Table 1

		Greater Glasgow & Clyde NHS Board Area									
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Service	A Pharmasist or Pharmacy	Greater Glasgow & Clyde NHS Board	Greater Glasgow & Clyde NHS Board - Acute Services Division	**Greater Glasgow & Clyde NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	0	0	2	0	**2**	1%	**15**	2%
	Appliances, equipment & premises	0	0	0	0	1	0	**1**	1%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	1	0	0	0	4	0	**5**	3%	**48**	6%
	Clinical treatment/diagnosis	7	12	2	0	47	26	**94**	53%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	7	0	0	8	3	**18**	10%	**91**	11%
	Complaints by NHS staff	0	0	0	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	1	0	0	1	2	**4**	2%	**20**	2%
	Continuing care	0	0	0	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	0	0	1	0	**1**	1%	**6**	1%
	Lists	0	0	0	0	1	0	**1**	1%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	1	0	0	0	0	0	**1**	1%	**1**	0%
	Nurses/nursing Care	0	0	0	0	1	2	**3**	2%	**10**	1%
	Other	0	0	0	0	0	0	**0**	0%	**2**	0%
	Policy/administration	1	1	1	1	19	11	**34**	19%	**156**	18%
	Record keeping	0	0	0	0	2	0	**2**	1%	**7**	1%
	Out of jurisdiction	0	0	0	0	0	0	**0**	0%	**3**	0%
	Subject unknown	0	0	1	0	9	2	**12**	7%	**68**	8%
	Total	**10**	**21**	**4**	**1**	**96**	**46**	**178**		**857**	
2010-11	Admission, discharge & transfer procedures	0	0	0	0	1	0	**1**	1%	**9**	1%
	Appliances, equipment & premises	0	0	0	0	0	0	**0**	0%	**5**	1%
	Appointments/Admissions (delay, cancellation, waiting lists)	1	1	0	0	3	2	**7**	5%	**35**	4%
	Clinical treatment / Diagnosis	3	10	0	0	42	32	**87**	57%	**402**	45%
	Communication, staff attitude, dignity, confidentiality	0	4	0	0	3	4	**11**	7%	**64**	7%
	Complaints handling	0	1	0	0	2	1	**4**	3%	**27**	3%
	Continuing care	0	0	0	0	0	0	**0**	0%	**3**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	**0**	0%	**1**	0%
	Hotel services - food, laundry etc	0	0	0	0	0	0	**0**	0%	**4**	0%
	Hygiene, cleanliness & infection control	0	0	0	0	0	0	**0**	0%	**1**	0%
	Lists (incl difficulty registering and removal from lists)	1	2	0	0	0	0	**3**	2%	**20**	2%
	Nurses / Nursing Care	0	0	0	0	0	2	**2**	1%	**13**	1%
	Other	0	0	0	0	1	0	**1**	1%	**8**	1%
	Policy/administration	1	2	0	0	6	7	**16**	10%	**143**	16%
	Record Keeping	0	0	0	0	0	0	**0**	0%	**10**	1%
	Out Of Jurisdiction	0	0	0	0	0	0	**0**	0%	**1**	0%
	Subject Unknown	0	0	0	0	14	7	**21**	14%	**142**	16%
	Total	**6**	**20**	**0**	**0**	**72**	**55**	**153**		**888**	

Table 2

Greater Glasgow & Clyde NHS Board Area

Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Opthalmic Services	A Pharmacy or Pharmacist	Greater Glasgow & Clyde NHS Board	Greater Glasgow & Clyde NHS Board - Acute Services Division	**Greater Glasgow & Clyde NHS Board Area Total**	**Sector Total**
2009-10	Discontinued before investigation	0	6	0	0	17	14	**37**	**176**
	Discretionary decision not to pursue	0	0	0	0	1	0	**1**	**1**
	Other	0	0	0	0	3	0	**3**	**7**
	Out of jurisdiction	1	1	0	0	8	3	**13**	**60**
	Premature	2	4	0	1	34	13	**54**	**319**
	Determined after detailed consideration	6	11	0	0	35	15	**67**	**314**
	Report issued: fully upheld	0	0	0	0	2	5	**7**	**33**
	Report issued: not upheld	0	0	0	0	1	2	**3**	**9**
	Report issued: partially upheld	0	1	0	0	5	3	**9**	**32**
	Total	**9**	**23**	**0**	**1**	**106**	**55**	**194**	**951**
2010-11	Premature	0	6	0	0	19	15	**40**	**260**
	Out of Jurisdiction	0	0	0	0	6	6	**12**	**59**
	Outcome Not Achievable	2	0	0	0	1	3	**6**	**25**
	No Decision Reached	1	1	0	0	24	14	**40**	**268**
	Fully Upheld	0	2	0	0	4	3	**9**	**65**
	Partly Upheld	0	3	0	0	2	2	**7**	**50**
	Not Upheld	2	8	1	0	9	8	**28**	**113**
	Total	**5**	**20**	**1**	**0**	**65**	**51**	**142**	**840**

Greater Glasgow and Clyde NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)	Hospital, GP, Practice or Dentists name (if relevant)
21/04/2010	200802296	(a) the decision to treat Mrs C's fracture conservatively was inappropriate (not upheld); and (b) the standard of follow-up treatment was inappropriate (upheld).	partially upheld	(i) apologise to Mrs C for the failings identified in this report; (ii) highlight the issues raised in this report to all relevant orthopaedic staff; (iii) remind clinical staff of the importance of documenting their discussions with consultants; and (iv) encourage consultants to consider taking a more proactive role in complex cases. The Board have accepted the recommendations and will act on them accordingly.	Royal Alexandra
19/05/2010	200801865	the management of Miss A's pain was unreasonable (upheld).	upheld	(i) highlight the issues raised in this report to all staff in the maternity unit, particularly anaesthetic staff, emphasising the importance of keeping clear, detailed and consistent records; (ii) offer Miss A an early appointment to be seen in an obstetric anaesthetic clinic, in line with the Adviser's comments at paragraph 23; and (iii) apologise to Miss A for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.	Paisley Maternity
19/05/2010	200901216	the Board did not provide: (a) adequate care and treatment to Ms C after a MTOP (upheld); (b) clear written guidance to Ms C about the expected duration of bleeding after the MTOP (upheld); and (c) accurate information to Ms C in their complaint responses (upheld).	upheld	(i) apologise to Ms C for the inadequate care and treatment provided to her after the MTOP; (ii) devise a protocol for the management of retained products of conception following a MTOP; and (iii) apologise to Ms C for failing to provide her with accurate information in their complaint responses. The Board have accepted the recommendations and will act on them accordingly.	Western Infirmary Southern General
23/06/2010	200802831	the process of the assessment within Clinical Psychology was inappropriate in that Mr C was denied the opportunity of providing supporting information and, as a result, the reports produced were inaccurate and Mr C's reputation was damaged (not upheld).	not upheld	(i) review their procedures to ensure that there are clear triggers in place for referring child safety concerns for prompt assessment by individuals with the relevant expertise; (ii) ensure that all mental health staff receive appropriate training relating to their child protection duties and obligations. This should be routinely covered in clinical supervision and staff should have access to the relevant guidance; (iii) highlight to all mental health staff the importance of explicit record-keeping surrounding child protection. This should include not only the reasoning for decisions but the rationale underpinning them and all verbal referrals should be followed up using the appropriate inter-agency form; (iv) ensure that, where appropriate, child protection concerns are communicated to the patients concerned prior to making a referral. When not informing patients, clear and specific reasons for not doing so should be recorded; (v) ensure that patients are notified of the outcome of mental health assessments as soon as is practicable; and (vi) remind mental health and complaint handling staff of the importance of taking steps to cla The Board have accepted the recommendations and will act on them accordingly.	

23/06/2010	200802989	the Board failed to: (a) provide the correct treatment for Mr C's Peyronie's disease (not upheld); (b) warn Mr C of the potential complications of the procedure that was carried out (upheld); and (c) provide adequate aftercare following Mr C's surgery (not upheld).	partially upheld	(i) provide patients with information relating to the potential complications of surgery, in writing, at the point of gaining their consent (ii) advise patients of the fact that the surgery provided may differ to that proposed prior to surgery and that they keep a record that this advice has been given; and (iii) remind staff of the importance of recording any advice, medication or supplies provided to patients. The Board have accepted the recommendations and will act on them accordingly.	Wishaw General Stobhill

Greater Glasgow and Clyde NHS Board (Medical Practice)

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)	Hospital, GP, Practice or Dentists name (if relevant)
16/03/2011	201000940	(a) the care and treatment provided to Miss C by her GP for a nut allergy prior to her death from anaphylaxis was inadequate (upheld); and (b) the tone and manner of the GP when she telephoned four days after Miss C's death were inappropriate (not upheld).	partially upheld	the GP write to Mrs C to apologise for failing to discuss the letter of 1 August 2007 with her.	Northcote Surgery
21/04/2010	200801102	(a) the Practice failed to follow recognised procedures in reaching a diagnosis that Ms C was suffering from diabetes (upheld); (b) the Practice did not arrange for appropriate follow-up for Ms C following the diagnosis of diabetes (upheld); (c) the Practice's communication with Ms C regarding her diagnosis and test results was inadequate (upheld); and (d) the Practice's response to Ms C's complaint was inappropriate (upheld).	upheld	(i) put in place a protocol to ensure that diabetes is diagnosed in line with recognised practices; (ii) put in place a protocol to ensure that newly diagnosed diabetics receive appropriate follow-up care; (iii) take steps to ensure they deal with complaints in line with the NHS complaints procedure; and (iv) write to Ms C with an apology for the failures identified in this report, including those relating to complaint handling and the content of the letter sent to Ms C on 14 July 2008. The Practice have accepted the recommendations and will act on them accordingly.	Yokermill