the amendment to a patient's prescription after on-line request sent to Pharmacy - training will be undertaken for staff to ensure correct procedure when amending prescriptions.

- Patient was unaware that his physiotherapy appointment had been cancelled as staff had not left a message on his answerphone due to protocol. Protocol reviewed to ensure adequate communication regarding cancellations in future.

- In light of issues raised about attendance at the Beatson for treatment, the process was reviewed to ensure patients are given clear information on where they should attend and purpose of visit.

- Plastic Surgery Clinics at Glasgow Royal Infirmary have put in place new procedures to resolve issues of unavailable results or x-rays.

- Implemented changes to the way in which blood results are communicated to GPs following patients attendance at an antenatal clinic following a complaint that blood results were not communicated to patient / GP which resulted in patient not receiving prescription.

- A review has been taken of the waste disposal system for Southern General Hospital and a decision taken to employ an alternative system for the collection and storage of waste.

- Research to be carried out into effects of applying blood pressure cuffs etc to patients with lymph node clearance and results to be shared as a teaching resource following complaint about swelling caused to patient by such a procedure being carried out.

5. Ongoing Developments

Partnerships/Mental Health Services

- The Mental Health Partnership has finalised its complaints handling protocol/process and this has been issued across the Partnership and copied to CHPs.

- Requests for training continue to be received on a regular basis and sessions are currently being provided by the Clinical Governance Support Unit on request across a variety of staff groups throughout the CH(C)Ps and Mental Health Partnership.

- Complaints handling issues arising from the Ombudsman's consideration of complaints relating to NHSGG&C Partnerships have been highlighted across all Partnerships with a view to ensuring the lessons highlighted are learned by all.

- DATIX - new software for patient safety, risk management, incident and adverse event reporting will shortly be implemented across the Board area. The software includes a complaints management module and it is anticipated that Partnerships will have access to this module locally for direct complaint entry/management and that the system will provide an excellent facility for local report production. Appropriate members of staff have been identified to receive training on the use of the complaints module, and it is anticipated that they will be trained over the next few months. In the meantime, the Clinical Governance Support Unit complaints office will log complaints centrally on DATIX for reporting, monitoring and tracking purposes until all Partnerships have been trained in the use of the system.

Acute

- The Datix computer system previously in place in South Glasgow and Clyde was introduced across the entire Acute Division from 1 April 2008 replacing separate systems in place in the former North and Yorkhill. This will provide improved and more consistent performance monitoring and recording information across the Division.

- Work is underway with the Learning and Education Department to develop a suite of complaints handling training programmes for staff covering from Induction for all new staff through to specialist courses for middle managers in complaints investigation. The training will be developed so that it applicable across the single system.

6. Conciliation

There were no requests for conciliation this quarter.

7. The Scottish Government Healthcare Policy and Strategy Directorate

The Scottish Government Healthcare Policy and Strategy Directorate has advised that they have invited the Scottish Health Council to lead work to evaluate the effectiveness of the NHS Complaints Procedure. The study will look at the process of the complaints handling through the experiences of patients, carers, and staff in operating the procedure. It will explore the sustainable learning from complaints and identify mechanisms to encourage an accessible inclusive and equitable complaints process.

8. Equality and Diversity Data

There has been an ongoing pilot to collect Equality and Diversity data covering the six Fair for All strands in three NHS Boards. It will now be necessary to extend this approach across all NHS Boards from 1 April 2008 to meet the requirements of the equality legislation. The Healthcare Directorate will shortly be issuing a launch of the Equality and Diversity survey form and pre-paid envelopes for issue to complainants for completion and return direct to the Information Services Division (ISD).

9. Independent Advice and Support Service

A meeting is being arranged with the Citizen's Advice Bureau to review the outcome of the first full year of the Independent Advice and Support Service and ensure appropriate support and publicity for this new service.

10. Conclusion

The NHS Board is asked to note the quarterly complaints report for the period 1 October – 31 December 2007.

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COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**17**
	➢ Medical/Dental	**8**
	➢ Nursing	**9**
	➢ AHPs	**0**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**0**
	➢ Other	**0**
02	Complaint handling	**2**
04	Shortage/availability	**1**
05	Communication (written)	**11**
06	Communication (oral)	**9**
07	Competence	**9**
	Waiting times for	
11	Date for admission/attendance	**1**
12	Date for appointment	**7**
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)	**3**
30	Aids & appliances, equipment	**0**
32	Catering	**0**
33	Cleanliness/laundry	**0**
34	Patient privacy/dignity	**3**
35	Patient property/expenses	**3**
36	Patient status/discrimination (eg race, gender, age)	**2**
37	Personal records(including medical, complaints files)	**4**
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)	**21**
	➢ Medical/Dental	**15**
	➢ Nursing	**6**
	➢ Other Staff	**0**
52	Consent to treatment	**0**
61	**Transport arrangements (including ambulances)**	**0**
71	**Other (where no definition applies)**	**10**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**29**
21	Dental (inc surgical)	**0**
31	Nursing, Midwifery, Health Visiting	**17**
41	Professions allied to medicine	**7**
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	**5**
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	**18**
32	Day patient	**0**
33	Outpatient	**0**
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	**1**

ACUTE
ANNEX 2

COMPLAINT CATEGORIES

Code	ISSUES RAISED	NUMBER
	Staff	
01	Attitude/behaviour	**72**
	➢ Medical/Dental	**34**
	➢ Nursing	**34**
	➢ AHPs	**0**
	➢ Ambulance (* paramedics)	**0**
	➢ Administration	**3**
	➢ Other	**1**
02	Complaint handling	**0**
04	Shortage/availability	**6**
05	Communication (written)	**16**
06	Communication (oral)	**57**
07	Competence	**6**
	Waiting times for	
11	Date for admission/attendance	**8**
12	Date for appointment	**21**
13	Results of tests	**5**
	Delays in/at	
21	Admission/transfer/discharge procedures	**10**
22	Outpatient and other clinics	**10**
	Environmental/domestic	
29	Premises (including access)	**9**
30	Aids & appliances, equipment	**12**
32	Catering	**1**
33	Cleanliness/laundry	**14**
34	Patient privacy/dignity	**5**
35	Patient property/expenses	**7**
36	Patient status/discrimination (eg race, gender, age)	**0**
37	Personal records(including medical, complaints files)	**6**
38	Shortage of beds	**7**
39	Mixed accommodation	**6**
40	Hospital Acquired Infection (MRSA)	**0**
	Procedural issues	
41	Failure to follow agreed procedure	**3**
42	Policy and commercial decisions (of NHS Board)	**5**
43	NHS Board purchasing	**1**
44	Mortuary/post mortem arrangements	**0**
	Treatment	
51	Clinical treatment (all aspects)	**136**
	➢ Medical/Dental	**91**
	➢ Nursing	**41**
	➢ Other Staff	**3**
52	Consent to treatment	**1**
61	**Transport arrangements (including ambulances)**	**4**
71	**Other (where no definition applies)**	**17**

Code	STAFF GROUP	NUMBER
11	Medical (inc surgical)	**140**
21	Dental (inc surgical)	**5**
31	Nursing, Midwifery, Health Visiting	**90**
41	Professions allied to medicine	**9**
51	Scientific/technical	**6**
61	Ambulance (inc. paramedics)	**1**
71	Ancillary/works/trades	**20**
81	NHS Board administrative staff/members (exc FHS administrative)	**6**
91	Division/CHP/PCO administrative staff/ members	**23**
01	Other	**12**

SERVICE AREA

	Hospital acute services	
11	Inpatient	**135**
12	Day case	**13**
13	Outpatient	**117**
14	Accident & emergency	**18**
15	Delivered in the community	**1**
	Care of the Elderly	
21	Inpatient	**8**
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	**5**
51	Ambulance	**0**
61	Community hospitals	**0**
65	Community services – not elsewhere specified	**0**
72	Purchasing	**0**
73	Administration	**0**
74	**Unscheduled Health Care (Out of Hours)**	**9**
81	Other	**2**