2009-10 Statistics Tables – Explanatory Notes and Commentary

After local authorities, the NHS is traditionally the sector about which we receive the next highest number of complaints in a year. As we say in our Annual Report, this is to be expected, given the way in which both sectors touch the lives of so many of Scotland's citizens. And we also know that each year authorities satisfactorily resolve many more complaints directly with members of the public.

The information provided consists of the statistics we recorded for 2008-09 and 2009-10, plus these explanatory notes and commentary. I'd encourage you to take time to review these and consider how you might use the information in taking forward your service improvement work.

Greater Glasgow and Clyde NHS Board

Complaints received
Table 1 details in bold the number of complaints we received for your Board for 2008-09 and 2009-10, alongside the total of complaints about the NHS for these years. The complaints are categorised by subject area, some of which are fairly broad. The subjects shown are confined to the main issue that the complainant raised with us, and many of the complaints will also have had other issues involved. The table also shows whether the complaint was about an FHS provider, the Board itself etc. In the majority of Boards the main area of complaint was, unsurprisingly, about clinical treatment/diagnosis. Rates of complaint about this subject ranged from 40 to 60 per cent across the larger regional Boards.

We recorded 178 complaints about your Board in 2009-10, compared to 154 in the previous year. Although we received more complaints about the Board in 2009-10, when taken as a percentage of the total number of complaints we received about the NHS in each year it shows a drop (from 22.5% of the total complaints received to 20.8%).

Complaints determined
Table 2 shows the outcomes of complaints that the SPSO determined about your Board in 2009-10 - i.e. it shows what we did with them. In most of the cases, we will have written and told you that we had received a complaint, and what our decision on it was. Normally we will also have sent you a copy of our decision letter to the complainant. We may not, however, have told you about all of the cases that we determined as premature, depending on the circumstances of the case. (There is an explanation of this in the FAQs on the Statistics page of our website.) The final section of these explanatory notes deals with the investigated complaints on which we reported to the Parliament.

The table also shows whether the complaint was about an FHS provider, the Board itself etc. After discussion with some Board representatives last year we agreed that it would not be helpful to break these down further by subject matter, given that our subject codes differ from those used by the NHS.

Please note that received and determined numbers do not normally tally exactly, and it is normal for us to carry some cases forward. This is because our work on a complaint received in one business year may not be completed until the following year. This is particularly relevant to health cases - for example we may find we need to obtain clinical advice, and this can take time.

Complaints determined as 'premature'
We determine some complaints as 'premature'. We consider a complaint to be premature when it reaches us before it has completed the NHS complaints process. There may be a number of reasons that people send us complaints too early – sometimes they have not tried to make the complaint to the NHS at all, sometimes they have made the complaint but come to us before they receive a final response. When we receive a premature complaint, we normally return it to the complainant and ask them to make the complaint directly to the relevant authority, or to contact the authority about it again. If it returns to us after that we will reopen the case. We may, however, accept a complaint before it has completed the process if it is clear that there has been significant delay by the authority in sending a response.

The number of premature complaints that we receive about the NHS is in fact very low compared to other sectors. This may reflect the fact that there is only a single-stage process involved. However, it may be worth considering whether there is any more that you can do to ensure that staff are aware of the process and can tell people how to access it and that members of the public have easy access to NHS complaints leaflets in premises within your Board area.

Investigated Complaints and Recommendations
We investigated and reported on nineteen complaints about your Board in 2009-10, of which we upheld seven, partially upheld nine and did not uphold three. The attached summary sheet shows these complaints and the recommendations made. As you are no doubt aware, in appropriate cases the Ombudsman may make recommendations where a complaint is not upheld, if he believes that there are lessons that may be learned. You will also be aware that SPSO complaints reviewers follow up to find out what changes have been made as a result of our recommendations.

……..

We hope that you find this summary useful. We are aware from our consultation that the way in which we categorise complaints does not mirror the NHS way of doing so, and it would be useful to know if any further explanation of our categories is required. We'd also welcome any other thoughts you may have on the information presented and ways in which we can further improve this feedback to you, which we plan to provide annually in future if Health Boards find it useful.

If you have any comments about this or enquiries about the statistics provided, please contact Annie White, SPSO Casework Knowledge Manager, on 0131 240 8843 or email awhite@spso.org.uk .

Statistical reports for all years are available on the SPSO website at:
http://www.spso.org.uk/statistics/index.php

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**	
2008-09	Admission, discharge & transfer procedures	1	0	0	0	1	1	**3**	2%	**18**	3%
	Appliances, equipment & premises	0	0	0	0	1	0	**1**	1%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	2	0	0	1	0	**3**	2%	**23**	3%
	Clinical treatment/diagnosis	5	18	0	1	43	26	**93**	60%	**374**	55%
	Communication, staff attitude, dignity, confidentiality	1	6	0	0	10	4	**21**	14%	**62**	9%
	Complaints handling	1	0	0	0	2	0	**3**	2%	**22**	3%
	Continuing care	0	0	0	0	1	2	**3**	2%	**10**	1%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	**0**	0%	**3**	0%
	Hotel services - food, laundry etc	0	0	0	0	0	0	**0**	0%	**1**	0%
	Hygiene, cleanliness & infection control	0	0	0	0	0	1	**1**	1%	**4**	1%
	Lists	0	1	0	0	0	0	**1**	1%	**5**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	0	0	**0**	0%	**2**	0%
	Nurses/nursing care	0	0	0	0	1	2	**3**	2%	**13**	2%
	Other	0	0	0	0	0	0	**0**	0%	**1**	0%
	Policy/administration	1	2	0	0	8	6	**17**	11%	**110**	16%
	Record keeping	0	0	0	0	0	0	**0**	0%	**12**	2%
	Out of jurisdiction	0	0	0	0	2	0	**2**	1%	**6**	1%
	Subject unknown	0	0	0	0	2	1	**3**	2%	**17**	2%
	Total	**9**	**29**	**0**	**1**	**72**	**43**	**154**		**684**	

Table 2

			Greater Glasgow & Clyde NHS Board Area						
	Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	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	Assessment	Discontinued before investigation	0	4	0	13	14	**31**	**160**
		Discretionary decision not to pursue	0	0	0	1	0	**1**	**1**
		Other	0	0	0	3	0	**3**	**7**
		Out of jurisdiction	1	1	0	8	3	**13**	**60**
		Premature	2	4	1	34	13	**54**	**319**
		Total	**3**	**9**	**1**	**59**	**30**	**102**	**547**
	Examination	Discontinued before investigation	0	2	0	4	0	**6**	**16**
		Determined after detailed consideration	6	11	0	35	15	**67**	**314**
		Total	**6**	**13**	**0**	**39**	**15**	**73**	**330**
	Investigation	Report issued: fully upheld	0	0	0	2	5	**7**	**33**
		Report issued: not upheld	0	0	0	1	2	**3**	**9**
		Report issued: partially upheld	0	1	0	5	3	**9**	**32**
		Total	**0**	**1**	**0**	**8**	**10**	**19**	**74**
	Total		**9**	**23**	**1**	**106**	**55**	**194**	**951**
2008-09	Assessment	Discontinued before investigation	1	5	0	16	10	32	**132**
		Out of jurisdiction	1	2	0	7	0	**10**	**52**
		Premature	4	6	0	16	14	**40**	**182**
		Total	**6**	**13**	**0**	**39**	**24**	**82**	**366**
	Examination	Determined after detailed consideration	2	10	1	21	10	**44**	**193**
		Total	**2**	**10**	**1**	**21**	**10**	**44**	**193**
	Investigation	Discontinued during investigation	0	0	0	0	0	0	**1**
		Report issued: fully upheld	0	0	0	3	0	**3**	**26**
		Report issued: not upheld	0	0	0	1	1	**2**	**27**
		Report issued: partially upheld	0	0	0	14	1	**15**	**46**
		Total	**0**	**0**	**0**	**18**	**2**	**20**	**100**
	Total		**8**	**23**	**1**	**78**	**36**	**146**	**659**

Greater Glasgow and Clyde NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
22/04/2009	200800128	(a) the process used by the Transplant Team to identify Mrs C's suitability for the nephrectomy prior to the operation was inadequate (not upheld); (b) the decision to abort the nephrectomy on 22 June 2007 was unreasonable (not upheld); (c) Mrs C's post-operation management was inadequate (upheld); and (d) the Board's handling of the complaint was unsatisfactory (upheld).	partially upheld	(i) the clinicians reflect on the Adviser's comments about the level of clinical information which has been entered in the clinical records; (ii) the Board apologise to Mrs C for the failings identified in her post-operation management; (iii) the Board review their discharge arrangements for surgery of this type and take steps to ensure there is appropriate post-surgery discharge planning in each case; and (iv) the Board remind staff of their obligations to manage complaints in line with the NHS complaints procedure and take action to ensure that information about the NHS complaints procedure which is held locally in hospitals and clinics is up to date. The Board have accepted the recommendations and will act on them accordingly
22/04/2009	200600740 200701011	(a) Mr C's heart problems were not diagnosed by GP 1 and GP 2 from the Practice at consultations on 20 October, 28 October and 11 November 2005 (not upheld); (b) Mr C's heart problems were not diagnosed by GP 3 and GP 4 from the Service at consultations on 30 November and 1 December 2005 (not upheld); (c) the Practice did not deal with Mrs C's complaint properly (upheld).	partially upheld	(i) apologise to Mrs C for failing to deal with her complaint properly; and (ii) reflect on their complaints policy, review their complaints protocol and discuss how to respond to complaints from non-patients. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman has no recommendations in respect of Greater Glasgow and Clyde NHS Board.
17/06/2009	200702628	(a) out-of-hours doctors should have admitted Mrs A to the Hospital earlier (not upheld); (b) Mrs A's care and treatment in the Hospital were inadequate (upheld); and (c) the Board lost some of Mrs A's medical records (upheld).	partially upheld	(i) ensure that all appropriate healthcare professionals in the Board's hospitals are made aware of the appropriate management of constipation in older people; and (ii) reflect on the lessons learnt from this complaint and take appropriate action to help avoid a recurrence. The Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
17/06/2009	200702913	(a) the decision to operate was not appropriate, in that further tests should have been taken prior to the operation (upheld); (b) the post-operative care provided to Mr A was inadequate (upheld); (c) communication with Mr A and his family, concerning Mr A's care and treatment, was not adequate (upheld); and (d) the Board did not respond appropriately to the complaint raised by Mr C (partially upheld, to the extent that there was a delay in responding with no reasonable explanation given for this).	partially upheld	(i) undertake a root cause analysis or similar tool to examine the reason why the pressure ulcers developed and why there was no proactive treatment once this occurred; (ii) provide the policy/guidance for the assessment and treatment of pressure ulcers, with particular reference to the referral to the specialist teams in tissue viability, pain and nutrition; undertake an audit to review the processes; and provide an action plan to address any shortcomings; (iii) undertake an audit of documentation to include nursing assessment, pain assessment and nursing care of Wards A and B; (iv) provide evidence of the education and training programme provided to nursing staff in relation to the assessment and care of pressure ulcers; (v) undertake an external peer review of the nursing care in Ward A, to include an examination of the clinical leadership and management, patient experience and quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the Scottish Government initiatives outlined in Leading Better Care; (vi) provide details of the action plan created as a result of the above recommendations and provide updates where relevant. Action plans should be specific, measurable, achievable, realistic and timely (SMART) and include robust quality indicators such as the Clinical Quality Indicator for Pressure Ulcer Prevention; (vii) as a priority, review the documentation provided to patients and provide the Ombudsman with the results of this; (viii) provide details of the audit made in response to report 200600345 and any action taken as a result; (ix) if not covered by that audit, undertake a specific audit of communication within Hospital 1, to include communication with families, and between staff; (x) reinforce to clinical staff the importance of responding to requests from complaint handling staff timeously; and (xi) make a full apology to Mr C and his family for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
22/07/2009	200800720	(a) the care and treatment provided to Mrs A was inadequate (upheld); (b) there was insufficient care taken by staff handling an outbreak of infection in Ward A (upheld); (c) the level of hygiene in and around the ward was inadequate (no finding); (d) there were significant failures in communication about the effect on Mrs A of the infection and the serious nature of Mrs A's condition (upheld); (e) there was a failure to ensure Mrs A's dignity (upheld); and (f) the Board did not respond appropriately to the complaint (upheld).	upheld	(i) use a root cause analysis or similar tool to examine the reasons for the clinical failures identified in treating Mrs A's diarrhoea and managing her fluid intake; (ii) provide clear evidence over the next 12 months that the new policy on professional standards of record-keeping is having significant improvements on the quality of documentation; (iii) provide the Ombudsman with evidence that the initiatives underway on infection control should prevent a recurrence of the failings identified in this report; (iv) use this complaint as part of their own ongoing programmes to improve cleanliness and, in particular, consider how hygiene standards can be tracked and monitored and how visitors and patients can be encouraged to feel they can approach staff about any concerns they have; (v) share with the Ombudsman the results of patient and staff surveys on communication over the next 12 months and the audit of communication following report 200600345 and any action taken as a result; (vi) keep the Ombudsman informed of the progress of implementation of the Liverpool Care Pathway over the next 12 months; (vii) ensure that guidance to complaint handling staff emphasises the need for full disclosure of relevant information; and (viii) make a full, detailed apology to Mr C and his family for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
22/07/2009	200503048	the Board failed to provide reasonable care following Ms C's operation on 18 April 2003 (upheld).	upheld	The Ombudsman has no recommendations to make on these issues because he is satisfied that the Board have made changes that address the concerns raised in this report.
19/08/2009	200801842	Greater Glasgow and Clyde NHS Board (the Board) failed to provide Mr A with all appropriate care and treatment in 2003/2004 and as a consequence missed an opportunity to secure an earlier diagnosis of prostate cancer (upheld).	Upheld	review the Urology Department protocol for the assessment and management of men with new lower urinary tract symptoms bearing this case in mind. The Board have accepted the recommendation and will act on it accordingly.
19/08/2009	200800634	(a) the Board failed to effectively manage Mr A's pressure sores (upheld); (b) Mr A contracted MRSA and other infections because the infection control measures were inadequate (not upheld); (c) there was a delay in referring Mr A to the palliative care team (upheld); and (d) there was a lack of continuity in the nursing care provided to Mr A (upheld).	Partially Upheld	(i) undertake a root cause analysis or similar improvement tool to examine the reason why Mr A received inadequate treatment for his pressure ulcers; (ii) ensure that the policies in place reflect current national best practice standards for pressure ulcer assessment, prevention and treatment and that robust systems are in place to review, monitor and report adherence; (iii) confirm that the learning from report 200702913, published by the Ombudsman in June 2009, is being transferred across the Board region; (iv) ensure that there are steps in place to verify that staff are able to diagnose patients who might benefit from palliative care and then make timely referrals to palliative care teams; (v) take immediate steps to implement the Liverpool Care Pathway or similar end of life care planning system; (vi) continue to review and monitor the nursing care in ward 3A in Hospital 2. This should include an examination of the clinical leadership and management; the patient experience; and the quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the implementation of the Scottish Government policy for Senior Charge Nurses – Leading Better Care; (vii) ask the Director of Nursing to verify that appropriate education and development is in place to ensure that nursing staff throughout the Board are aware of and adhere to national standards in relation to pressure ulcers, control of infection and end of life care ; (viii) ensure that systems are in place to review and monitor standards of all aspects of nursing documentation in line with professional standards; (ix) ensure that patient transfer policies exist and are used in the best interests of patients, ensuring that communication and continuity of care is paramount; and (x) make a full and detailed apology to Mrs C for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
23/09/2009	200702752	(a) the Board's requirement that Mr C attend Gartnavel Hospital at 09:00 on 11 January 2007 for a procedure that did not begin until 11:35 was unreasonable (no finding); (b) the Board's administration of steroids to Mr C during his admission in January 2007 was not reasonable (upheld); and (c) the Board did not take adequate action in response to Mrs C's complaints about discussions with Mr C's family on 12 January 2007 about his resuscitation (not upheld).	partially upheld	(i) apologise to Mr C's family that the dosage of steroids was not increased following either the suspicion of sepsis or the incident of septic shock; (ii) take steps to ensure that medical staff are aware of the need to increase the dose of steroids following suspicion of sepsis or incidents of septic shock; and (iii) ensure that induction materials for medical staff clearly cover the specific requirements of the Board's resuscitation policy. This would serve to draw inductees' attention to the policy, and, specifically, its application in terms of provision of information to, and discussion with, patients, relatives and carers and provide evidence of this to the Ombudsman. The Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
21/10/2009	200802430	(a) proper informed consent was not obtained prior to surgery (upheld); (b) the clinical treatment which was provided was inadequate (not upheld); and (c) following surgery, staff failed to take prompt action to establish the cause of Ms A's concerns (upheld).	partially upheld	(i) review their consent process, to ensure that patients have enough time to digest the information provided by staff and in information leaflets and that sufficient space is available on the consent forms to list what has been discussed; (ii) share this report with the staff involved and ask them to reflect on the advisers' comments about considering alternative procedures prior to surgery; and (iii) apologise to Ms A for the failings which have been identified in this report. The Board have accepted the recommendations and will act on them accordingly.
21/10/2009	200701693	(a) the Board did not feed Mrs C in a sufficiently upright position (not upheld); and (b) the Board failed to notice that Mrs C had developed a chest infection and treat it in time (partially upheld, to the extent that, whilst the Board failed to correctly identify the significance of Mrs C's symptoms on 16 February 2007 and respond appropriately, I cannot say that their failure to do so resulted in Mrs C's death).	partially upheld	(i) apologise to Mr C for failing to notice that Mrs C had developed a chest infection on 16 February 2007 and provide appropriate treatment at that time and for failing to produce a care pathway for Mrs C when the course of her treatment changed; (ii) feed back the adviser 's views on what he considers would have been the appropriate course of treatment for Mrs C on 16 February 2007, to the staff involved in cases of this type and in Mrs C's care, in particular; (iii) provide training to staff to ensure that, in all appropriate cases, where the direction of a patient's treatment changes, a new care pathway is devised - this could be by introducing a multi-disciplinary record or audit of documentation; (iv) ensure the staff involved in Mrs C's care are made aware of the need to record accurate information on patient mobility in their records; (v) review their current policy on the use of special mattresses and beds, incorporating the NHS QIS standards and flowchart; and (vi) provide feedback to the staff involved in Mrs C's care on the importance of seeking guidance from a more senior member of the medical team on appropriate treatment and/or to ask technical staff for assistance, in cases where the accuracy of medical equipment, such as a pulse oximeter, is in question.
21/10/2009	200801237	surgery should have been done near the start of the first hospital admission, there was inadequate communication with Ms C about the nature and outcome of her condition and the after-discharge support was inadequate (upheld).	upheld	(i) apologise to Ms C for not having operated earlier; (ii) reflect on this report's conclusions and take appropriate action in respect of each; (iii) satisfy themselves that the consultant in question has an appropriate understanding of CES; and (iv) update the Ombudsman's office on the main audit findings and main plans regarding after-discharge support.
21/10/2009	200700438 200800535	(a) NHS 24 failed to provide proper care and treatment to Mr C (upheld); and (b) the Board failed to provide proper care and treatment to Mr C (upheld).	upheld	(i) NHS 24 provide an apology to Mrs C and her family for the delay in transferring the necessary clinical details to the correct out-of-hours service; (ii) NHS 24 conduct an evaluation into a review of the improvements introduced by NHS 24 as a result of this complaint; (iii) NHS 24 ensure call handlers' basic training is developed enough to ensure staff are able to determine how to manage information they are given when a call is made from a service user, and the mechanism to transfer vital clinical information between services is reviewed to avoid mistakes in transmission arising; (iv) NHS 24 ensure the algorithms are fit for purpose in so far as they are able to capture the appropriate detailed information to assist the nurses to make the appropriate decisions; (v) the Board provide an apology to Mrs C and her family for the delay in picking up on the clinical symptoms described by Mr C and his family; (vi) the Board undertake a further review of the triage doctor's clinical practice in order to ensure their understanding of the signs and symptoms of a subarachnoid haemorrhage; and (vii) the Board ensure the triage doctor reflects on the lessons of the case, shares it with his appraiser during his next appraisal and is aware of the possibilities of rare diagnoses such as subarachnoid haemorrhage for future work. NHS 24 and the Board have accepted the recommendations and will act on them accordingly.

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
18/11/2009	200800569	(a) the Board failed to correctly diagnose the severity of Mrs C's spinal problems (not upheld); (b) the Board failed to treat Mrs C's spinal symptoms (not upheld); and (c) the Board's complaint handling was poor (not upheld).	not upheld	(i) consider reviewing Mrs C's case with a view to identifying any aspects of the communication between consultants and her GP that could be improved; and (ii) consider how NHS Scotland's publication: Can I help you? Learning from comments complaints and suggestions should be taken into account when making decisions on complaint time limits. The Board have accepted the recommendations and will act upon them accordingly.
23/12/2009	200703138	there was: (a) alleged clinical failure during surgery to repair a coarctation of the aorta (not upheld); and (b) poor communication from the Board both before and after surgery (not upheld).	not upheld	The Ombudsman has no recommendations to make.
20/01/2010	200803152	the Board failed to identify that Mrs A had a broken femur, following falls at Stobhill Hospital (the Hospital) in December 2008 and despite concerns about her mobility being raised by her family (upheld).	upheld	(i) remind staff of the need to carry out and record medical assessments in line with policy; (ii) provide him with the results of the audit referred to in paragraph 10; and (iii) consider implementing the Adviser's suggestions in paragraph 18. The Board have accepted the recommendations and will act on them accordingly.
24/03/2010	200802662	(a) there was a delay in referring Miss A for a Magnetic Resonance Imaging scan and, consequently, in diagnosing her spinal infection (upheld); and (b) the provision of anti-coagulant medication to Miss A prevented the possibility of surgical treatment of her spinal infection and a potentially more positive outcome (not upheld).	partially upheld	(i) apologise to Miss A for the delay in diagnosing her spinal infection; (ii) review their process in respect of identifying 'red flag' features in patients and taking relevant action upon identification of these; and (iii) ensure that complaints officers accurately reflect clinicians' feedback in their response to complaints. The Board have accepted the recommendations and will act on them accordingly.
24/03/2010	200901358	(a) the standard of care Mr A received fell beneath the level expected of medical practitioners (upheld); and (b) the Board's responses to the complainant, when Mrs C sought an explanation for Mr A's death, were poor (upheld).	upheld	(i) apologise directly to Mrs C for the serious failings identified in this report; (ii) reflect on the medical lessons to be learned from this case and consider appropriate action; (iii) produce an action plan, to include education and training, to address the equality, diversity and person-centred care failings identified in this report; (iv) apologise to Mrs C and the CAB for the shortcomings identified in this report in their correspondence with them; (v) reflect on their handling and investigation of complaints involving the sudden, unexpected death of a patient; and (vi) reflect on their handling and investigation of complaints where the family has involved an advocacy organisation such as Action Against Medical Accidents. The Board have accepted the recommendations and will act on them accordingly.