Table 1

		Ayrshire & Arran NHS Board Area						
	Complaints Received by Subject	A GP or General Medical Practice	Ayrshire & Arran NHS Board	Ayrshire & Arran NHS Board - Patient Services	**Ayrshire & Arran NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	0	**0**	0%	**15**	2%
	Appliances, equipment & premises	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	1	1	0	**2**	4%	**48**	6%
	Clinical treatment/diagnosis	4	24	1	**29**	56%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	1	4	0	**5**	10%	**91**	11%
	Complaints by NHS staff	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	1	0	**1**	2%	**20**	2%
	Continuing care	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	0	**0**	0%	**6**	1%
	Lists	0	0	0	**0**	0%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	1	1	**2**	4%	**10**	1%
	Other	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	7	0	**7**	13%	**156**	18%
	Record keeping	0	0	0	**0**	0%	**7**	1%
	Out of jurisdiction	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	6	0	**6**	12%	**68**	8%
	Total	**6**	**44**	**2**	**52**		**857**	
2010-11	Admission, discharge & transfer procedures	0	2	0	**2**	3%	**9**	1%
	Appliances, equipment & premises	0	2	0	**2**	3%	**5**	1%
	Appointments/Admissions (delay, cancellation, waiting lists)	0	4	0	**4**	6%	**35**	4%
	Clinical treatment / Diagnosis	9	22	1	**32**	50%	**402**	45%
	Communication, staff attitude, dignity, confidentiality	0	4	0	**4**	6%	**64**	7%
	Complaints handling	0	1	0	**1**	2%	**27**	3%
	Continuing care	0	1	0	**1**	2%	**3**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**1**	0%
	Hotel services - food, laundry etc	0	0	0	**0**	0%	**4**	0%
	Hygiene, cleanliness & infection control	0	0	0	**0**	0%	**1**	0%
	Lists (incl difficulty registering and removal from lists)	0	1	0	**1**	2%	**20**	2%
	Nurses / Nursing Care	0	0	0	**0**	0%	**13**	1%
	Other	0	0	0	**0**	0%	**8**	1%
	Policy/administration	0	5	1	**6**	9%	**143**	16%
	Record Keeping	0	1	0	**1**	2%	**10**	1%
	Out Of Jurisdiction	0	0	0	**0**	0%	**1**	0%
	Subject Unknown	0	10	0	**10**	16%	**142**	16%
	Total	**9**	**53**	**2**	**64**		**888**	

Table 2

Ayrshire & Arran NHS Board Area

Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	Ayrshire & Arran NHS Board	Ayrshire & Arran NHS Board - Patient Services	**Ayrshire & Arran NHS Board Area Total**	**Sector Total**
2009-10	Discontinued before investigation	0	0	11	1	**12**	**176**
	Discretionary decision not to pursue	0	0	0	0	**0**	**1**
	Other	0	0	0	0	**0**	**7**
	Out of jurisdiction	0	0	4	0	**4**	**60**
	Premature	0	2	13	0	**15**	**319**
	Determined after detailed consideration	1	5	16	1	**23**	**314**
	Report issued: fully upheld	0	0	1	0	**1**	**33**
	Report issued: not upheld	0	0	2	0	**2**	**9**
	Report issued: partially upheld	0	0	3	0	**3**	**32**
	Total	**1**	**7**	**50**	**2**	**60**	**951**
2010-11	Premature	0	0	13	2	**15**	**260**
	Out of Jurisdiction	0	2	2	0	**4**	**59**
	Outcome Not Achievable	0	0	2	0	**2**	**25**
	No Decision Reached	0	0	15	0	**15**	**268**
	Fully Upheld	0	1	8	0	**9**	**65**
	Partly Upheld	0	3	3	0	**6**	**50**
	Not Upheld	0	1	7	0	**8**	**113**
	Total	**0**	**7**	**50**	**2**	**59**	**840**

Ayrshire and Arran NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
19/05/2010	200801946	(a) there was a failure to recognise Mr A's existing vascular condition and the decision to operate was inappropriate (upheld); and (b) Mr A's post-operative treatment was inappropriate (upheld).	upheld	(i) highlight this report to the relevant staff, particularly junior doctors, to ensure that they are aware of the deficiencies which have been identified; and (ii) apologise to Mr A for their failure to identify and take into account his vascular condition when deciding to operate on his ankle fracture, and for the delay in referring him for vascular review when his surgical wound failed to heal. The Board have accepted the recommendations and will act on them accordingly.
18/08/2010	200901416	the care and treatment which Mr A received at the Hospital was inadequate and brought about his death prematurely (I upheld the complaint that the care and treatment were inadequate. However, I did not find that poor standards of care had led to Mr A's premature death).	upheld	(i) provide the Ombudsman's office with a specimen copy of the new in-patient admissions booklet; (ii) provide the Ombudsman's office with a report on the findings of the audit of the Abbreviated Mental Test section of the patient medical admission form; (iii) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in this report; (iv) reflect on the comments of the specialist Advisers in paragraphs 15 and 22 of this report; (v) issue an apology to Ms C and her family for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.

Ayrshire and Arran NHS Board / Scottish Ambulance Service

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
16/03/2011	201001146 201001520	(a) the care and service provided to Mr C by the Service were not reasonable (upheld); and (b) the care and treatment provided to Mr C by the Board was not reasonable (upheld).	upheld	the Service: (i) remind all crews in the South West Division to contact their Area Service Office and await instructions if cancellations on their patient list would mean that other patients would be transported to hospital several hours before their appointment time; and (ii) remind all crews in the South West Division of the importance of passing on relevant information about a patient's needs following an outbound journey, such as whether a stretcher facility is required for a return journey, to their Area Service Office. the Board: (iii) ensure that a record is made of the time a patient is admitted for their procedure and also of all advice given to patients on admission by nursing staff. This requirement should be incorporated into the new guidance; (iv) remind nursing staff of the importance of treating people as individuals, even in a very busy unit, as set out in the NMC Code; and (v) provide him with evidence of audit and evaluation of the first six months' operation of the new guidance and action plan for dealing with vulnerable adults arriving for Endoscopy appointments. The Service and the Board have accepted the recommendations and will act on them accordingly.