HEALTH SERVICE COMMISSIONER

FOR ENGLAND, FOR SCOTLAND AND FOR WALES

ANNUAL REPORT FOR 1995–96

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Health Service Commissioner

FOURTH REPORT FOR SESSION 1995–96

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"The Board of Health may hope little, and perhaps desire little, for the applause of men; but I do much deplore that our anxieties and labours should be thrown away, and we be told that we have done nothing, attempted nothing, imagined nothing, wished nothing..... We have indeed toiled unceasingly, and not as mere officials, but with earnestness and feeling..... As for the staff of the Board, miserably paid as they are, with scanty hopes of preferment, or even of continued employment, I am unable to speak with adequate praise."

September 17th 1849. Diary of Lord Shaftesbury (about a time of cholera in London).

1 INTRODUCTION

1.1 I preface the introduction to my final annual report with the above quotation from one of the public spirited philanthropists of the nineteenth century because some of it is not without relevance to the National Health Service of today. An Ombudsman is at risk of being misunderstood or reinterpreted according to the whim of those who receive or read the reports of the investigations undertaken into complaints. An Ombudsman who has to explain why a complaint is not being investigated is liable to have the anger of the complainant transferred from the organisation which gave rise to the complaint to the Ombudsman's office. An Ombudsman who has to find fault with individual professionals or hospitals or Trusts is subject to being regarded as inimical to the whole enterprise. That is not the case. That is why I pay tribute to what the NHS achieves. The ratio of complaints to episodes of care still remains commendably in its favour.

1.2 My report for 1994-95 was a reflection on the experience of the past five years. This year's introduction is therefore shorter. The high level of complaints received in 1994-95 has been sustained. I have been able to add to my staff numbers with the extra resources made available by the Government. The time taken to screen complaints put to me has been restored to a much more acceptable norm. The time to complete investigations is still too long but steps have been taken to reduce it and I believe they will work by the end of 1996.

1.3 The Health Service Commissioners (Amendment) Act completed its passage through Parliament just before the end of the year on which I report. The discussions which I had undertaken during the summer and autumn of 1995 with representatives of patients, of the health care professions, of the regulatory bodies and of the Health Departments were reflected in a document which I issued in December. References made to it during the proceedings in both Houses of Parliament indicated that it was of use. The Act's provisions came into effect on 1 April 1996 in respect of complaints about events which occurred on or after 1 April 1996. Internal screening and investigations procedures have had to be reviewed, additional accommodation prepared and a start made on recruiting extra staff. I have issued a completely revised public information leaflet, in several languages and also in formats designed to help those who have poor sight or learning difficulties, about the extended role of my Office. I have sent a booklet to all family health service practitioners explaining my responsibilities and how I investigate complaints. Precise figures for extra workload arising from my wider jurisdiction are impossible to predict.

1.4 From June 1995 the scope of my jurisdiction over complaints about maladministration widened. I can consider complaints alleging failure by a NHS body to release information under the NHS Code of Openness. So far that has not been an onerous task, only 15 complaints having been received since June – of which four were accepted by me for formal investigation. I refer to this area in Chapter 5. Later this year I intend to publish a separate report about openness.

1.5 Given the sustained growth in my workload both as Health Service Ombudsman and as Parliamentary Ombudsman, and with the prospect of major change ahead, I have reviewed the extent to which I can be involved personally in considering every case sent to me. My directors are now authorised, on the basis of clearly defined criteria and procedures which guarantee any necessary referral to me, to issue on their own responsibility final reports on the more straightforward cases investigated. Cases falling within that category are essentially those involving no substantial dispute as to the facts, those where the findings and proposed remedy are readily accepted by the NHS body concerned, and cases which show no evidence of systemic fault or novel or contentious features. My deputies and I continue to see all reports. I observe that the whole approach to an investigation might be different if every chief executive took the opportunity, which the majority seize, of sending me their formal comments on the matters set out in the summary of complaint. Indeed, in some cases it might be possible to conclude the matter to the satisfaction of the complainant without the need for any investigation by me.

1.6 Six complainants wrote to me about a particular Trust's failure over several months – in one case 12 months – to send a definitive reply. Intervention, not once but several times, by my screening staff eventually led to the chief executive concerned writing to the complainants. It is greatly to be preferred if matters can be resolved locally. A full investigation into the Trust's complaints handling would take several months and might result in much needed changes to improve local performance, but would not necessarily provide further information about the substance of the complainants' concerns. Another instance involved arrangements for dealing with extra–contractual referrals. Only as a result of my office asking the health authority whether they operated an appeal procedure was the complainant's case reviewed and substantial reimbursement was made to her. My main aim is to secure satisfactory resolution of a complaint and if that can be done without an investigation, so much the better. Such cases should be counted as investigations rather than as rejected cases, which was the practice in the past.

1.7 Parliament allows the Ombudsman absolute discretion in deciding whether to look into any particular complaint. That point was dealt with by Lord Reid in the House of Lords on 18 April 1970 in the case of Fletcher v. Court of Appeal in the words: "It is left to the Commissioner to determine whether he will take up a case or not. That is the construction of the Act." I do not generally decline to take up a case simply because it seems to involve a relatively minor matter, as the issue may be of a very great emotional or practical importance to the individual affected. For the first time I exercised my discretion in 1995–96 by undertaking, on the basis of several individual complaints, a systemic investigation into complaints handling by a particular Trust. I

had reported to the Select Committee in 1995 that I had already looked into some complaints about the Trust's performance, and was still receiving more. It would in my view have been extravagant and wasteful if I had mounted separate investigations into each case. If systemic fault is evident, improvements can be made for the benefit of all the Trust's other complainants. It may also assist other Trusts to review their own methods of work.

1.8 In the past year, significant progress has been made in reducing backlogs of cases, both in screening and investigations. The backlog of cases awaiting screening has been virtually eliminated: at the beginning of the year there were 233 cases awaiting an initial response and by March 1996 that figure had reduced to 71, most of which were received in the last few days of the reporting year. In 1994–95 only 42% of letters received by my screening directorate received a definitive reply within 18 days. In 1995–96 that figure rose to 63%. On the investigation side, 229 reports were issued, compared with last year's record of 166. About half of that increase reflects the work of an additional directorate, but there has been a sustained effort throughout the office to conclude investigations more quickly, without sacrificing quality. Particular attention was paid to cases which had been with the office for a long time and that has pushed up the average time taken to 66 weeks. Viewed in isolation, that is unsatisfactory, but the objective is to continue to clear the oldest cases and to reduce to zero by the end of December 1996 the number of cases with the office for more than a year. The average time taken should fall quickly in future years. For the first time for many years, the number of investigations completed has exceeded the number started, and a smaller workload of investigations in progress has been carried forward into 1996–97.

1.9 I have introduced changes to the structure and content of this Annual Report. Chapters 2 and 3 are shorter as the details of most of the cases falling within the main topics selected – or into the category of a 'special case' – have already been published. Chapter 4, though long, contains a short summary of every case completed during the year and indicates the wide variety of matters examined and remedies secured. It also demonstrates that by no means all of the complaints to me are upheld. Chapter 5 is about openness. Chapter 6 contains statistics and an account of how complaints to me are handled. Some complaints are about insensitive attitudes. I welcome the new guidelines on doctors' conduct, issued by the General Medical Council. In addition to my customary reports to Parliament I intend to publish a Special Report containing cases relating to continuing, or long term, care. The Government issued new guidance to NHS authorities on this topic (Department of Health circular HSG(95)8) following my Special Report of February 1994 (HC 197) "Failure to provide long term NHS care for a brain–damaged patient". I continue to receive a significant number of complaints on this subject. The circumstances of each case are different.

1.10 My thanks are due to all those within the NHS and outside it who have co–operated in an investigation by me. They are very much in the majority. I am conscious always that time spent assisting my staff could have been devoted to those currently needing care. Demands are therefore kept to the minimum necessary to conduct a thorough investigation and arrive at findings which are demonstrably fair, although I am sure that bringing a complaint to a just conclusion is an

integral part of delivering a patient–centred service. I am very much indebted to all my staff for their hard work and for their commitment. In particular I pay tribute to Mr Richard Oswald who, after a period of ill health, retired early in 1996 from the post of Deputy Health Service Commissioner.

W K REID
Health Service Commissioner June 1996

2 INVESTIGATION: MAIN TOPICS

(i) Handling Complaints

2.1 The importance of handling complaints effectively was acknowledged when a committee chaired by Professor Wilson, the Vice-Chancellor of Leeds University, was appointed to carry out a review of the complaints systems operating in the NHS. He wrote in the introduction to the report:

> "Responding to complaints well is a positive act. It involves being heard and making good: responding to the dissatisfaction of complainants, and, where necessary, putting right what was wrong."

The outcome has been the introduction on 1 April 1996 in England, Scotland and Wales of a new system for handling of complaints about the NHS.

2.2 The new system emphasises the importance of resolving complaints at an early stage ("local resolution"). Often after issuing reports of my investigations I am told by complainants "If only the hospital/Trust/Board had told me that at the beginning". Dealing with dissatisfied, and sometimes angry, patients and relatives is not easy. Making the new complaints system work will be a challenge for all NHS staff. Those at the receiving end, if trained how to handle complaints, can prevent some expressions of discontent from becoming full-blown complaints which take time to resolve.

2.3 The three cases in this section illustrate areas of complaint handling where errors often occur: ineffective management of the complaint, including poor record keeping; inadequate involvement of senior management; and unsatisfactory written replies.

E.659/94–95: page 122 of HC464

2.4 The Royal Hospitals NHS Trust, London, failed to follow the principles of their own complaints procedure and I criticised the Trust because their management of complaints had not improved, despite undertakings which they had given after previous investigations by my office. In June 1994 a man and his wife complained to the Trust about aspects of the care and treatment which he had received from a consultant urologist, about communications between the hospital and his GP, and about delays in outpatient clinics. They received a reply from the Trust's chief nurse. It contained errors and it left out what it should have included. The nurse's letter effectively reproduced what the consultant had himself provided. The customer care unit, which was responsible for the management of complaints, played no active role in investigating the complaint or checking whether the reply was adequate. When the complainants wrote again they were given misleading information about the clinical complaints procedure. They were wrongly told that the consultant's consent was required before it could proceed and that there was a requirement for the complainant to meet the consultant before the Regional Medical Officer would consider the case. The customer care unit with three staff was expected to deal with about 1,200 formal and 1,000 informal complaints each year and I found it difficult to see how it could exercise effective quality control. Poor complaint handling by the Trust was apparent in two other cases my

office investigated during the year. I was told by the Trust that a further review was under way of its procedures for handling complaints, and of the resources required.

E.819/94–95: page 138 of HC464

2.5 A woman complained to the Essex and Herts Health Services that doctors at the Princess Alexandra Hospital in Harlow had failed to treat a problem with her knee. Her complaint, made in November 1992, was acknowledged promptly but in spite of written reminders from the Community Health Council acting on her behalf, and telephone calls from the woman herself, no substantive reply was sent for 19 months. The acting chief executive explained that a doctor concerned had left the hospital and suggested that an investigation at that late stage would not achieve anything. The woman considered that unacceptable and sought a full investigation of her complaint. She then had to wait a further four months before receiving a substantive reply and only after she had referred her complaint to me. I found that there was no central record of complaints. The only way of checking how long a complaint had been outstanding was to go through the business manager's files. There was no effective monitoring by senior staff and the chief executive was unaware of the complaint although reminder letters had been addressed to her. Organisational changes had added to previous workload problems: responsibilities had been delegated to Essex and Herts Health Services as they prepared for NHS Trust status; and they functioned for two years with no effective accountability for certain aspects of their management, although North Essex Health Authority retained statutory responsibility. I criticised senior staff of Essex and Herts Health Services for managerial failings. The Princess Alexandra NHS Trust agreed to ensure that the Trust board monitor complaint handling regularly.

E.1241/94–95: page 185 of HC464

2.6 At the Central Sheffield University Hospitals NHS Trust it was common practice for letters to complainants to be signed by the assistant chief executive using the chief executive's name in order to give the impression that the complainants' right under the Patient's Charter to a reply from the chief executive was being honoured. In the past I have criticised chief executives for allowing letters to be sent to complainants which purported to carry their specific authority but which they had not seen. In this case, I criticised the chief executive and the assistant chief executive. In July 1993 a woman wrote to the chief executive of the Trust to complain about the attitude of a consultant. She was sent a copy of a curt and dismissive letter which the consultant had sent to a business manager at the Trust; and she later received a reply from the chief executive which did not offer a proper apology for the consultant's inappropriate action and did not fully answer the woman's concerns. The chief executive undertook to sign letters to complainants personally in future and agreed to provide the complainant with a full response to her outstanding concerns.

(ii) Language issues

2.7 Failure to communicate is a recurring theme in my Annual Reports. The first case below illustrates the difficulties which can arise when a patient is unable to speak English. Unless attention is paid to helping such patients they may be denied the right to information about their treatment – a right set out in the Patient's Charter.

2.8 Recognition of the need is not sufficient. Effective arrangements are needed to cope with predictable difficulties such as annual or sick leave of staff. The second case shows what can go wrong.

E.990/94–95: page 155 of HC464

2.9 A woman was scheduled to have a gallstone operation in March 1994 at King George Hospital, Ilford which is managed by Redbridge Health Care NHS Trust. The operation was cancelled twice. The woman's son complained to the Trust after the first cancellation about the difficulties it had caused because his mother spoke no English and the family had to arrange to stay with her. He also complained generally about the lack of proper arrangements for communicating with his mother. The hospital had arrangements for interpretation by hospital staff or external interpreters, but staff rarely used them, preferring to rely on the services of the patient's relatives. That was not satisfactory. I concluded that the potential need for interpretation and other help with communication should be considered for all patients with difficulty in communicating in spoken English, and that help should be offered where appropriate without undue reliance on relatives. The staff did not know that operation consent forms were available in languages other than English and so the complainant's mother was asked to sign a form in English. The Trust agreed to remind staff of the availability and use of consent forms in languages other than English and to give guidance to staff on communicating with patients who have difficulty with spoken English.

W.33/94–95

2.10 On 2 May 1993 two sisters wrote in Welsh to Ysbyty Gwynedd to complain about the care their mother had received in the hospital. The business manager promised a substantive reply by 27 August but did not allow time to make proper arrangements for its translation into Welsh. The official translator, who was based at Gwynedd Health Authority, was on holiday. The business manager therefore asked a Welsh speaking member of the hospital staff at short notice to translate the letter. Although the member of staff did his best in the time available, he was not accustomed to translating letters and his translation, which was sent unchecked to the complainants, was inaccurate. Even before my investigation Gwynedd Hospitals NHS Trust, who now manage the hospital, had introduced a new complaints procedure and appointed a qualified translator to be based at the hospital.

(iii) Consent to treatment

2.11 Patients should consent to any treatment proposed for them. When the treatment is a major intervention, such as surgery, such consent should be, and for the most part is, obtained after fully informing the patient and carefully recording the reply. There are occasions, however, when the patient is, or is perceived to be, unable to make the decision about consent. Errors can easily be made when staff are considering what to do in such circumstances. The next two cases arose from occasions where relatives were involved in the process of giving consent. In both cases the system failed. It is ironic that in the second case the complaint was made against a doctor who had acted correctly.

E.1285/94–95

2.12 A complaint about a man's treatment raised issues about the procedures for obtaining consent to surgery involving anaesthesia. The man had a recurrent urological problem and had to be admitted to

hospital regularly. The man's wife believed from what she had been told at another hospital that he should not be given a general anaesthetic. Before his admission in June 1994 to Edgware General Hospital, which is managed by Wellhouse NHS Trust, she told staff that she did not want him to be given a general anaesthetic. After he had undergone surgery she learned that he had been given a general anaesthetic. I found that the man had signed a consent form, but it was not clear whether he had been told the type of anaesthesia proposed. The consultant anaesthetist had not been able to have access to the man's full medical records, and he was not made aware of the concerns of the man's wife until immediately before the operation. The Trust agreed to review their procedures and guidance to staff about obtaining consent to surgery involving anaesthesia, to remind staff to make sure that requests from patients and their relatives were communicated to those directly concerned, and to ensure that patients' records were stored more securely.

E.687/94–95 2.13 A woman who was an inpatient, during February and March 1994, in Hull Royal Infirmary, which is managed by Royal Hull Hospitals NHS Trust, needed an angiograph and surgery to remove gangrenous toes. Her daughter and son-in-law were asked by a consultant to sign a form consenting to the surgery on her behalf. They did so because they thought she was incapable of signing the form and because they wanted the surgery to proceed. They signed two more consent forms for further surgery during the following month. Two weeks later a different consultant refused to carry out another operation because the patient had not signed the consent form herself. He considered that she was sufficiently in control of her faculties to make her own decision. The patient did not give her consent. Her daughter and son-in-law complained to me that if the patient had been incapable of making that decision three times before, the same should have applied on the fourth occasion and they should have been allowed to sign again on her behalf. The national guidance on consent is clear that relatives cannot sign consent forms on behalf of other *adults*. I found that the woman's family had been wrongly led to believe by staff who were unaware of the national guidelines that they could sign on her behalf. Inappropriate forms had been used when gaining consent. I found that staff varied in their understanding about whether the family, in signing the forms, were consenting formally or simply acknowledging that they had no objections. I recommended that the Trust board should urgently review their policy on consent to treatment to make sure that local guidance fully met national requirements; that all staff fully understood their responsibilities in this matter; and that the implementation of this policy was monitored regularly.

(iv) Delay in Accident and Emergency (A and E) Departments

2.14 In January 1995 the Patient's Charter laid down for the first time national standards for waiting times in A and E departments. In due course they were translated into local charter standards. The first case below exposed an area of doubt about the national charter standard which applies to all A and E departments so I brought it to the attention of the Department of Health. The second case demonstrates a systemic problem wherever standards are set: unless performance is recorded and monitored, the standard becomes meaningless.

E.1046/94–95: page 165 of HC464

2.15 A woman was referred by her GP to the A and E department of Mayday University Hospital in December 1993. She waited at least five hours before seeing a doctor and after a decision had been taken to admit her she waited a further two hours before being transferred to a ward. That was unacceptable. She was not assessed under the hospital's system of allocating priorities because she had been referred by her GP and was regarded as an 'accepted' patient. Although the Patient's Charter standard on waiting times for assessment did not apply to accepted patients, her long wait was contrary to the spirit of the Charter. This complaint exposed uncertainty about the application of national charter standards to patients referred to A and E departments by their GPs. Local charter standards existed for the wait before assessment and for the wait for a bed after a decision to admit, but Mayday Healthcare NHS Trust and Croydon Health Authority confirmed that the required local standard had not been set for the wait between assessment and the patient being seen by a doctor. Unfairness could arise where less exacting standards on waiting times (or no standards at all) were applied to seriously ill patients referred by their GP than were applied to less seriously ill patients who went directly to A and E. I drew that matter to the notice of the Department of Health. The Health Authority agreed to develop a local charter standard with the Trust on waiting time after assessment.

E.124/94–95: page 49 of HC464

2.16 A woman was taken by her daughter to the accident and emergency department of Southend Hospital in January 1994, at the insistence of her GP. There she had to wait over four hours to be admitted. She died the following day. Her daughter complained about the delay and other matters. The 'Target Hospital Standards' for Southend Health Care NHS Trust, which manage the hospital, provide that all patients should be seen for initial assessment by a qualified doctor or nurse within five minutes of arrival in the A and E department. The assessment aims to place patients in one of four priority categories and patients should normally be seen by a doctor within time scales determined by their assessed priority. The woman was assessed as priority 2a and should have been seen by a doctor within one hour and admitted to a ward within four hours. The recollection of the patient's family, which they admit was hazy, was that she arrived in the A and E department at about 12.30pm, was seen by a doctor between 1.30 and 2.00pm and was admitted to a ward at 4.00pm – a total wait of around three and a half hours. The woman's medical records were not fully completed by A and E staff. That made it impossible to be certain exactly what happened and when but the patient probably waited in the A and E department for longer than she should have done. As a result of my investigation the Trust agreed to monitor admission times from the A and E department and to remind all staff of the importance of completing admission records adequately.

(v) Supervision of patients at risk

2.17 When patients have mental health problems which affect their ability to care for themselves, the task which nursing staff have of providing care for hospital inpatients is a highly responsible one. The consequences of failure can be very serious. The first of the two cases below shows the importance of providing staff with adequate guidelines for discharging their responsibilities. Such guidance, however

comprehensive, can only be effective if staff first make a full and adequate assessment of patients' needs—a point illustrated in the second case.

E.1002/93–94: page 30 of HC464

2.18 A patient in Orpington Hospital suffered from dementia and had a history of wandering when in hospital. Three days after his admission in November 1992 he went missing from the ward. His body was found some hours later in the hospital grounds. Although he had repeatedly wandered away from the ward earlier that day, he was not adequately supervised. The hospital had no clear guidance on how to deal with patients who wandered, or on what to do when a patient went missing. The searches for the man were incomplete and uncoordinated and I criticised hospital managers accordingly. Bromley Hospitals NHS Trust, which now manage the hospital, agreed to produce more detailed guidance on managing patients who tend to wander; to monitor performance; to review arrangements for patient security; and to draw up instructions on action to be taken when a patient goes missing.

E.517/94–95: on pages 136–147 of HC11

2.19 A woman who had suffered a stroke was transferred to St Charles Hospital. Her daughter complained that despite information she had given to the nurses her mother did not receive appropriate supervision at night. I found that nursing staff paid no attention to the relevant notes from the previous hospital and did not act on the information provided by the patient's daughter. That information made it clear that the patient was likely to become agitated if left alone at night, and that one quiet night was no indicator that problems would not arise in future. It was only after the patient became very disturbed on the third night, and was placed on a mattress on the floor for her own safety that an extra member of staff was employed so that a nurse could sit with her at night. The chief executive said that each patient was individually assessed by nursing staff and, as the woman had not been distressed on the first night after transfer, it had not been appropriate then to allocate an additional nurse to the ward. St Mary's NHS Trust (London) which manage the hospital, agreed to remind staff of their duty to take account of relevant information available about patients' needs, especially medical records and the views of relatives. They would also introduce guidelines on dealing with patients who were very distressed or agitated.

(vi) Private treatment

2.20 In their second report (May 1996 Cm.3270 – I, page 12) the Nolan Committee on Standards in Public Life observe: "It is sometimes thought that privatising or contracting out a service to a private body relieves the sponsoring public authority of responsibility for service provision. It is important to be clear . . . that this is not so . . . Where a citizen receives a service which is paid for wholly or in part by the taxpayer, then the government or local authority must retain appropriate responsibility for safeguarding the interests of both user and taxpayer regardless of the status of the service provider." My jurisdiction as Health Service Commissioner covers the actions of private providers who are caring for patients by arrangement with NHS bodies; and it covers the actions of NHS health authorities and Trusts responsible for giving information to patients about the options open to them, whether or not these include private care. In the next two cases the complaints I investigated arose

because the NHS authority concerned failed to give the patient adequate information about options. In both cases, as a result of my investigation, the patient was reimbursed costs.

E.220/93–94: on pages 15–20 of HC11

2.21 A woman was told in March 1993 by a consultant surgeon that there was an urgent need for her to be examined under general anaesthetic. When she spoke to his secretary, she was told that she might have to wait a year or more for the examination so she asked the consultant to do it privately. The results indicated that she needed surgery. The consultant purported to be able to give no indication of when that could be carried out under the NHS so the woman had the operation done privately. The woman and her husband had received information only from the consultant and his secretary, and I found that they were not given any advice about what they could do if they felt that the waiting times were too long. The Havering Hospitals NHS Trust had not been informed of the woman's concern about waiting times: if they had been, it was possible that she could have been offered admission within a relatively short time as a NHS patient. The Trust could have done more to assess the waiting lists of their consultants. They agreed to issue guidance to their staff on how they should deal with enquiries about waiting times and admission dates; and to reimburse the costs of the woman's examination and surgery.

E.558/93–94: on pages 20–26 of HC11

2.22 A woman needing highly specialised dental treatment for an unusual and distressing condition paid for it as a private patient because she was not made aware that there were NHS options available. She was referred to the Charles Clifford Dental Hospital, Sheffield in March 1992, where she underwent a NHS assessment by a professor of dentistry. The treatment she required could not be provided at the hospital under the NHS so she agreed to have it privately. I found that the position about costs had not been properly explained to the woman and that no consideration was given to the possibility of applying to her home health authority – which later accepted responsibility for her future treatment at a different hospital – for funding as an extra-contractual referral. As she was offered no alternative to private treatment she was denied the opportunity of exploring other possibilities for treatment on the NHS which might have saved her considerable expense. Sheffield Health Authority apologised and agreed to reimburse the woman the cost of her dental treatment.

3 CASES OF SPECIAL INTEREST

3.1 Some cases investigated involve significant issues, which do not fall into a category or illustrate a recurring theme, yet merit wider notice. In this chapter are cases dealing with: discharge of patients from long term care; management of medical records; delay in assessing and providing for a patient's needs; investigation of a complaint about private health care provided; powers of a family health service authority; action by the Family Health Service Appeal Unit; possible breach of confidentiality; and investigation of handling of a complaint which was requested by a health authority.

E.639/94–95 page 106 of HC464

3.2 The circumstances which gave rise to the next case should serve as an object lesson to any health authority or Trust planning the discharge of patients from hospital to long term care elsewhere. The way in which a key decision was taken by Winchester Health Authority fell far short of the standards of accountability which a public body should observe.

3.3 In March 1994 an elderly man suffering from dementia was discharged, with several other elderly patients, from Park Prewett Hospital to a private nursing home. The man's son-in-law complained to me that he had not received a satisfactory explanation for the circumstances surrounding the man's discharge. My investigation, which followed a local independent enquiry, established that the man's discharge and the closure of the ward in which he had been a patient were part of a programme for the phased run down of the hospital's services. An implementation plan for closing the ward was changed by Winchester Health Authority, and the discharge of the patients was brought forward by 21 months. That decision was taken at a meeting of the health authority which was described as 'informal'. That meant that it was not open to the public. I found it undemocratic that a public body should have decided a policy matter of such importance to patients and their families in that way. A little over six weeks after the decision was made the ward was closed. That left little time to make all necessary practical arrangements and for consultation with relatives. North Hampshire, Loddon Community NHS Trust, which manage the hospital, failed to apply official guidance about discharge arrangements and elderly patients were discharged without proper arrangements in place for medical cover. As a result, after he was discharged the man whose family complained to me was not registered with a general practitioner until the day before he died. I also expressed doubt about whether a consultant's acquiescence to the move amounted to the authority necessary for the patient's discharge. In the light of the report of the local independent enquiry action was taken by North and Mid Hampshire Health Authority – which succeeded Winchester Health Authority – and the Trust to provide more satisfactory arrangements for future discharges of patients from long term care.

W.43/94–95

3.4 One case concerned failures in the management of medical records, a theme in my last annual report. A man who attended an outpatient appointment at Neath General Hospital in May 1994 was told that his medical records could not be found. They were still missing at his next appointment a month later. A temporary record should have been created for use at the second appointment but was not. The hospital's computer system showed the man's records as having been sent to Neath

General Hospital from Port Talbot Hospital, where the man had previously been treated. My investigator found that there was no trace of the records, or several others said to have been sent at the same time, ever having been received. That suggested that the records were never sent to Neath General Hospital. After a further thorough search at my staff's instigation the records were found at Port Talbot Hospital. It should not have needed the intervention of my office to achieve that. Glan-y-Mor NHS Trust who now manage both hospitals agreed to review the action to be taken when records were not available for outpatient appointments. They also revised medical records department guidance and introduced a new computerised tracking system to record the movement of medical records.

E.1059/94-95

3.5 A woman severely disabled by multiple sclerosis was a patient at Dulwich Hospital, which is managed by King's Healthcare NHS Trust. Twice, in July 1994, she visited a home, where she is now resident, for an assessment of her care needs. Each time she spent several hours in a wheelchair which was unsuitable for her needs. Her head was unsupported and she tended to slip from the correct posture in the chair, especially when distressed. It took considerably longer than the Trust's standard of five working days for the patient's wheelchair needs to be assessed. The Trust said that was because of staff changes and the fact that the assessment request was not classed as urgent. When finally assessed, the patient was found to need a headrest and also other wheelchair accessories to meet her needs. She waited two months for a headrest to be provided because neither the Trust nor the supplier had any in stock. I regarded it as a failure in service that so disabled a patient had no effective care plan to deal with her needs, and that over four months passed before she was provided with a suitable wheelchair. I could not question professional judgment but found that there was a failure by staff to deal with a situation in which common sense should have produced a solution much sooner. The Trust now have headrests for immediate issue.

E.1353/94-95

3.6 Hospital complaints procedures have to comply with statutory directions made by the Secretary of State under the Hospital Complaints Procedure Act 1985. The Act makes no distinction between complaints about NHS care and complaints about care as a private patient in a NHS hospital. I investigated the handling of a woman's complaint about her father's care in the private patients unit of University College Hospital, London in August 1993. Because the initial handling of the woman's complaint was flawed and unsatisfactory, she was left with a misleading impression of the medical cover available to private patients. Despite her repeated requests, the chief executive did not explain fully the medical cover which had been provided for the woman's father and failed to explain that those arrangements had since been revised. No attempt was made to establish why staff had been unable to find her father's personal effects after he died and efforts to trace his missing records were not documented as they should have been. The chief executive acknowledged that the initial reply to the complaint was dilatory and that later letters sent by a general manager could have been more helpful and less defensive. Even longer delays occurred after the chief executive took over the handling of the complaint. University College London Hospitals NHS Trust agreed to: revise guidance to staff on handling

patients' personal property; remind staff of the importance of recording the movement of records and details of searches for missing records; and review the arrangements for monitoring complaints.

E.75/94–95 3.7 One case which I investigated raised issues about the powers of a Family Health Service Authority (FHSA), since April 1996 part of integrated health authorities, to assign a patient to a GP when the patient does not live in the GP's practice area. A man asked to be removed from the list of his GP, and in April 1993 he was assigned by the FHSA to a second GP at the same practice. Later the man asked the FHSA to remove him from the second GP's list and to assign him to another practice, although he did not live within its area. The FHSA told the man that it did not have the power to assign him to a practice if he did not live in the practice area. The FHSA had not assigned the man to the other practice because such an assignment would have led to an appeal against the allocation, which the FHSA would have upheld. The assignment of patients to GPs is dealt with by Regulation 21 of the National Health Service (General Medical Services) Regulations 1992. Under Regulation 21, the FHSA could not assign the man to a new GP unless he had applied to, and been refused by another GP, *and* he was not on the list of any GP. I considered that the FHSA should have told the man they could remove him from the second GP's list, but could not immediately reassign him, so that he could consider his position. The FHSA took no action on the request for removal from the second GP's list, and took three months to tell the man so. I criticised them for not telling the man he was still registered with the second GP. I doubted that the Regulations did preclude the FHSA from assigning a patient to a doctor whose practice area did not include the patient's area of residence. In my view the FHSA *could* have assigned the man to the other practice, *if* he had been refused registration, *and* was not on any GP's list. I concluded that by considering the possible outcome of an appeal against the allocation of the man, the FHSA had prejudged what would have happened, and placed a limitation on themselves which did not exist under the Regulations. I drew my Report to the attention of the Secretary of State for the Department of Health to consider whether there was a need to clarify the powers of FHSAs under Regulation 21.

E.132/95–96 3.8 In paragraph 3.2 of my Annual Report last year I commented on a case where, because of a legal impasse, a man was prevented from taking further his complaint about a dentist. Another case involving a serious complaint about primary care may never be satisfactorily resolved. In late 1994 a woman complained, through her local Community Health Council, to Manchester Family Health Services Authority (FHSA) about the treatment she had received from her GP for an eye condition. Although the complaint was submitted outside the normal time limit, the FHSA's Medical Service Committee considered that she had shown reasonable cause for the late submission. As the GP would not consent to an investigation, the FHSA applied to the Family Health Services Appeal Unit for a decision which would allow the complaint to be investigated by the Medical Service Committee. That application was refused. The CHC contested the basis on which the Appeal Unit had refused the application. The Family Health Services Appeal Authority – which in April 1995 took over the functions of the Appeal Unit – replied that, although an incorrect assumption had been made, that had not affected the Appeal Unit's decision; and that there was no provision for the Appeal Authority to reconsider the matter. The

Appeal Unit's decision was based on a misunderstanding about why the woman had left her GP's list, and on mistaken assumptions about the woman's condition and about why she was complaining. It was not possible to say whether, but for those misunderstandings, consent to an investigation would have been granted. The Appeal Authority offered evidence, based on legal opinions provided in other cases, that they had no power to reconsider the decision to refuse the FHSA's application once that decision had been taken. It is for the Courts, not me, to determine whether the Appeal Authority were correct in that view. The Appeal Authority later told me that they had received Counsel's opinion that they had no power to reconsider their decision. They agreed, as part of a review of their administrative systems, to consider the circumstances in which it would be helpful to use their powers to make formal enquiries of FHSAs.

E.1115/94–95

3.9 A case which was concluded just after the end of the year covered by this report, raised the question of whether Sunderland Health Authority had breached patient confidentiality in providing information to the Department of Health. A woman wrote in October 1992 to her Member of Parliament about the care she had received in hospital. The Department asked the health authority to provide them with background notes to enable the Minister to reply to the Member. The Minister's reply, which the Member forwarded to the woman, contained a brief reference to the woman's condition while in hospital. I found that the health authority had made the woman aware that they had received a request from the Department for information in connection with her complaint and would be replying. They also made it clear to the Department that the information they were supplying was provided in confidence. In the circumstances I did not uphold the woman's complaint that the health authority had failed in their duty of confidentiality towards her.

G.1/93–94 on pages 165–172 of HC11

3.10 A case involving the handling of a complaint by a District Health Authority was referred to me by the authority, as statute allows. Worcester and District Health Authority had been in protracted correspondence since 1985 with a woman who alleged that she had been deprived of an adequate community nursing service and that errors and omissions in her medical records had not been dealt with. In October 1993 the authority asked me to investigate whether their handling of the woman's complaints since June 1992 had been adequate. I agreed to do so having established that the woman consented and regarded the authority's handling of her complaint as unsatisfactory. In March 1992 the woman's GP had asked for district nursing services, which had been provided some years earlier by the authority, to be reinstated. In June the Authority told the woman that they could offer visits by a continence advisor but made no mention of district nurses. In March 1993 the authority told the woman that a district nursing service could not be offered, but did not explain why. Later in March the woman complained to the authority that there were omissions and inaccuracies in her hospital and GP records and that, although staff in the chief executive's department were aware of that, they had done nothing. On 10 May two non-executive directors of the authority considered papers on the woman's case (which comprised more than 1,000 pages of correspondence, nursing notes and other relevant paperwork) and later the same day produced a two page report on her complaint; making four recommendations for future action. The chairman of the authority made changes to the report, including the deletion of one of the

recommendations and the insertion of a statement that no evidence of maladministration by the chief executive's department had been found, before it was sent to the woman.

3.11 Whether the woman needed nursing support was a matter of professional judgment which is not open to question by me but I found it unsatisfactory that she received no explanation at all about that. The complaints which the woman put to the authority in March 1993 were not properly investigated and I criticised strongly the way in which the authority, and in particular its chairman, had dealt with the non-executive directors' report. I concluded that by 1993 the authority had closed their minds to the possibility that there might be any substance in the woman's representations and that their intention in initiating the non-executive directors' review, and then in inviting my involvement, was essentially to seek justification for the stance they had taken. The authority apologised for the shortcomings I identified and agreed to carry out a new investigation of the woman's complaints, involving the Family Health Services Authority and other agencies as necessary.

4 CASE SUMMARIES AND REMEDIES

4.1 This chapter gives a brief summary of all the complaints – whether or not they were upheld – which I investigated this year. My purpose in doing so is primarily to show what problems can arise in delivering an effective service and therefore the summaries emphasise the shortcomings I have identified and the remedies that were recommended. The summaries are divided under topic headings; where the complaint investigated contained several different aspects the summary is presented to the heading I deem to be most relevant. Cross-references are given under other appropriate headings.

Implementing my recommendations

4.2 Changes to the structure of the NHS continue to occur; the most significant recently being the merging of health authorities and family health service authorities. In each of my investigations I have identified and held a relevant authority responsible for implementing the recommendations I have made. The authority named in the summaries in this chapter is the authority which was responsible for the organisation complained against **at the time of the complaint**. Where this authority has been superseded since the time of the complaint, the name given is that of the successor body.

Financial remedies

4.3 It is unusual for me to recommend financial redress for complainants but I do so where there has been an identifiable loss or cost as a direct result of maladministration. In 1995–96 I made eight such recommendations (E.558/93–94, E.213/94–95, E.264/94–95, E.615/94–95, E.672/94–95, E.685/94–95, W.71/93–94 and W.35/95–96).

Categories of complaint

4.4 The case summaries are grouped under two main headings. Part A relates to the substance of the complaints, sub-divided into topic headings. Part B deals with complaints put to me about the way NHS authorities have handled complaints put to them. The summary uses the following keys to identify where further details of some cases can be found:

(a) – full text of report (but anonymised in respect of the complainant) published in the volume of selected investigations completed April – September 1995, HC11.

(b) – as above but in the volume for October 1995 – March 1996, HC.

(c) – case features in either Chapter 2 or Chapter 3 of this report.

PART A

4.5 The cases summarised in this part relate to the *substance* of the original complaints.

Accident and Emergency (A and E) Department

E.203/93–94: Northamptonshire Health Authority

A man complained that during July 1993 he received inadequate care in the A and E department and should have been admitted to hospital. Staff reminded of the need to consider admitting patients, whether or not their admission is justified on purely clinical grounds. I did not find made out the man's complaints that staff neglected his comfort, and upheld his complaint only in so far as he should have been admitted to a ward. GPs to be sent all necessary information about patients attending the A and E department and patients to be given better written information.

E.851/93–94: East Kent Health Authority *(see also complaint handling) (a)*
I did not uphold part of a complaint that inadequate care was given to a young woman who was brought to hospital in April 1993 suffering from meningitis and who later died. I did not find made out a further part of the complaint – that there was excessive delay in the attendance of the 'crash' team – but I recommended that all relevant staff be reminded of the importance of following agreed procedures for cardiac arrest and emergency calls, and of completing audit records.

E.15/94–95: Northamptonshire Health Authority
A man complained about care provided to his 87-year-old mother who was admitted to Northampton General Hospital several times in November 1993. I upheld, in part, complaints about aspects of the woman's care in the A and E department and about delay before she was admitted. I also upheld, to a limited extent, a complaint about the way the complaint was handled. I recommended that nurses be reminded of the need to record the care given and the reasons for any delays in transfers to wards, and that the time patients wait in the A and E department before admission should continue to be closely audited.

E.124/94–95: Southend Healthcare NHS Trust *(b) and (c)*
I upheld a woman's complaints that in January 1994 her mother waited too long in A and E; that there was confusion over administration of steroids after she was admitted to a ward and that the patient and her family received insufficient medical attention before she died. I believed that a doctor did discuss with the woman his decision about not resuscitating her mother, although she denied it. Staff to be reminded about completing admission records adequately and the need to adhere to procedures about recording and administering drugs. Another reminder given to Trust, following a previous case, about maintaining and recording contact by doctors with patients and relatives.

E.296/94–95: Kingston Hospital NHS Trust, London *(see also complaint handling)*
In April 1994 a man with a suspected heart attack waited on a trolley in an A and E department for six and a quarter hours after being referred to the hospital by his GP. I upheld the complaint. Steps to be taken by Trust to ensure that target waiting times in both national and local charters are met.

E.614/94–95: South Devon Healthcare NHS Trust
I found that, in December 1993, there was an avoidable delay before an elderly woman was transferred to a ward from the A and E admissions department at Torbay Hospital. She was also given little information while she was waiting to be moved. I made no finding on a complaint that there was a delay in ward nurses attending to her. I did not uphold further complaints that resuscitation equipment was missing or that news of the woman's death was given to her son in an insensitive and thoughtless way. I recommended that the Trust consider establishing a local standard for maximum waiting times in A and E admissions; that nurses make proper entries in the records; and that a reminder should be issued to staff on the procedures to be followed when notifying relatives of deaths.

E.730/94–95: West Kent Health Authority
A woman complained that in July 1993 her mother waited in an A and E department for over two hours before being seen by a doctor and given pain

relief. Arrangements for providing surgical cover to the A and E department to be reviewed. A complaint about delay in the x-ray department was not upheld, but a notice in that department was removed because it implied, incorrectly, that patients on stretchers would always be given priority over those who were able to walk.

E.898/94–95: Havering Hospitals NHS Trust, London *(see also complaint handling) (b)*
A complaint that a patient experienced unacceptable delays in the A and E department in January 1994 before receiving attention was not upheld as the allegation was not supported by the clinical records kept.

E.1046/94–95: Mayday Healthcare NHS Trust, Surrey *(b) and (c)*
I found that a patient referred to an A and E department by her GP in December 1993 waited at least an hour and a half before being assessed by a nurse, at least five hours before seeing a doctor and eight hours before being admitted to a ward. The health authority to agree with the Trust a local charter standard for the waiting time after assessment. I invited the Department of Health to consider uncertainties exposed by the investigation about the application of charter standards to patients referred to A and E by GPs. I upheld a complaint that the woman's medical notes were mislaid and some information was omitted from the letter sent when she transferred to a second hospital, but I found no evidence that that delayed her treatment. Staff to be reminded of the importance of filling in transfer forms fully and safeguarding medical records. I did not uphold complaints that, when the woman returned to the first hospital, she was not helped to eat and staff did not notice a drip had become disconnected. I upheld a complaint that insufficient attention was paid to prevent pressure sores developing during her journey by ambulance to a hospice. Trust to remind staff to consider giving advice on that to ambulance staff.

E.58/95–96: United Bristol Healthcare NHS Trust
I did not uphold a complaint that a man had to wait too long before seeing a doctor in an A and E department in October 1994. The patient was seen as soon as necessary in the clinical judgment of the nurses, and within the local charter standard. I upheld a complaint that the patient's GP was unable to obtain details over the telephone to the extent that full details were not given. The Trust to review the implementation of their complaints procedure to make sure that, even when litigation is possible, complaints are dealt with as comprehensively as possible without prejudicing legal proceedings.

A and E discharge

S.41/94–95: Monklands and Bellshill Hospitals NHS Trust, Airdrie *(a)*
I did not uphold a man's complaint that in April 1994 he was offered no assistance to arrange transport when he was discharged from an A and E department at 3.00am. I found that the nurses had offered what help they could, but that the man had insisted that he wanted an ambulance to take him home and had refused to consider alternatives. I criticised his selfish and demanding behaviour.

Ambulance emergency transport

E.895/93–94: Northumbria Ambulance Service NHS Trust
I did not uphold complaints of delay by the ambulance service in responding to a '999' call in February 1993 and lack of urgency in obtaining treatment at the hospital for a patient who had suffered a heart

attack. There was a minor delay when the ambulance became stuck on wet grass, but I found no avoidable delay by the service in dealing with the matter.

Ambulance non-urgent transport

E.910/93–94: South and West Devon Health Authority and Westcounty Ambulance Services NHS Trust

I criticised the health authority for their delay in October 1992 in referring to the ambulance Trust a complaint about a delay in an ambulance arriving to take a man to hospital. This meant that the patient's son did not discover that there might be grounds for a complaint against a GP until it was too late to pursue the matter. I did not uphold a complaint that the ambulance Trust's reply was inadequate but recommended that they keep written records of investigations of complaints.

E.974/93–94: London Ambulance Service (LAS) (South Thames Regional Health Authority) *(see also complaint handling)*

In June 1993 a young woman who had been taken from St George's Hospital, Tooting to the Royal Marsden Hospital for treatment three days after a serious road accident waited on a trolley for more than three and a half hours for an ambulance to take her back to the first hospital, despite follow up calls to LAS. Clear and up-to-date guidance to be provided to all LAS staff about procedures for dealing with outstanding transport requests. The Trusts who administer the hospitals concerned to review their systems for authorising alternative transport. I did not uphold part of the complaint concerning the time taken to travel between the two hospitals.

E.1134/93–94: London Ambulance Service (South Thames Regional Health Authority)

A woman complained that an ambulance crew refused to take her husband to hospital in February 1993. Delay in starting the LAS investigation meant that tape recordings, which might have shed light on what happened, were no longer available. If a reply had not been deferred, pending the outcome of a disciplinary hearing, the complainant might not have resorted to legal action. RHA to monitor complaint handling by the LAS. Senior member of LAS to deal with serious complaints and LAS to review those which are the subject of disciplinary proceedings.

E.8/94–95: Wirral Hospital NHS Trust, The Walton Centre for Neurology and Neurosurgery NHS Trust, Mersey Regional Ambulance Service NHS Trust

A man complained about the distress caused to his elderly mother in February 1993 when she was transferred by ambulance from Arrowe Park Hospital to the Walton Centre. I found the woman's request for a sedative before the journey was not adequately dealt with and a breakdown in communication between the staff of the two hospitals over the booking of the ambulance resulted in her having to endure a longer journey than was necessary and not having a nurse escort. Wirral Hospital NHS Trust to remind staff about advice to patients about medication. The three Trusts to review their procedures for arranging ambulance transport.

E.842/94–95: South Thames Regional Health Authority

I upheld a man's complaint that the handling of his complaint in 1994 by the London Ambulance Service (LAS) was superficial and unsatisfactory. During the course of the LAS's investigation the ambulance's log went missing. I found that the ambulance crew involved had misinterpreted control centre records. I recommended that all staff involved in the handling of complaints

be reminded of the importance of safeguarding the original records. The LAS should also make sure that ambulance crews know how to interpret control centre records.

E.961/94–95: Derbyshire Ambulance Service NHS Trust
In November 1993 an elderly woman suffered an injury to her leg which she said had been caused while she was being transported in an ambulance. I upheld her complaint and recommended that ambulance crews be reminded of the need to record all such incidents, whether or not they witness the events or an injury is found. I strongly criticised the Trust's handling of the complaint, and noted that their complaints procedure did not comply with the Patient's Charter. I recommended immediate action to amend it.

E.1230/94–95: West Kent Health Authority
After a fall, a woman waited nearly four hours for an ambulance to take her from a nursing home in July 1993 to an A and E department. An ambulance had arrived after about two hours but left to deal with an emergency call. The crew were following instructions from ambulance control and it was accepted practice at the time to divert ambulances in that way. That is no longer done and ambulance service staff have been reminded to record all follow-up calls about delays in collecting patients. Apology given.

W.13/94–95: Mid Glamorgan Health Authority
A complaint that on both 27 May and 7 June 1993 an ambulance from Mid Glamorgan Ambulance Service called at 8.30am to take a man to hospital for a 1.00pm appointment was not upheld because the investigation revealed that the appointment times were, in fact, 9.45am and 10.30am. There were failures in the authority's handling of the man's complaint and it was recommended that they review procedures to make sure complaints are investigated thoroughly and that policies for the retention of records are clear to all staff.

E.83/95-96: Salford and Trafford Health Authority and Salford Royal Hospitals NHS Trust
A woman complained that on 17 December 1993 there was an unreasonable delay in arranging the transfer by ambulance of her husband from Hope Hospital Salford to the intensive care unit of another hospital; she complained also about the dilatory and unsatisfactory handling of her complaint by the authority and the Trust (which has managed Hope Hospital since 1 April 1994). I upheld both aspects of the complaint. The Trust to ensure that staff are fully aware of the available ambulance services, and the Trust's board to exercise with greater vigour their responsibility for monitoring complaints.

Appointments, waiting times

E.220/93–94: Havering Hospitals NHS Trust, London *(a) and (c)*
In April 1993 a woman had an examination under anaesthetic, and then surgery, carried out privately. That was because after a consultant told her that the examination was needed urgently his secretary said that she might have to wait over a year; and when told of the need for surgery the consultant said that he could give no assurance about an admission date because he had no NHS beds available. According to the Trust, if the consultant had drawn managers' attention to the situation the woman should have been offered NHS treatment within weeks. The Trust reimbursed the costs of the private treatment and issued guidance to staff on how they should deal with enquiries about waiting times.

E.830/93–94: United Bristol Healthcare NHS Trust
I did not uphold a complaint that in May 1993 a cardiac surgeon gave a woman to understand that she could jump the queue for heart by-pass surgery by paying £10,000. I found that, in reply to a question from the woman, the surgeon quoted the sum she could expect to pay for treatment as a private patient, which the hospital was allowed to do, and which was done at weekends in time not funded by NHS contracts. I was satisfied that the surgeon had not intended acting outside the guidelines for private treatment. I upheld complaints about the way in which the woman's complaint was handled.

E.238/94–95: Salford and Trafford Health Authority and the Salford Royal Hospitals NHS Trust
In August 1993 a man was referred by a rheumatologist to a consultant anaesthetist in the pain management clinic at Hope Hospital, Salford. The referral letter arrived but was then mislaid and no action was taken for over four months. He complained about that delay, the attitude of the consultant anaesthetist in his correspondence with him, and about the handling of his complaints. I upheld the complaints about the mislaid referral letter and the handling of the complaint. I recommended that the Trust consider what steps might be taken to prevent referral letters from going astray and that they remind staff that whenever practicable letters to patients – and particularly to complainants – should be signed.

E.287/94–95: North Thames Regional Health Authority *(a)*
On 14 May 1993 a woman's GP informed her that a recent mammogram showed the early stages of cancer. There was a delay before she was given an appointment on 26 May at Chelsea and Westminster Hospital because of difficulty in obtaining the test results and further delay before her next appointment at Charing Cross Hospital on 20 July. The delays were caused by maladministration. The Trusts now responsible for the two hospitals to remind staff of the need to respond quickly to requests for medical records and to tell junior doctors to notify senior medical staff where this had not been done. There was a delay in finding the woman's medical records and in obtaining comments from a professor. Trust responsible for Chelsea and Westminster hospital to review their handling of complaints within a year and remind medical staff to deal promptly with complaints. Both Trusts to remind staff of the importance of maintaining systems for tracking medical records.

E.304/94–95: Forest Healthcare NHS Trust, Essex
I upheld a complaint that a man waited for an unreasonable length of time for a reversal of his vasectomy. He was placed on a waiting list in February 1989 and waited until February 1994 to be offered the surgery under the NHS – by which time he had paid to have the operation performed privately. I upheld his complaint that he was told that he could not have the surgery as a NHS patient and that the Trust unreasonably refused to reimburse the costs of the man's private operation. The Trust offered to make an ex-gratia payment equivalent to the cost of his operation.

E.328/94–95: St James's University Hospitals NHS Trust, United Leeds Teaching Hospitals NHS Trust
I found that a woman had not been given adequate explanation between mid-1992 and mid-1993 about delay in arranging cardiology tests and that she was misled about how long she then would have to wait for a heart operation. Staff were reminded that complainants were entitled to a full written response.

E.353/94–95: Forest Healthcare NHS Trust, Essex, and Redbridge and Waltham Forest Health Authority

I did not uphold a complaint that in 1993, because a woman was given inaccurate information about when her hip operation might be performed, she was compelled to have it carried out privately and that the health authority's refusal to reimburse the cost was unreasonable. I found that the Trust were not fully complying with Department of Health guidance to provide easily accessible information to patients about waiting times and that the health authority were lax in not monitoring that compliance. Despite that I was satisfied that the woman would have had her operation within the 18 months maximum waiting time. I found no grounds for recommending that the health authority should meet the cost of her private treatment.

E.562/94–95: James Paget Hospital NHS Trust, Norfolk

A man who attended an outpatient clinic in May 1994 was told that he would have to wait for an hour, then that he would have to wait for another hour and a quarter. He cancelled the appointment and complained to the chief executive of the Trust who replied with an apology and a new appointment but no explanation for the delay. I found that the main reason for the delay had been the unexpected absence of a doctor. Trust to remind clinic staff to explain to patients the reasons for waits of more than 30 minutes and to remind complaints staff to answer complaints with appropriate explanations and apologies.

E.679/94–95: West Sussex Health Authority

A man complained that his admission to hospital in October 1993 was cancelled without notice; that his name was then placed unfairly at the bottom of the waiting list; that the health authority refused to fund treatment at a specialised centre for arthritis and that they misled him about the prospect of admission to another hospital. I did not uphold the complaints but the health authority apologised for not keeping the man informed about his position on the waiting list and for failing to monitor his situation.

W.19/94–95: Bro Taf Health Authority *(b)*

In September 1991 a couple were placed on a two-year waiting list for in vitro fertilisation (IVF) treatment. After two years they were told that they might have to wait another two years. The couple complained that the list had been mismanaged. I did not find that to be the case but I criticised the authority for failing to inform patients when it became clear that they would have to wait much longer than had originally been expected.

Communication with patients and relatives

E.50/93–94: Bedfordshire Health Authority and Bedford and Shires Health and Care NHS Trust

I upheld a complaint from the parents of a man with a learning disability that in December 1992 he was transferred to a ward for patients with challenging behaviour without their agreement. I recommended that the Trust issue guidance to staff that care planning should cover all foreseeable contingencies and that carers should be consulted and informed as much as possible. I did not uphold a complaint about the way in which the patient was moved. The parents also complained that the Trust's investigation of their complaints was not independent as they had promised. I did not uphold the complaint as I found that the investigation had been independent in an acceptable sense and that the Trust had not intended to mislead the complainants in describing it as such. I suggested that the Trust should take care to explain their investigation procedures clearly to complainants.

E.868/93–94: North West Lancashire Health Authority *(b)*
The parents of a stillborn baby agreed to a post mortem in February 1993. They complained that due to administrative errors it was not carried out; the mother's post natal appointment was delayed for 12 weeks; only then did she learn that no post mortem had been done; and when the couple complained to the hospital the response was delayed and inadequate. I upheld all three complaints. Trust to review and improve post mortem procedures and issue written instructions.

E.923/93–94: Lincolnshire Health Authority
An elderly woman was discharged from hospital in March 1993 but collapsed 24 hours later. She was re-admitted to another hospital but died three weeks later. I upheld a complaint that the arrangements for her discharge were inadequate because neither her son nor her GP were informed and there was a delay in providing home care. The Trust now responsible for the first hospital undertook to review and improve procedures for discharge planning and informing GPs and relatives. I did not uphold a complaint that explanations about the woman's care and treatment were inaccurate and inadequate. There was a delay in warning the son about his mother's critical condition in her last hours, with the result that he did not arrive at the hospital until after her death, as his work telephone number had not been entered on the admission form. Wording on the admission form to be changed. I upheld a complaint about delays by the health authority in replying to the son's complaint. Complaints procedures to be reviewed to make sure that targets for replies are met.

E.1005/93–94: Guy's and St Thomas' NHS Trust, London
A man complained that St Thomas' Hospital had no record of treatment which his mother had received during part of her stay there in July 1993 and that her family were not informed of the seriousness of her condition when she was discharged. I found failures in record-keeping by junior medical staff but did not uphold the complaint as the patient's medical condition continued to be monitored and no injustice or hardship was caused. Junior medical staff to be reminded about the importance of maintaining records. I found that poor communication with the family about the patient's condition before discharge led to misunderstandings. Staff to check that carers understand advice on discharge and to record information. Communication with the GP and the social services was adequate. The handling of the family's complaint was dilatory and unsatisfactory with clear breaches of the complaints procedure. I noted with approval that the Trust had since improved those procedures.

E.1017/93–94: Bromley Hospitals NHS Trust
I did not uphold a complaint by the parents of an 18 year old woman who had acute lymphoblastic leukaemia that they should have been contacted during the young woman's final hours in March 1993 because that decision rested on the exercise of the nurse's professional judgment. I did uphold the complaints that: there was a twelve hour delay in the provision of blood for transfusion; during the resuscitation there was a delay before an anaesthetist arrived and two sets of defibrillator batteries failed; and the family were inadequately prepared for the young woman's appearance after death. The Trust had taken action on some of the matters complained about. Trust to review procedures for checking resuscitation equipment, issue clear instructions and monitor performance and to remind staff about the need for sensitivity in handling bereavement and the viewing of bodies.

E.20/94–95: Leicester Royal Infirmary NHS Trust
I upheld a man's complaint that a discharge letter dated 10 April 1991 from the infirmary to a GP contained an error which had subsequently been amended only on the infirmary's copy. The Trust handled the man's complaint about the matter in an unsatisfactory manner. Trust to remind medical staff of the need to check letters carefully before they are sent; any subsequent amendments to copies of letters to be clearly initialled and dated and recipients of the original correspondence told of such amendments; staff to be reminded of the need to handle complaints sensitively and in accordance with their complaints procedure, and Trust to make sure that the database of patients' GPs is properly maintained and used.

E.22/94–95: The Cornwall Healthcare NHS Trust
A woman complained about aspects of her grandmother's care while she was a patient in Barncoose Hospital towards the end of 1993; about poor communication; and about the way in which an outbreak of infection had been handled. The hospital produced an action plan but the woman considered it inadequate. I did not uphold the complaint but found there was a need for better information for staff and patients about procedures for handling patients' monies.

E.46/94–95: St Mary's NHS Trust, London *(a)*
In July 1993 the complainant saw a consultant who told her that she had breast cancer and made arrangements for surgery and for further tests. The following day the consultant said that she did not have cancer, but a cyst. Her GP was informed of the initial diagnosis, but not of the revised one. The woman did not receive a definitive reply to her complaint about that. I upheld the complaint that the consultant had not made it clear that the diagnosis was tentative and recommended that greater care be taken in communicating with patients with breast lumps and that discussions with patients should be recorded in the medical records. I upheld complaints about the way in which the diagnosis had been communicated, that the GP was not told of the revised diagnosis, and about the handling of the complaint. Trust to review procedures to make sure clinic letters are typed and medical records retained on file, to reply to the complainant and review implementation of their complaints procedure.

E.56/94–95: Oxfordshire Health Authority
In 1992 a boy was admitted to the Park Hospital for Children, Oxford, for psychiatric treatment. He attended the hospital's school and on discharge went to a mainstream school. Due to his behavioural problems he was suspended from that school and was later accepted at a school for children with special problems. The boy's parents complained, among other matters, that the hospital did not take due account of their advice about his behaviour and failed to provide the two schools with information requested. The weight given to the parents' advice and the treatment provided concerned the exercise of clinical judgment. I did not uphold the other complaints but commented that it would be helpful for guidelines to be prepared on the provision of clinical information to mainstream and special schools. I recommended that Oxfordshire Mental Healthcare NHS Trust, which now manage the hospital, discuss that with the local education authority.

E.140/94–95: Medway Health Authority, Kent
A man whose father was treated in Medway Hospital in July 1993 and then transferred to All Saints' Hospital complained about aspects of the care

provided in both hospitals. I found that nurses should have told the man about a fall that his father suffered in Medway Hospital but I did not uphold his complaints that the fall resulted from lack of supervision and that his father was not able to reach a call bell. I did not find that the complainant suffered any injustice through not being aware of a temporary ward closure in Medway Hospital. In All Saints' Hospital the man removed a soiled towel which had been left in his father's locker. The towel had been used appropriately to mop up a spillage but it should have been laundered and placed in a labelled bag. Trust now responsible for Medway Hospital to remind nurses to carry out actions outstanding from the previous shift. Trust now responsible for All Saints' Hospital to review instructions to nurses on handling and laundering of soiled material.

E.213/94–95: East Norfolk Health Authority *(b)*
A man complained that the hospital which treated his mother-in-law in June 1993 for a fractured collar bone failed to ensure that she and her relatives were properly advised before her discharge about the options for care during her convalescence and the cost of care provided outside the NHS, with the result that his mother-in-law incurred avoidable expenses during her stay in a local authority residential home. I was concerned that the hospital's A and E department had no written discharge procedure and that it had no useful records of what had been discussed and how the placement had been arranged. I upheld the complaint. The health authority and the NHS Trust now responsible for the hospital undertook to agree discharge procedures for the A and E department. The health authority agreed to reimburse the patient's costs for part of her stay at the local authority home.

E.399/94–95: The Bethlem and Maudsley NHS Trust, Kent
A man complained to the hospital in April 1993 that he had not been told at the time of his treatment that it did not have the facilities or expertise to help him with his problem of benzodiazepine dependence. A request for a meeting with his consultant was denied. The consultant subsequently wrote to him requesting clarification of his complaint. I was satisfied that the treatment, advice and help provided to the man was satisfactory. However, I considered that the consultant's refusal to meet him was premature. Trust to remind all staff dealing with complaints of the need to respond promptly, positively and fully.

E.430/94–95: St Helens and Knowsley Hospitals NHS Trust, Merseyside
I did not uphold a woman's complaints that she had been inadequately informed of her husband's condition and that there had been delay in informing her of his death in October 1993. I upheld her complaint that the reply to her complaint about soreness which her husband suffered was insensitive and derogatory. Trust to remind nurses of the importance of making contemporaneous notes, including about non-clinical matters relevant to patient care and of importance to patients and their families. Trust to include guidance in their complaints policy about what is acceptable to be included in replies to complaints.

E.507/94–95: Hillingdon Hospital NHS Trust, London
I upheld a complaint from a woman that on 8 September 1993 she was given inadequate information about how long she would have to wait before being admitted to a ward. The Trust agreed to review their procedures for confirming the availability of beds, and for keeping patients informed of any delays. The woman was also given inadequate information on 9 September

about how long she would have to wait before going to the operating theatre. I did not uphold her complaint that her hygiene needs were inadequately assessed. The handling of her complaint was dilatory after the papers were misfiled by the Trust.

E.574/94–95: Thameside Community Healthcare NHS Trust, Essex
On 29 November 1993 the complainant's son, who has learning difficulties, was accused of rape by an inpatient at South Ockendon Hospital which he attended daily. I did not uphold a complaint that inadequate steps were taken to inform the family of the allegation. Policies on dealing with emergencies and notifying relatives to be clarified and applied. In the circumstances I did not consider that it was excessive for the parents to have to wait for 24 hours after they were informed of the incident and before they could see the consultant responsible for their son's care. I did not uphold a complaint about the Trust's arrangements for counselling the son after the incident but I found that there was confusion about the roles of different staff in responding to the complainant's concerns. Trust to make sure that replies deal with all the issues raised by complainants.

E.579/94–95: Bradford Hospitals NHS Trust
I did not uphold a man's complaint that he was given incorrect and contradictory information about a letter which he believed his locum GP had sent to a consultant in February 1994. There was no firm evidence that the letter was sent. I did not uphold his complaint about the consultant's attitude at an outpatient consultation the following month. However, I criticised the tone of a letter which the consultant sent to him afterwards. I found that the Trust's investigation of the man's complaint lacked thoroughness and that their reply was unsatisfactory. Trust to remind staff to investigate complaints thoroughly and to follow their complaints procedure.

E.637/94–95: Trafford Healthcare NHS Trust, Salford and Trafford Health Authority
I did not uphold a man's complaint that medical staff did not keep him informed about his mother's deteriorating condition after she suffered a stroke in January 1994. Neither could I find any evidence that the Trust's responses to the man's formal complaint were inadequate or designed to frustrate him. I felt there was little more the Trust could have done.

E.659/94–95: The Royal Hospitals NHS Trust, London *(b) and (c)*
There were delays on several occasions when a man attended the urology clinic and the x-ray department at Royal London Hospital for diagnostic tests. In March 1994 he was told he had a malignant tumour. His GP was not aware of the diagnosis when the man saw her a few days later. When the man complained about his treatment, his complaint was poorly handled. The Trust to consider whether the arrangements for informing GPs could be improved; and to review arrangements for outpatient clinics and for handling complaints.

E.665/94–95: Weston Area Health Trust, Avon
A woman complained about aspects of her husband's care between October 1993 and his death in January 1994. I upheld a complaint that the Trust failed to provide a satisfactory explanation for the cancellation of an outpatient appointment and I recommended that explanations be given in cancellation letters. Complaints about the postponement of a bone scan and about lack of hygiene care were not upheld, but staff to be reminded of the importance of recording the nursing care both planned and given. A

complaint about inadequate arrangements for the patient's care after his discharge home was upheld to the extent that no list of medication was given. Staff to record requests for home oxygen in the nursing notes, provide lists of medication to patients on discharge and document fully any discussion about discharge arrangements. I also upheld a complaint about the insensitive return of the property of the woman's late husband. Training in bereavement to be available to all staff who come into contact with bereaved relatives.

E.712/94–95: Pinderfields Hospitals NHS Trust
A woman attended the hospital's A and E department on 7 September 1993 after a fall. X-rays were taken and she was sent home. She was referred to a second hospital on 7 December 1993 because of continued pain, and x-rays then revealed two fractures of her pelvis. I did not uphold her complaints that the Trust were incorrect in saying that her pelvis was x-rayed on 7 September and that at a meeting to discuss her grievance a consultant was insulting to her and suggestions were made that she was confused. I did not uphold a complaint that when she expected to be admitted to hospital on 7 December no one was available to authorise that: radiographers to avoid misleading patients by anticipating medical decisions. I upheld a complaint about arrangements for her discharge from outpatient care to the extent that a discharge letter was not sent. The consultant to be reminded of the importance of sending such letters.

E.751/94–95: The Royal Free Hampstead NHS Trust, London
In February 1994 a woman was transferred to the Royal Free Hospital for investigation of a liver condition. Her daughter complained that she was unable to find someone who would explain her mother's care and treatment, that she was not involved in the discharge arrangements and that after her mother died she was denied the opportunity of a discussion with the consultant. I upheld the complaint that the woman's daughter was not consulted about the discharge arrangements. I also recommended that the Trust remind staff of the importance of documenting significant discussions with relatives.

E.780/94–95: Forest Healthcare NHS Trust, Essex
In October 1993 a nurse at Whipps Cross Hospital did not properly inform a woman that her mother's condition was critical. The medical records were subsequently lost, which adversely affected the way in which the Trust handled the relatives' concerns about their mother's care and treatment. The Trust reminded nursing staff of the need to make full entries in the nursing notes and to provide relatives with clear information, especially when a patient's condition was critical, and of the importance of properly recording and monitoring the movement of records. The Trust agreed to introduce a more structured and managed system to search for missing records.

E.863/94–95: East Surrey Healthcare NHS Trust and East Surrey Health Authority *(see also complaint handling)*
I found that the Trust did not fully appreciate the fears raised by the complainant about damage to her perineum during childbirth in October 1993. There were several missed opportunities to discuss her fears during the antenatal period and her comprehensive birth plan was not read until she went into labour. Trust to ensure that if a birth plan is drawn up, it is discussed before the woman goes into labour. Complaint upheld.

E.868/94–95: Ashford Hospital NHS Trust, Middlesex
A man complained that in July 1994 his father, who was suffering from cancer, was not given adequate information about a diagnostic procedure or about his condition and prognosis but his father did not share those concerns. I upheld the complaint that the consultant failed to carry out an undertaking to refer the father to a surgeon. The Trust was slow in replying to the son's complaint and I criticised the consultant for not ensuring that the patient understood the arrangements. Staff to be reminded to check that patients and carers understand arrangements for treatment and of the importance of meeting targets for replies.

E.990/94–95: Redbridge Health Care NHS Trust, Essex *(b) and (c)*
A man complained on behalf of his mother who was scheduled to have a gallstone operation in March 1994. The patient speaks no English and arrangements were made for the family to stay with her. The operation was cancelled twice, first to make way for an urgent case and secondly so that the consultant could attend a training course. I made no finding on the complaints about the cancellations as decisions on clinical priorities were a matter of clinical judgment and I could not establish whether the consultant was aware of the family's situation when he cancelled the second date. I upheld complaints about the arrangements for communicating with the woman in a language she understood, about the loss of her gallstones and about a dilatory and inadequate reply to her son's complaint. All staff to be reminded that consent forms are available in other languages and the Trust to develop comprehensive guidance for staff on communication with patients who have difficulty with spoken English. The Trust to remind staff to make sure that complainants are aware of the complaints procedure; the Trust Board to satisfy themselves that replies to complaints are signed by the chief executive from April 1996.

E.1064/94–95: Thameside Community Healthcare NHS Trust
The complaint concerned the way in which staff communicated with relatives both before and after a woman's death in June 1994 in the mental health unit at Basildon Hospital. I upheld aspects of the complaint. I recommended that the Trust remind staff of the need to investigate any concerns expressed by relatives and to provide full responses.

E.1089/94–95: Frenchay Healthcare NHS Trust, Avon *(b)*
A woman was admitted to Frenchay Hospital in Bristol in September 1994. Although her husband expressed concerns about her condition to both a doctor and a nurse she was not seen by a doctor until nearly three hours after her admission, when she suffered a fatal heart attack. I upheld the husband's complaint that staff failed to respond to his concerns about his wife's condition. Trust to remind staff of the need to respond fully to concerns expressed by relatives about patients and to record observations and significant communications with relatives. Trust to produce written guidelines to nursing and medical staff on the importance of, and procedure for, calling more senior doctors where necessary.

S.3/94–95: Greater Glasgow Health Board
A woman was put on a waiting list for a temporary colostomy in July 1991 and eventually had her operation in December 1993. I upheld her complaint that from June 1992 she was given conflicting and misleading information about her admission date. Staff reminded of the need to make sure that information given to patients is factually correct.

S.9/94–95: Monklands and Bellshill Hospitals NHS Trust, Airdrie
A woman complained of inordinate delay before the final results of a post mortem examination of her stillborn baby, which was carried out on 19 March 1993, were given to her GP. The pathology department which carried out the examination was part of a different Trust, against which the woman had not complained. However I upheld the complaint to the extent that Bellshill Maternity Hospital made no attempt to expedite the final report and had no procedure for monitoring outstanding post mortem reports. They have since instituted such a procedure.

S.64/94–95: Dundee Teaching Hospitals NHS Trust
A couple complained about the manner of a registrar on three occasions during the woman's pre natal care and that after the birth, on 1 November 1993, they were not given any information about the condition of their baby and were not allowed to see her for several hours. On the evidence available I could not make a finding on two of the complaints relating to the registrar's manner and I did not uphold the complaint about the third occasion. I did not uphold the complaint about lack of information and I found that there did not appear to have been undue delay before the woman saw her daughter.

W.18/94–95: South and East Wales Ambulance NHS Trust and Llandough Hospital NHS Trust
I upheld a complaint about the late arrival of an ambulance called to a woman by her GP on 4 May 1993. The Trust agreed to produce written guidance reminding staff to inform GPs if an agreed target time was unlikely to be met. When the woman reached hospital there was a delay before she was examined by a doctor. That was a matter for the doctor's clinical judgment but I recommended that the Hospital Trust remind staff of the importance of clear communication about clinical matters. I upheld a complaint that the doctor spoke abruptly to the woman's husband but did not uphold a complaint that no explanation was given for an infection warning notice placed on the door of the woman's room.

W.12/95-96: Gwent Community Health NHS Trust
Because of failures in communication, neither a woman's relatives nor her carers were told until November 1994 that x-rays taken in February 1994 had showed the woman to have two fractured ribs. Before the investigation report was issued, the Trust had reminded medical staff of the importance of communicating all relevant information to relatives and carers.

Communication between staff

E.784/93–94: West Yorkshire Health Authority and Leeds Health Authority
A man complained that in February 1993 inadequate arrangements between two hospitals led to a delay in the transfer of his father and the postponement of cardiac bypass surgery. I could make no finding due to poor recollection by staff and the absence of a key witness. However I criticised both hospitals for inadequate documentation. Staff to be reminded of the need to record significant discussions about patient care.

E.233/94–95: Airedale NHS Trust, West Yorkshire *(a)*
An x-ray report that a man probably had lung cancer was filed in November 1992 without having been seen by a doctor. As a result his condition was not discovered until a year later. I found a lack of training and supervision of the ward clerk and inadequate arrangements for monitoring x-ray reports. I

criticised the Trust for delay in replying to the man's complaint. New procedures to be kept under review and staff reminded of the need to respond quickly to complaints.

Community care and treatment

E.931/93–94: Sefton Health Authority

Two brothers with learning disabilities in a health authority nursing home faced a move in February 1993 to another home. Their mother complained that the proposal to move them would be unsettling and detrimental. I found no evidence to support the claim that the proposed move would cause the brothers any distress in the long term or of maladministration in the health authority's planning of the move. I did not uphold the complaint.

E.787/94–95: Oxfordshire Health Authority

A woman complained that the health authority took an unreasonably long time, from May 1993 to December 1994, to decide on the provision of long-term health care for her husband who suffered from Alzheimer's Disease. The woman believed that the NHS should meet all the costs of her husband's nursing home care. The health authority believed that they had a duty to fund the health care element of the support which the man needed and the local authority social services department (SSD) were prepared to meet those costs for which they were liable. However, the woman refused to be financially assessed by the SSD who could not arrange care without the assessment. The health authority accepted they could not force the man to enter a nursing home against his will and clinical advice prevented his discharge home. Care in a community hospital was funded by the health authority until the man died. I found that the health authority acted reasonably in the circumstances.

E.835/94–95: Bradford Community Health NHS Trust

A man complained that community nurses failed to attend to him at agreed times in January 1994. Although I upheld the complaint in the terms put to me, I considered that the Trust had given the man assurances which led him to have unrealistic expectations of the nursing staff. The Trust to ensure that patients are given a realistic explanation of the service they can expect to receive. I did not uphold a further complaint that the man had been accused unjustly of abusing nursing staff and that the Trust's responses had not addressed that issue adequately.

Consent

E.585/94–95: Wellhouse NHS Trust, Middlesex

In November 1993 a woman was advised at Edgware General Hospital to have a hysterectomy. One doctor persuaded her to agree to the removal of her ovaries at the same time, though the consultant had said earlier that that was not necessary. She complained that she was not given sufficient information to enable her to give informed consent to the removal of her ovaries, and that undue pressure was applied to obtain her consent. I did not uphold the complaint but recommended that medical staff be reminded that consent forms should not be amended or altered.

E.1285/94–95: Wellhouse NHS Trust, Middlesex

A woman complained that contrary to her expressed wish, her husband was given a general and not a local anaesthetic in June 1994. She also complained about the way her complaint was handled by the Trust. The choice of a general anaesthetic was made in the exercise of clinical judgment. However, the woman's concerns were not adequately communicated to the anaesthetist, partly because records were not available. Staff to pay closer attention to requests from patients or their

relatives and to ensure that such requests are communicated directly to those concerned. Greater care to be taken to make sure that records are not mislaid; complaint handling procedures to be reviewed, particularly in respect of complaints which are renewed after an initial response.

Discharge arrangements

E.935/93–94: Redbridge and Waltham Forest Health Authority *(a)*
I upheld complaints that in December 1992 a terminally ill patient was inappropriately transferred from one hospital to another, that a delay in the arrival of the ambulance and the journey to the second hospital caused the patient and his wife additional distress, and that inadequate arrangements were made for the transfer. Trust to review discharge and transfer procedures and to make sure staff are aware of their responsibilities in those respects.

E.1162/93–94: The Lewisham Hospital NHS Trust, London
When an elderly patient was discharged from hospital in December 1993 her daughter was concerned to find that her arm was bruised and swollen but the hospital provided no explanation. My investigation did not find one but I criticised the hospital for failing to give proper attention to the injury before the patient was discharged and for failing to tell her daughter, the district nurse or the GP about it. The investigation and reply to the complaint were inadequate. I recommended that the Trust revise their discharge policy and that replies to complainants should be monitored to make sure they adequately addressed all matters raised.

W.24/93–94: North Wales Health Authority
I did not uphold a man's complaint that his elderly mother was discharged to a nursing home in March 1993 without her, or his, informed consent. I found no evidence that the mother, who agreed to the arrangements, was unable to understand what was happening. She did not give power of attorney to her sons until after her move.

W.71/93–94: Pembrokeshire Health Authority and Pembrokeshire NHS Trust *(a)*
I did not uphold a man's complaint that the health authority was obliged to fund nursing home fees for his wife who was discharged from hospital to a private nursing home in April 1992 but I urged the Trust to conclude discussions with the local authority about the provision of continuing care in a nursing home after a patient's discharge from hospital. I criticised the hospital for not having a full discharge policy. The Trust apologised for the shortcomings I found but declined to offer any financial redress.

E.94/94–95: Salford and Trafford Health Authority
In July 1993 an elderly woman living alone was discharged home after treatment for a fractured right foot but the nurse's arrangements for social services to visit her at home were faulty. I upheld the complaint because the people with whom the arrangements were made had a different understanding of what was required. I criticised the A and E department for not having a clear discharge procedure, despite national guidance, and recommended that instructions be drawn up without delay.

E.174/94–95: Birmingham Health Authority
A woman complained that the hospital's discharge arrangements for her late mother were unsatisfactory in that they did not take account of her mother's disabilities and the family's inability to care for her at home. I found serious failings in the discharge procedures which were made in November 1993

and the hospital's working arrangements with the local authority. The Trust which now administers the hospital agreed to set up safeguards to make sure patients were not discharged home without adequate community support. I did not uphold a complaint that the hospital was wrong to inform a hospice to whom the patient was referred that she did not want to be transferred there. The hospital did, however, state incorrectly to the local Community Health Council that the woman had been assessed by the hospice before her discharge from hospital. I noted with approval that they had already apologised for that mistake. Trust to remind nursing staff of the importance of clear recording of information.

E.206/94–95: Oxfordshire Health Authority and Oxford Radcliffe Hospital NHS Trust

The family of a terminally ill man complained after his death that hospital staff had exerted undue pressure on them in January 1994 to consider transferring him to a private nursing home; that the hospital's response to the family's request for counselling was inadequate and that the Trust's replies to the family's complaint were dilatory, superficial and inaccurate. I upheld the complaint about the Trust's handling of their complaint. Trust to remind all senior staff of their obligation to observe the Trust's complaints procedure and ensure that complaints are answered fully and in time.

E.615/94–95: The United Bristol Healthcare NHS Trust and Avon Health Authority

A man complained that in April 1993, when his mother was discharged from the Bristol General Hospital to a private nursing home, hospital staff failed to complete the necessary forms correctly and failed to inform him in writing of the financial consequences. I upheld the complaint about the completion of the forms, but did not uphold the complaint about the failure to inform him of the financial consequences. The Trust and the authority to clarify, with the local social services department, the arrangements for such discharges. I made no finding on a further complaint that the authority should have funded her stay in a nursing home; but I considered that their policy at the time on purchasing continuing care was unreasonable and I invited them to make an *ex-gratia* payment to the man. They declined to do so.

E.672/94–95: North Cheshire Health Authority

A woman complained that she was made to arrange her husband's discharge to a nursing home from hospital in November 1992 without being given adequate advice about the costs of, or alternatives to, that care. She also complained that the health authority should have funded his future care. I upheld the complaint about the lack of advice but made no finding on the matter of funding. An *ex gratia* payment was made to the woman by the authority in recognition of the distress caused by their maladministration.

E.685/94–95: East Kent Health Authority

A woman complained that the arrangements for the discharge of her late mother from the Royal Victoria Hospital, Folkestone in December 1993 did not accord with Department of Health guidance and that she was put under undue pressure to arrange and accept financial responsibility for her mother's placement in a private nursing home. I upheld the complaint about the failure to comply with national guidance and, although it was possible that the outcome – discharge to a nursing home with the costs borne by the complainant's mother – would have been the same if the

discharge arrangements had been satisfactory, I recommended an *ex gratia* payment in recognition of the injustice and distress caused, which the health authority agreed to make.

E.745/94–95: Walsall Hospitals NHS Trust *(b)*
I investigated complaints about failures in discharge arrangements from a GP ward for a patient in November 1993 (resulting in discharge to unsuitable accommodation) and delay in the investigation of the complaint made on behalf of the patient's wife by her MP. I did not uphold the complaint about the discharge arrangements but the Trust to remind all staff in the ward of the importance of completing all relevant records, particularly authorisations for discharge, and to make sure that all GPs using the ward are aware of the operational policy. Confusion about accountability of GPs using the ward caused some delay in handling the complaint and the Trust failed at first to inform all relevant staff about the MP's concern.

E.1006/94–95: Leicester General Hospital NHS Trust
A man complained that in May 1994 his brother was allowed to discharge himself from hospital in his dressing gown while unfit to do so and without his family being contacted or transport being provided. The man complained about the contents of a letter given to his brother by a doctor and alleged that a nurse was callous and uncaring. I did not uphold the complaints about the patient's self-discharge but Trust to introduce a self-discharge policy and guidance note without delay. I made no finding on the complaint about the attitude of the nurse.

E.1121/94–95: Swindon Health Authority and Marlborough NHS Trust
A woman complained that her husband, who suffered from severe amnesia as well as behavioural and communication difficulties, was discharged from hospital in April 1994 to a nursing home still suffering from abdominal pain. Trust to remind staff to ensure that patients' discharges are properly planned and that those who are to take over responsibility for their care are adequately informed and able to meet their needs. Investigation of complaints to be fully documented and movement of records adequately recorded.

E.1265/94–95: Scarborough and North East Yorkshire Healthcare NHS Trust
I upheld a complaint that there was a lack of communication between staff at Scarborough Hospital and the relatives of an 82 year old woman which resulted in appropriate clothing not being available to her when she was discharged in November 1994. I was very critical of the documentary evidence about aspects of the discharge arrangements. I could not make a finding on a complaint that the type of ambulance used to transport the woman home was unsuitable because that involved a matter of clinical judgment. Trust to amend their discharge policy to specify that staff should discuss with patients their clothing needs on discharge and make sure that patients are appropriately attired when they leave the hospital. Full details of discharge arrangements to be recorded in the nursing notes. Trust to remind staff to keep a written record of all ambulance transport requests and of the policy on ordering ambulances for the sole use of a patient.

E.1269/94–95: Bassetlaw Hospital and Community Services NHS Trust
A woman complained that in March 1994, when her mother was an inpatient at Bassetlaw Hospital, hospital staff paid insufficient attention to her dietary

needs and failed to make satisfactory arrangements for her discharge from the hospital. I upheld both aspects of the complaint. Trust to remind all nursing staff of their responsibilities under the Trust's nutritional guidelines; to ensure that suitable arrangements are made for all patients' discharges; and to remind nursing staff of the importance of completing care plans and discharge plans fully and accurately.

E.1309/94–95: Bolton Hospitals NHS Trust
A woman's father was discharged from hospital in September 1994 but she was not told in good time of the discharge and arrangements for his transport and arrival home were inadequate. Staff to be reminded of the need to complete discharge summaries accurately, and Trust to monitor the implementation of new discharge procedures. I was unable to make a finding on a complaint about arrangements for home care services and did not uphold a complaint about the woman's father arriving home wet and in need of a wash.

E.1401/94–95: Royal Cornwall Hospitals NHS Trust
In August 1994 a woman was admitted to hospital suffering from breathlessness and was diagnosed as having a blood clot requiring an operation but was too frail for surgery. Her condition was stabilised and she was discharged. Her husband complained that the discharge arrangements were inadequate and that the investigation of his complaint was unsatisfactory. Communication between the husband, the nurses and the medical staff was very poor, discussions about the discharge were very brief and general and no arrangements were made for support at home until the woman had left the hospital. The Trust introduced measures to improve discharge planning. I found that the investigation of the complaint was largely satisfactory, though I was concerned about a comment in the chief executive's reply about the woman's discharge from hospital.

Equipment

S.128/93–94: Forth Valley Health Board
A woman admitted to a geriatric ward in May 1993 was only occasionally provided with a nurse call bell and I found that, contrary to the beliefs of nurse managers, such equipment had not been routinely issued to patients in the ward for years. When the woman's son complained he received inaccurate and misleading information. Use of the call bell system now being monitored.

E.230/95-96: Central Nottinghamshire Healthcare NHS Trust *(see also complaint handling)*
A woman complained that after Trust staff decided in late 1993 that in order to comply with an EC Directive on manual handling of loads, a hoist was needed to lift her mother, long delays occurred in providing a suitable hoist. The woman and her family had been reluctant to accept a hoist and I upheld the complaint only to the extent that there had been delay in assessing the patient's needs. I did not uphold a complaint that the Trust's handling of the woman's complaint was inadequate. Trust to ensure that complainants are told clearly what to do if they are not satisfied with Trust's replies.

Funding/Expenses/ Charges

E.558/93–94: Sheffield Health Authority *(a) and (c)*
A woman complained that it was not explained to her at a NHS assessment on 15 June 1992 that the dental treatment she was to receive would be on a private basis, nor was she told about alternative available treatment. I found that the position about costs was not properly explained and that no thought

was given to applying to her home health authority for funding as an extra-contractual referral. Sheffield Health Authority agreed to reimburse the treatment costs incurred by the woman.

E.1004/93–94: Moorfields Eye Hospital NHS Trust, London *(a)*
An advice centre complained to me on behalf of a young man about charges by the Trust for the supply and later the repair of his spectacles. I found the original supply charges made in 1992 to have been correct, but the hospital took insufficient steps to find out if a contribution was justified towards the cost of the repair. I criticised both the handling of the complaint, which continued until 1994, and delays due to loss of records. The Trust reviewed the position on repair charges and later refunded the cost. They also agreed to review record-holding and complaint-handling procedures.

E.1082/93–94: Enfield & Haringey Health Authority and Camden and Islington Health Authority
A woman complained about a refusal in December 1993 by the Enfield and Haringey Health Authority to fund her operation as an extra-contractual referral. I found that an initial decision not to fund the operation was flawed because it was not based on sufficient or up-to-date clinical information. I upheld the complaint.

E.118/94–95: Buckinghamshire Health Authority
A man aged 91, who was registered blind, deaf and had difficulty walking, was admitted to hospital after a fall. In February 1993 he was discharged to a nursing home. I did not uphold a complaint by his sister-in-law that he was obliged to pay for continuing care which should have been provided free of charge by the NHS.

E.191/94–95: Haringey Health Care NHS Trust and Enfield & Haringey Health Authority
I upheld a man's complaint that up to October 1993 there had been undue delay in referring him to an independent psychiatrist. I found that his complaint that neither the Trust nor the health authority had responded to his request for reimbursement of the cost of private counselling was justified at the time it was put to me, but that the matter was remedied during my investigation.

E.264/94–95: Worcestershire Health Authority *(a)*
I found that the health authority had failed to provide a service which it was their duty to provide when in 1993 they declined to fund the long term care of a man in his fifties who had had a stroke and needed nursing home care. I also found shortcomings when the man was discharged from hospital. The health authority reconsidered their decision and in 1995 accepted responsibility for funding his care. They also made an *ex-gratia* payment to his wife for costs already incurred; and agreed to monitor the relevant Trust's adherence to agreed discharge guidelines.

W.52/94–95: Dyfed Powys Health Authority
In June 1993, a mentally ill youth was transferred from an inpatient unit to a day patient unit 25 miles from his home but, because of maladministration, arrangements for his travel were not made until 24 August. In the meantime, his family had to provide transport and bear the related cost. I recommended reimbursement. I criticised the authority for inadequate replies to the family's complaint. Staff to be reminded that complainants are entitled to a full reply to the issues they raise.

Failure in care and treatment

E.553/93–94: Wellhouse NHS Trust, London Barnet Healthcare NHS Trust

The family of a psychiatric patient complained that in early 1993 there was a delay in giving her dental treatment after an injury; that staff did not communicate adequately with the family and that inadequate supervision was a factor in circumstances leading to her suicide. I upheld all three complaints. Wellhouse NHS Trust to improve procedures for arranging treatment. Barnet Healthcare NHS Trust have improved procedures for supervising patients. To keep practice under review.

E.759/93–94: Sunderland Health Authority

I upheld a complaint of unacceptable delay before a woman was examined by a doctor after her admission to hospital on 21 June 1993. I did not uphold a complaint that there was undue delay in issuing the certificate of cause of death the next day, although I criticised the fact that it was initially issued unsigned. Junior doctors are now instructed to carry out an assessment of patients within 30 minutes of admission. Nurses to be reminded of the need for care when communicating with relatives about certificates of cause of death.

E.831/93–94: Bradford Hospitals NHS Trust

I found that, as a result of poor communication and poor record keeping, a patient spent ten days in hospital in February 1993 before it was discovered that he required eye drops for glaucoma; there was no evidence that he received the drops even then. I did not uphold other complaints about the care and attention given to the patient except that when his family asked about bringing food from home they were given an unhelpful reply. Procedures for obtaining medical histories to be reviewed; nurses reminded to record significant information from relatives; junior doctors reminded to write and date prescriptions accurately; Trust to make sure that proper procedures were in place for supervising the work of new junior doctors.

E.833/93–94: Bournewood Community & Mental Health Trust

A woman complained that while her husband, who suffered from Alzheimer's disease, was in St Peter's Hospital, Chertsey, in November 1992, he fell after being left unattended in a lavatory; was made to wear incontinence pads unnecessarily; and was treated inconsiderately by being taken to the dining room against his will and having water poured over his head when he was being washed. I did not uphold those complaints and found that staff had made commendable efforts to explain matters when the woman complained to the Trust. However, I criticised a failure to give her a detailed written reply to her specific complaints after a meeting.

E.914/93–94: South Devon Healthcare NHS Trust *(see also complaint handling)*

A man recovering in hospital after an emergency admission in September 1993 developed a bed sore on his lower back. I upheld a complaint that nursing staff allowed the bed sore to develop because they were untrained in the use of a special bed to the extent that that may have been a contributory factor. Trust to implement a regular programme of formal, mandatory training in the use of the special beds. I did not uphold a complaint that nursing staff were dilatory in treating the bed sore.

E.933/93–94: Walsgrave Hospital NHS Trust, Coventry

Two sisters complained about the nursing care their late mother received during the night of 17/18 February 1993. I found that nursing observations

were adequate but that a blood test result had not been recorded in the nursing records. Nurses to be reminded to record the results of significant tests contemporaneously. I found that a nursing record was lost but was assured that the system for storage of records had since been changed. I was satisfied that the Trust replied fully to the sisters' concerns but considered that their final reply was unduly delayed.

E.986/93–94: East London and The City Health Authority
I did not uphold a complaint that an elderly man had received inadequate nursing care in hospital between April and June 1993 and made no finding on a complaint about administration of medication. Staff at the hospital did not take due account of the role of the man's son as his carer but the son's own overt racism contributed to that failure.

E.1002/93–94: Bromley Health Authority and Bromley Hospitals NHS Trust *(b) and (c)*
A woman complained about the circumstances surrounding her husband's death in November 1992 in Orpington Hospital. He had been suffering from dementia; he went missing from the ward and his body was found some hours later in the grounds. I did not uphold a complaint that the hospital failed to move her husband to a psychiatric ward but I found that, although he repeatedly wandered away from the ward on the day in question, he was not adequately supervised. Hospital staff also failed to search the grounds thoroughly. The woman had to wait far too long for a reply to her complaint to the hospital and the reply she eventually received was inadequate. Trust to produce more detailed guidance on managing patients who tend to wander; to monitor implementation of the guidance; to review arrangements for patient security; to draw up instructions on action to be taken when a patient goes missing; to monitor effectiveness of new complaints procedure.

E.1028/93–94: North West Lancashire Health Authority and Blackpool Victoria Hospital NHS Trust
A woman was admitted to hospital in February 1993 with abdominal pain and underwent a laparotomy operation. Her daughter complained that she did not receive adequate medical attention due to inadequate monitoring, poor communication and inadequate medical staffing. A complaint was made under the clinical complaints procedure and the independent professional review made recommendations about clinical practice. The daughter complained that the health authority's handling of the complaint was not sufficiently thorough and that their responses were delayed and contained errors and omissions. I upheld the complaint about the complaint handling. The Trust now managing the hospital to review current complaint handling procedures and practice.

E.1055/93–94: Wirral Hospital NHS Trust
A man complained that his late father developed pressure sores during his stay in the hospital from July to October 1993, as a result of inadequate nursing care. I found that the nursing care had been adequate and did not uphold the complaint. The arrangements for recording the assessment of patient's vulnerability to pressure sores were unsatisfactory in one respect and I invited the Trust to review them.

E.1104/93–94: Wirral Hospital NHS Trust
A woman complained that her elderly husband was left with his legs tied in a wet bed. On another occasion his urine bag was left full of blood and

blood stained sheets were left on the floor. On other occasions a staff nurse was hostile and rude to the woman and a sister made disparaging comments about her in a report. She thought that the Trust's response to her complaint was evasive and ignored two major areas of complaint. I upheld the complaints about restraint, the staff nurse's attitude and the handling of the complaint. Trust to remind staff about guidance on the use of restraint on elderly patients and ensure that complainants receive full written replies in accordance with the Patient's Charter.

S.87/93–94: Lothian Health Board
A hospital inpatient waited for at least eight hours after medical attention was first requested before she was seen by a doctor. Nurses to be reminded of the importance of recording and accurately timing events in their records. Written guidance to be provided to nurses and junior medical staff.

W.21/93–94: Gwent Health Authority and Glan Hafren NHS Trust
I found that a woman's mother was afforded adequate protection when, because of hospital site constraints, she had to be taken to the EEG (electroencephalogram) department by an uncovered outdoor route. I also found that adequate arrangements were made for an outpatient appointment before she was discharged. The woman complained about the number of times her mother was moved within the hospital during her stay in late 1992 but I found that in the main the moves were because of her mother's condition. Inadequate efforts were made to replace a splenic abscess drainage bag which became detached and the woman was denied the opportunity of seeing her mother's consultant. I did not consider that the woman's complaint had been inadequately handled.

E.36/94–95: Horizon NHS Trust, Hertfordshire *(a)*
During the night of 25/26 June 1993 a patient sustained injuries in a ward at Leavesden Hospital, Watford. There was a delay before the patient received medical attention. That delay could have been significantly reduced if there had been more effective communication between the nurse who discovered the injuries and the duty doctor. I criticised Trust staff for not acting in accordance with the hospital's untoward incident procedure. There were two inquiries, the second of which was chaired by the Trust's director of nursing, but I did not see how she could have been perceived as independent. The Trust reminded nursing staff of the importance of accurate communication about a patient's injuries when requesting the attendance of medical staff. The Trust's guidance for on-call doctors was again drawn to the attention of medical staff.

E.53/94–95: Royal Free Hampstead NHS Trust
I upheld a complaint that after the birth of a baby on 7 February 1994 the bed in the post natal ward was not ready for the mother. I upheld complaints that after the birth vitamin K was given to the baby without parental consent and that there was no reference to vitamin K in the discharge form; and I recommended that the Trust review its policy on consent and consider the routine inclusion on the discharge form of information about vitamin K. I did not uphold a complaint that a paediatrician had not examined the baby, but I recommended that the Trust remind paediatricians that the mother must be there when babies are examined. I upheld a complaint that it was unethical for the paediatrician to leave information about the baby with another patient to pass to the mother. I found the level of ward security was inadequate. Trust to consider displaying photographs of relevant staff in post natal wards.

E.79/94–95: Mid-Surrey Health Authority *(a)*
A man complained about the health authority's refusal in mid 1993 to fund his daughter's treatment in a private clinic specialising in the treatment of anorexia nervosa. I found that the decision of a panel which the health authority had set up to consider appeals about such matters were flawed. The health authority agreed to review the decision a second time and to issue clearer guidance to GPs about their policy for extra-contractual referrals.

E.93/94–95: Southampton University Hospitals NHS Trust *(a)*
A woman attended an A and E department after a fall in May 1993, was discharged and admitted to a ward the next day at the request of her GP. Staff in the ward believed that the possibility of a fractured hip had been excluded while the woman was in the A and E department when in fact only her left knee had been x-rayed. It was doubtful whether written information about the clinical investigations carried out in the A and E department was communicated to the woman's GP. The ward doctors relied on the GP's understanding that a fracture had been ruled out, but they did not check that information. Three days later the woman was found to have fractured both femurs. Trust to communicate better with GPs about patients who attend the A and E department and advise doctors to check x-rays taken in the A and E department if patients are re-admitted. I found serious shortcomings in the way the complaint was handled.

E.111/94–95: Mid Cheshire Hospitals NHS Trust
A woman complained that she was told that x-rays of her mother's spine were inconclusive when in fact they showed a fracture. She believed that her mother received inadequate nursing care during her stay in the hospital in Autumn 1993. She considered that information she gave as her mother's carer was not taken into account and that she received inadequate information about her mother's condition, treatment and medication after discharge. I upheld the complaint about information given on discharge finding that the nurses had not followed their procedure and that instructions about morphine provided for pain relief were inadequate. Trust to review their discharge arrangements and issue instructions on procedures to be followed and matters to be recorded.

E.197/94–95: North West Lancashire Health Authority
I did not uphold a woman's complaint that her brother was left unwashed and unshaven during part of a hospital stay in November 1993, or that nurses failed to relieve his anxieties about his condition. I was satisfied that the necessary checks were made before he was discharged but I found that staff should have helped arrange for a taxi to pick him up.

E.218/94–95: Queen's Medical Centre, Nottingham, University Hospital NHS Trust *(b)*
A woman complained about aspects of her mother's care and treatment and, in particular, that she was not attended by a doctor until four days after her admission in September 1993. I upheld that complaint and found serious weaknesses in communications and record keeping. Trust to remind staff of their responsibilities for monitoring patients' anti-coagulant medication. Nursing care plans to be prepared as soon as possible after admission, to be kept under review and to include provision for patients' nutritional needs. Patients' records to be audited regularly and staff to be given guidance about the extent to which they should record care given.

E.265/94–95: Dudley Health Authority *(b)*
I upheld complaints about the lack of care of an elderly woman in June 1993, mainly concerning a fall out of bed, pain control, and the lack of communication between staff and with relatives. I found the handling of the complaint was unsatisfactory. The Trust now responsible to review communication policy and to remind staff about the need for records, particularly accident report forms and drug charts, to be completed accurately. The Trust agreed to make regular maintenance checks of equipment such as cot sides and to review complaints handling procedures.

E.284/94–95: Bradford Hospitals NHS Trust *(b)*
Although I did not uphold a man's complaint that his wife received inadequate assistance from nurses while being rehabilitated in a 'self care' unit in April 1993, I strongly criticised the Trust for their dilatory and inept handling of the man's complaint, which I considered amounted to serious maladministration.

E.307/94–95: West Kent Health Authority
On 30 June 1994 a man was admitted to Medway Hospital after a suspected stroke. He developed a large pressure sore which became infected, and for which he received extensive surgery before his death. I upheld a complaint about his care in a short stay ward where he spent the first three days of his hospital stay and I strongly criticised poor management arrangements and the inadequate nursing care. Staff to be reminded of the importance of the prompt completion of care plans and nursing notes, and regular reviews to be carried out of the use of (and nursing standards in) the assessment unit which replaced the short stay ward.

E.374/94–95: Forest Health NHS Trust
I did not uphold a woman's complaints that in June 1993 her husband received inadequate care in respect of the use of a feeding line; the provision of x-ray machines; and the supply of oxygen while in hospital. I found that staff did explain to the woman and her husband the nature and extent of his illness and treated him accordingly, while taking her wishes into account.

E.504/94–95: East Kent Health Authority and South Kent Hospitals NHS Trust
A man complained that due to lack of care his wife fell in July 1993 and seriously injured her leg while she was an inpatient at the William Harvey Hospital. She was not examined by a doctor for over 24 hours. On 17 August 1993 a pin located in her ankle became dislodged and had to be replaced in the correct position. I upheld only the complaint about the delay before a doctor attended.

E.517/94–95: St Mary's NHS Trust, London *(a) and (c)*
A woman complained about the care of her late mother, admitted to the Trust in April 1994. I found that a suitable diet was not provided and recommended that the Trust remind all staff of the importance of correct nutrition. Staff disregarded information available to them on the woman's nursing needs and I recommended that they be reminded of their duties in that respect. I made no finding on a decision to nurse the patient on a mattress on the floor but recommended that guidelines be introduced on dealing with agitated patients. Evidence suggested that the floor of the cubicle was dirty. The reply from the Trust was inadequate and insensitively inaccurate.

E.592/94–95: St James's and Seacroft University Hospitals NHS Trust, West Yorkshire

A mother complained about the standard of care received by her son between December 1993 and February 1994. I made no findings on complaints of inadequate monitoring of his condition, of a failure to maintain a safe environment, and of the incorrect positioning of a feeding tube, although I criticised the Trust for losing nursing records. Trust to remind staff that decisions on fitting cot sides should be discussed with relatives. I upheld a complaint that a leak in a feeding tube went undiscovered for up to five hours. Trust to remind nurses of the need to check that tubes are functioning correctly.

E.620/94–95: Harrogate Health Care NHS Trust

A man took up a complaint on his mother's behalf, following her death, that because of inadequate care and supervision his father suffered six falls between November 1993 and March 1994. I made no finding on this aspect of the complaint: the decision about how to care for the patient was taken in the exercise of clinical judgment by nurses, and it was not possible to judge whether further falls might have been avoided if care plans had been written earlier. Staff were reminded of the importance of drawing up care plans and recording discussions with relatives about care. I upheld a complaint that there was a delay in telling the man's mother about one fall and the patient's transfer to another hospital.

E.636/94–95: West Kent Health Authority

A family complained that the nursing care received by their elderly mother in Medway Hospital in October 1993 was deficient. I did not uphold a complaint about a fall or that she was later left without care for several hours. I made no finding on a complaint that she was left on a commode in an unsafe position. I upheld a complaint that the patient was without her identity bracelet for up to 20 hours. Doctors to inform nurses immediately if they remove identity bracelets and staff to be reminded to check bracelets when carrying out drug rounds.

E.740/94–95: Huddersfield NHS Trust

I did not uphold complaints that in May 1994 a patient's pressure area and incontinence care were inadequate and that he was washed in excessively hot water. While the patient's intravenous drip had failed intermittently I found no fault on the part of the Trust. I could make no finding on complaints about the attitude of a member of staff and about the Trust's handling of a request by the complainants for information on how to contact me.

E.761/94–95: Dudley Group of Hospitals NHS Trust

A woman had agreed with her consultant before the birth of her second child that the baby would be delivered by caesarian section and that sterilisation would be carried out at the same time. She complained that when her child was born on 5 May 1994 the sterilisation was not undertaken and that the explanation given to her for the failure was unsatisfactory. I upheld both aspects of the complaint. Trust to remind surgeons of the importance of checking clinical records and consent forms and to remind staff to ensure accuracy of operating lists. Safeguard system to be considered.

E.874/94–95: Milton Keynes General NHS Trust
A woman complained about the nursing care her husband received in Milton Keynes General Hospital in June 1994. I did not find evidence of any failure in care in his being sat out of bed, or in the management of his incontinence, both of which were a matter of professional judgment. Due to a conflict of evidence I could make no finding as to whether nurses had ignored requests for him to be returned to bed. I criticised communication failures in the handling of the woman's complaint. Trust to remind staff of the need for accuracy in all communications and to maintain comprehensive and accurate records of communications with complainants.

E.904/94–95: Barnsley District General Hospital NHS Trust *(b)*
A woman complained about the attitude of a consultant radiologist who treated her in 1993. He did not introduce himself, did not explain the procedure he was performing and gave no explanation for the severe pain she experienced during an x-ray. A meeting held to discuss the complaint was managed badly. Trust to ensure that radiologists have access to patients' medical records when carrying out x-rays and that those who attend meetings are given prior notice of matters to be discussed and that complainants are informed of their right to contact me.

E.1025/94–95: United Bristol Healthcare NHS Trust
A woman complained about the nursing care her mother received in Bristol Royal Infirmary in June 1994. I found no failing with regard to the allocation of a named nurse, pressure area or personal hygiene care, provision of a private room or concern about discomfort caused by a leg frame. I made no finding about nurses requiring the mother to use a commode because that was in accord with their professional judgment. I criticised the adequacy of the Trust's response to the woman's complaints. Trust to provide a full response to complainants in the future.

E.1055/94–95: Royal Hospitals NHS Trust, London
A man who had a back condition and diabetes complained that hospital staff told him not to get into bed and that he was not offered any suitable food. There were clinical reasons for wanting the man to sit in a chair, but they were not explained at the time and it was doubtful whether staff knew enough about his back condition. He was not offered a choice of food and a meal was not hot. Staff reminded of the importance of obtaining and recording relevant clinical information, and of arrangements for obtaining meals outside normal mealtimes.

E.1059/94–95: King's Healthcare NHS Trust, London *(c)*
I upheld a complaint from a matron of a home that in July and August 1994 a severely disabled woman made two visits from hospital to the home, where she is now resident, and had to spend several hours in discomfort in a wheelchair which was unsuitable for her needs. She tended to slip from the correct posture in her wheelchair especially when distressed and waited over four months for a headrest for the wheelchair. I regarded it as a failure in service that there was no effective care plan to deal with that aspect of her needs. The Trust now keep headrests in stock.

E.1109/94–95: Haringey Healthcare NHS Trust, London
A patient's family were concerned about the care given to him during late 1993 because he had fallen out of bed several times, allegedly dislocating his shoulder on at least three occasions. He had also sustained an injury during a visit to the lavatory despite being accompanied by a physiotherapist who

remained outside. Nursing and physiotherapy records showed that the patient was unsteady and needed supervision when moving around but that he was very independent and would not always wait for an escort. Complaint about the falls not upheld as put. Trust to review the level of staffing available for the supervision of elderly patients. I found that the way the injury was sustained meant that the physiotherapist would not necessarily have been able to prevent the accident. Complaint not upheld.

S.31/94–95: Aberdeen Royal Hospitals NHS Trust
I did not uphold a man's complaint that inadequate care and supervision caused his late mother to fall in hospital during the early part of 1993. I considered, however, that the Trust's investigation of the woman's fall and subsequent death was inadequate as they had not made any effort to obtain evidence from the junior doctors attending the woman. The delays in answering the man's complaints were unacceptable and the responses did not provide adequate explanations of all the issues he had raised. Trust to re-examine man's complaints and provide full response.

S.32/94–95: South Ayrshire Hospitals NHS Trust
A man complained that his father was discharged from hospital in November 1993, and again in March 1994, with severe pressure sores which developed because of inadequate care. I found no evidence of inadequate care during the first admission, but I was concerned that the problem had not been properly assessed. I accepted that pressure area care was given during the second admission, but felt that it may have been inadequate. Nurses reminded to adhere to the local detailed standard on pressure area care and Trust to issue guidance on turning patients and stress the importance of proper documentation.

S.34/94–95: Dundee Teaching Hospitals NHS Trust *(b)*
I did no uphold a woman's complaints about the nursing care received by her late father when he was in hospital during 1993 but criticised staff for failing to ensure that the man's allegation that he had been abused by a nurse was documented and investigated. I found that communication with the family was inadequate and I criticised staff for failing to ensure that a wheelchair was available when the man's wife visited the hospital.

S.36/94–95: Angus NHS Trust
A man complained that on 23 March 1994 his father fell because he was not adequately assisted or supervised by nurses and that there was then an unacceptable delay before he was x-rayed. I found that a nurse had judged the man fit enough to walk unaided and unsupervised, a decision taken in the exercise of clinical judgment as was the priority given to the x-ray which placed both beyond my jurisdiction. I found no lack of care.

S.75/94–95: West Lothian NHS Trust
A teenage girl, who was being treated for anorexia nervosa in a residential unit, was arrested for shoplifting in August 1994. Her mother complained that staff had failed to act on information she provided two days earlier about alleged shoplifting by other residents. I did not uphold the complaint as I found that the charge nurse exercised her professional judgment in deciding to allow the girl unsupervised time in the company of another resident and that in reaching that decision she took into account the mother's allegations and balanced any potential risks against the benefits to the girl's programme of preparation for discharge.

W.99/94–95: East Glamorgan NHS Trust

A woman fell in hospital in August 1994 after her family had expressed concerns about her ability to walk with limited support. The extent to which the woman was encouraged to walk and the support given were matters for the nurses' professional judgment but the fact that she was given an incorrectly adjusted walking aid was criticised, as was communication about the family's concerns. Proper consideration was given to a lifting aid suggested by the family after the fall. The Trust agreed to make sure that all staff involved with walking aids were fully aware of and trained in their proper use.

Lifting and mobility of patients

W.14/94–95: Dyfed Powys Health Authority

I did not uphold a man's complaint that physiotherapy provided to his wife while she was in hospital in January 1993 had caused her undue pain. The authority's response to the man's complaint did not deal with all the issues he had raised and procedures for the investigation of clinical complaints were not invoked. The authority agreed to remind staff about the need for a full investigation of complaints and about the special procedure for clinical complaints.

Maternity Care

E.808/93–94: Mid Kent Healthcare NHS Trust

A woman complained about events during the delivery of her fourth baby on 18 April 1993. I upheld a complaint that the records of the delivery were incorrect and recommended that the Trust remind staff of the need for accuracy in record-keeping. I was unable to make findings about her being treated without respect and the information provided to her, in the latter case because the records were inadequate. I criticised the Trust for their poor records and lack of written guidance to staff about explanation or consent to treatment during childbirth and recommended that they should produce guidance. I did not uphold other complaints.

E.1405/94–95: Royal Shrewsbury Hospitals NHS Trust

I did not uphold complaints by a woman that inadequate facilities were provided for the delivery of her baby in October 1994, and that she was moved soon after the birth to a bath in the general area of the ladies' lavatories, which caused unnecessary distress to her and her husband. I found that although the service the parents received undoubtedly fell below their expectations, the staff did the best they could and provided a safe environment at a time of unusually high demand. Trust to monitor the demand for maternity unit facilities to establish whether peaks in demand are so frequent as to show that more delivery rooms are needed.

Nutrition and diet

E.741/94–95: Southend Health Care NHS Trust

I did not uphold a complaint by a woman's two sons that she was not given adequate nutrition and fluid during her stay in hospital in December 1993. I made no finding on their complaint that special arrangements for feeding her were inadequate. A doctor made an insensitive comment about the positioning of the woman's feeding line in the hearing of her sons. Staff to be reminded of the need to be sensitive to the feelings of patients and relatives. I did not uphold complaints about standards of hygiene in the ward or about difficulties identifying and meeting medical staff. Nurses to be reminded that requests to see a doctor should be recorded in the nursing notes.

Nursing and residential homes

W.35/94–95: Morgannwg Health Authority *(b)*

I upheld a man's complaint that the authority had not adequately discharged their responsibilities as the registering authority for a nursing home because I found that, in 1991 and 1992, they had failed to monitor adequately or secure compliance with recommendations made after their inspections. I recommended a review of inspection and monitoring arrangements. I found too that the authority had failed to make available promptly the report of an investigation they had conducted. Because of that the man had incurred additional legal expenditure. I recommended a compensatory *ex gratia* payment.

Primary Care

E.75/94–95: West Sussex Family Health Services Authority (FHSA) – now West Sussex Health Authority *(c)*

A man complained that the FHSA had not assigned him to a new GP after he asked them to do so in January 1994. The FHSA considered that their powers did not enable them to assign the man to the list of a GP whose practice area did not include the patient's area of residence. I questioned that view of their powers. I drew the matter to the attention of the Secretary of State for him to consider whether there was a need to clarify FHSAs' powers of assignment.

Records

E.1108/93–94: Birmingham Health Authority *(a)*

Despite several enquiries, a man had to wait until 9 December 1993 before he was given the results of a scan done on 9 July. At the 9 December appointment his medical records were not available and he had to wait about three hours to be seen. I found that the return of scan results was not monitored and recommended patient referral systems be reviewed. A failure in the appointments system and the loss of the man's records had led to the delay at the 9 December appointment. I found that the Authority had failed to maintain an adequate grip on an important area of patient activity during a period of major change.

E.3/94–95: Herefordshire Health Authority (HA) and West Midlands Regional Health Authority (RHA)

A woman who was considering legal action against Herefordshire Health Authority was told in December 1992 that relevant x-rays were missing and could not be accounted for. The x-rays were shown as being sent from the HA to the RHA's legal department, but were not shown as being received although other notes in the same package were. The RHA's system for receipt and registration of documents had failed. I upheld the complaint. I did not uphold a further complaint that the woman's clinical records recorded, incorrectly, an outpatient appointment on 19 December 1991 for documentary evidence showed that that was not so.

E.260/94–95: Redbridge Health Care NHS Trust *(a)*

A man complained that in April 1994 his mother fell out of bed and no one was present to give her immediate attention. The family were not contacted after the fall and found her bed empty (she was being x-rayed) when they visited the following afternoon. They also complained about the handling of their complaint. I made no finding about the fall but criticised the Trust for failing to maintain adequate records. Trust to remind staff to complete documentation fully and to check standards of documentation periodically. I deplored the lack of effective communication with the family and recommended the introduction of clear guidelines for contacting relatives about accidents. The Trust's investigation of the complaint was cursory. All staff to be made aware of and implement the new complaints procedure.

E.277/94–95: Birmingham Family Health Services Authority (FHSA) – now Birmingham Health Authority

A woman complained that her medical records were lost when she changed GP in 1992. I could not establish for certain whether the records were lost by the GP's practice or the FHSA, or in transit between the two. I upheld the complaint and criticised the FHSA's management and monitoring of records being transferred. I upheld a complaint about the FHSA's handling of the woman's enquiries about the missing records and recommended that they consider setting quality standards in that area.

E.676/94–95: East London and the City Health Authority

A woman's medical records included a letter which, although headed with her correct name, address and date of birth, contained information which clearly related not to her but to another patient: the letter was dated July 1981. She had complained about the matter in 1994 but was dissatisfied with the response. The authority made wrong assumptions about how the error occurred and therefore how it should be put right. The authority to ensure that the woman's records were accurate and that other bodies did not hold the incorrect records.

E.686/94–95: West Lambeth Community Care NHS Trust

A man complained that, when his mother sustained a head injury on 4 September 1993 while she was an inpatient at the South Western Hospital, staff failed to complete an incident report form until some time after the incident, and failed properly to investigate his concerns. I upheld the complaint about the completion of the form, which I found to have been completed carelessly and only partially on the day of the incident. Trust to remind staff of the importance of full and prompt completion. I did not uphold the complaint about the Trust's handling of the complaint.

E.788/94–95: East Surrey Health Authority

A couple complained that in late 1993 staff of the authority breached their duty of confidentiality towards their son by the unauthorised disclosure of information, which they knew to be incorrect, to their GP, the Local Education Authority and the Social Services Department of the Local Authority. I found that disclosure to the GP had been a matter of clinical judgment, on which I could make no finding. I did not uphold the other aspects of the complaint.

E.790/94–95: Mayday Healthcare NHS Trust, London

I upheld a complaint that in 1994 Mayday University Hospital, Thornton Heath, failed to safeguard part of a patient's nursing records. I recommended that the Trust carry out a further urgent search for the records; remind staff that when records went missing there was a need to establish which documents are involved; and complete and introduce as soon as possible their written policy for safeguarding patients' records.

E.925/94–95: The Royal Hospitals NHS Trust, London

In February 1994 a woman asked for her complaint about an incident in April 1993 in St Bartholomew's Hospital, where her 26-year-old son was a patient, to be referred to the regional medical officer (RMO) for him to consider arranging an independent professional review. The Trust delayed making the referral and did not make the nursing records of the incident available to the RMO. Trust to remind staff of their duty to safeguard records,

and to introduce a policy on the action to be taken when records were missing and to ensure that clinical complaints were referred promptly to the RMO.

S.80/94–95: Lanarkshire Health Board and Common Services Agency
I did not uphold a woman's complaint that her x-rays had been mislaid and were confused with those of another patient in 1992, causing her to undergo an unnecessary surgical procedure. I did not find that the investigation of the matter by the Board in 1993 was inadequate or that the handling by the Board and the Central Legal Office (CLO) of what was a potential claim rather than a complaint was significantly or deliberately delayed, although I noted that on occasion correspondence from the woman's solicitor could not be dealt with for some considerable time at the CLO due to pressure of work.

W.43/94–95: Morgannwg Health Authority *(c)*
I upheld a complaint that a man waited several hours before being seen at two outpatient appointments in May and June 1994 because his medical records were missing. The records had remained at another hospital which the man had attended in July 1993 and after a thorough search, the records were found there. Medical records department guidance was revised and a new computerised file tracking system introduced. Trust to review action to be taken when records were not available for clinics.

Staff attitude

E.568/93–94: Mid Kent Healthcare NHS Trust
A man complained that staff present at an outpatient appointment in May 1993 did not introduce themselves and reacted insensitively when he described his symptoms. He also complained that at a later appointment the consultant did not take adequate precautions to prevent blood borne infection when he gave the man an injection while a cut on his finger was bleeding and also that he became abusive. I upheld the first complaint to the extent that the consultant had not introduced his staff, and I recommended that the Trust issue guidance on proper practice. The complainant withdrew the claim that the consultant had been abusive but I found that the consultant's cut may have been bleeding when he gave the injection and he failed to offer counselling on risks of infection. I recommended that the Trust remind all staff of the precautions needed to avoid blood-borne infection and revise their guidance on inoculation injuries to make it clear that it applied to patients as well as staff.

E.383/94–95: Peterborough Hospitals NHS Trust *(b)*
A woman complained that a registrar who saw her mother as an outpatient in November 1993 at a cancer clinic was rude and uncaring and did not explain to her mother about a physical examination. I was satisfied that the registrar had behaved properly and I did not uphold the complaint but I accepted that the consultation had been a distressing experience for the patient. The Trust agreed to consider ways of reducing the risk of similar misunderstandings in the future.

E.423/94–95: Havering Hospitals NHS Trust, Essex
A woman complained about a consultant's attitude while the woman's mother was ill in 1993 and also after her death. I upheld her complaints that he failed to ensure that the patient understood the nature and seriousness of her illness, and that he threatened to sue the complainant for libel. Trust to ensure that communications with patients and their families were unambiguous and recorded properly. I did not uphold complaints that

when the patient was later referred to another hospital, the consultant was uncooperative in that he sent her clinical records to the referring general practitioner; or that he refused to agree to meet the complainant until she had initiated the clinical complaints procedure.

E.593/94–95: Northern and Yorkshire Regional Health Authority (RHA) *(a)*
Although I did not uphold a woman's complaint about the conduct of the assessors during an independent professional review held on 11 March 1994, I found that the RHA had taken no action when the woman complained to them and that there was a difference of opinion between the RHA and the Joint Consultants Committee (JCC) over who should investigate such complaints. The RHA to ask the NHS Executive to seek agreement with the JCC on that issue.

E.1207/94–95: Blackpool Victoria Hospital NHS Trust
A woman complained that between February and June 1994 two consultants who were treating her were abrupt and insensitive. I found no clear evidence to confirm or refute her allegations about the first consultant and made no finding on that aspect of her complaint. The second consultant admitted making the alleged inappropriately-phrased remarks, but had spoken abruptly because of the complainant's reluctance to accept his earlier attempts to explain that nothing was physically wrong with her. The Trust's investigation of her complaint was not sufficiently thorough. Trust to review their procedures so that staff were not asked to investigate complaints about managers to whom they reported.

S.59/94–95: Southern General Hospital NHS Trust, Glasgow
I did not uphold a woman's complaints about the attitude of nursing staff towards her father while he was a patient in the Southern General Hospital in February 1994 and about the attitude of a consultant whom she met to discuss her father's treatment. I found that there was some delay before the administration time of a particular medication was changed to suit the patient and I criticised the way in which a drug prescription sheet had been amended. The Trust reminded junior medical staff of the correct way to do that.

Ward conditions/ accommodation

E.327/94–95: Plymouth Hospitals NHS Trust *(b)*
I did not uphold a woman's complaint about the lack of appropriately segregated bathing and showering facilities on a hospital ward in April 1994, as she was accommodated in a room with her own facilities. I could find no evidence that door locks were broken in the shower room and bathrooms and was satisfied that patients' dignity and privacy could be maintained in the bathrooms if not completely in the shower room. Action to be taken by the Trust, within existing accommodation constraints, about privacy in the shower.

E.356/94–95: Poole Hospital NHS Trust
A man whose wife died in April 1994 shortly after being transferred between wards complained that she was transferred against her – and his own – wishes. Trust to clarify where responsibility lay for authorising transfers and issue instructions to record such decisions in patients' records. Guidance to be given about the use of oxygen when transferring patients and about the circumstances in which patients should have a nurse escort.

E.716/94–95: Mid Kent Healthcare NHS Trust *(see also complaint handling)*
A woman complained that arrangements at an outpatient clinic were unsatisfactory in October 1993 in that there was a lack of privacy and a risk of breach of confidentiality. The Trust have since taken steps to improve conditions but I criticised them for not acting sooner.

PART B These cases focus on the local *handling* of complaints.

Complaint handling

G.1/93–94: Worcester District Health Authority *(a) and (c)*
The health authority asked me in October 1993, after protracted correspondence with a woman, to investigate their handling of her complaints about her medical records and inadequate community nursing. I found that since June 1992 she had received no explanation for the withdrawal of nursing services, and that her complaints had not been properly investigated. I strongly criticised the authority for the way in which they dealt with a report on the case by two non-executive directors, and found that the intention in asking for that review, and then in referring the case to me, had been essentially to provide justification for their actions. The authority to carry out a review of the woman's complaints, involving other agencies as necessary.

E.608/93–94: City and East London Family Health Services Authority (FHSA) – now East London and The City Health Authority
There were several delays between May 1993 and January 1994 in replying to complaints as well as inadequate review procedures for complaints. FHSA had revised their procedures and were to issue clear instructions to staff dealing with complaints. I did not uphold a man's complaint that replies sent to him by the FHSA were unhelpful.

E.825/93–94: Barnet Healthcare NHS Trust *(a)*
An elderly man with Parkinson's Disease was admitted to the hospital for respite care in June 1992. He was left unattended in a ward bathroom, contrary to the nursing care plan; he fell, fractured his spine and died a few days later. His daughter wrote to the Trust asking for an explanation of the circumstances of the fall and complained to me when she had still not received a reply after many months. I found that because the Trust did not have a satisfactory procedure for monitoring complaints referred to their solicitors they took 13 months to reply to the daughter's request. The response did not answer the daughter's questions directly and honestly and offered no apology. Trust to improve arrangements for monitoring complaints and to remind staff that replies should be informative about the reasons for any failure in service and should contain an apology where appropriate.

E.851/93–94: East Kent Health Authority *(see also A and E Department) (a)*
When the father of a young woman who died in hospital complained in June 1993 about the care she had received, the investigation by the hospital was inadequate in that not all the staff involved in the patient's care were interviewed and the response did not address all the points raised by the father. All staff to be reminded to clarify complaints, obtain evidence from all relevant staff and follow established procedures. I upheld a further aspect of the complaint regarding a delayed response, only in respect of the delay in providing the definitive reply.

E.914/93–94: South Devon Healthcare NHS Trust *(see also Failure in care and treatment)*
I did not uphold a complaint that no explanation for ineffective nursing care was given by the Trust in response to a complaint made in January 1994 because I was not persuaded that that was the cause of a man's bed sore. I recommended that staff who handle complaints should be required to keep records of meetings with complainants. I upheld a complaint that the Trust did not give details of the remedial action to be taken.

E.965/93–94: Bromley Hospitals NHS Trust
A woman was dissatisfied with the Trust's reply to her complaint in August 1993 about her hospital treatment. When she sought a meeting with her consultant the hospital refused to allow her to be accompanied by a Community Health Council (CHC) officer. When the woman met the consultant she discovered that he had not contributed to the reply which had been sent to her. I found that the consultant should have been informed about the complaint and provided information for the reply, and recommended that staff be reminded of the importance of recognising and treating complaints as such. I criticised the Trust for not allowing the woman to be accompanied by the CHC officer at the meeting.

E.974/93–94: London Ambulance Service (LAS) (South Thames RHA) *(see also Ambulance non-urgent transport)*
The father of a young woman who waited more than three and a half hours for an ambulance complained to the LAS in July 1993. In the beginning, his complaint was handled adequately but later the handling fell short of the requirements of the LAS complaints procedure. All LAS staff to be reminded to follow correct procedures.

E.1061/93–94: York Health Services NHS Trust
A woman was concerned that the Trust's reply to her complaint, made in November 1993, about being removed from a waiting list did not offer satisfactory explanations and contained allegations about her behaviour which were untrue, unsupported and blackened her character. I found that insufficient detail had been obtained from witnesses and information obtained at second hand had not been checked. I recommended that the Trust respond fully to the issues raised in the complaint and that they remind staff to make sure that complaints were fully investigated and that the person signing the reply was satisfied with its accuracy.

E.1079/93–94: Addenbrooke's NHS Trust, Cambridge *(b)*
A man complained about aspects of his late mother's care and treatment at Addenbrooke's Hospital towards the end of 1993. I found that because of a breakdown in communications she was not assessed by a psychogeriatrician as previously agreed. I did not uphold the man's complaint about his mother's fall from a chair in a ward. I criticised the Trust for dealing with his complaint in a dilatory and unsympathetic way and for failing to answer all the points which he raised. I recommended that the Trust consider revising psychogeriatric referral procedures; that they remind their staff about recording accidents and keeping close relatives informed when patients sustain injuries; and that they remind staff of the need to comply fully with their complaints procedure.

E.1140/93–94: St Mary's NHS Trust, London
A woman complained that the Trust had taken a year to reply to her complaint dated March 1993 about contradictory diagnoses of her son's

illness. The Trust's handling of the complaint was extremely poor, with maladministration evident in more than one part of the organisation and nobody taking responsibility for a prompt reply. The Trust had introduced a new, more comprehensive, complaints procedure and I recommended that the implementation and effectiveness of the new procedure be reviewed after a year.

E.38/94–95: Lincolnshire Health Authority (HA) and Trent Regional Health Authority (RHA) *(a)*

I did not uphold a woman's complaint that the HA dealt with her complaint in a dilatory and unsatisfactory manner or that there were inaccuracies in the general manager's reply sent in July 1993. Staff to be reminded that statements they prepared about complaints were signed and dated. I did not find that the RHA misled her about the procedure for independent professional review of a clinical complaint but found it unacceptable that they did not provide written guidance sooner. I upheld the woman's further complaint that the RHA delayed the review of the case. Complainants to be supplied with a written account of the procedure as early as possible and RHA to issue guidance on handling clinical complaints.

E.49/94–95: Leicestershire Health Authority and Leicester Royal Infirmary NHS Trust

A man who complained in February 1992 about his mother's care did not receive a final reply until over two years later. Replies to be signed only by the chief executive or by an authorised deputy. Better monitoring arrangements recommended. Trust to improve supervision and training of staff responsible for handling complaints. Complaints about clinical judgment to be handled in accordance with official guidance.

E.57/94–95: Sheffield Health Authority (HA) and Central Sheffield University Hospitals NHS Trust

I found that a man was denied a satisfactory answer to a complaint which he made on 30 August 1990 about the care of his late wife because the HA and then the Trust dealt with his concerns in a dilatory and inadequate manner. At the time the HA operated no formal complaints procedure. I also criticised the HA for the loss of the woman's medical records. Trust to liaise with the complainant and seek to answer his complaint in full; remind staff about the Trust's new complaints procedure and monitor its effectiveness; implement a more effective records tracking system; and issue written instructions on handling records.

E.74/94–95: Bradford Hospitals NHS Trust

A man complained to the Trust in February 1993 about his wife's treatment in the Accident and Emergency department of Bradford Royal Infirmary, but he did not get a written reply – which he considered did not provide adequate explanations – until late in March 1994. I fully upheld the complaint of excessive delay by the Trust in replying, but I considered that the explanations provided were adequate.

E.107/94–95: Queen Mary's Sidcup NHS Trust

Receptionists at an outpatient clinic told a consultant that a woman accompanying her mother to the clinic had spoken abusively to them in June 1993. He declined to give the mother another appointment, and she complained to me about this refusal. I found that the consultant's action was

reasonable and did not uphold the complaint. I upheld a complaint that the Trust's reply to her complaint was delayed and unsatisfactory. Trust to review new procedures for monitoring progress in dealing with complaints.

E.158/94–95: East Riding Health Authority (HA)
I found avoidable delay by the HA in dealing with a man's complaint about bruising which his granddaughter had apparently sustained while in the care of their staff in November 1993. However I did not find that their investigation lacked thoroughness. The Trust now responsible for the service to keep their complaints procedure under review and remind staff conducting investigations of the need to report comprehensively.

E.177/94–95: Addenbrooke's NHS Trust, Cambridge
In September 1993 a woman complained to the Trust about the circumstances of her partner's death at Addenbrooke's Hospital in May 1993. She had received no substantive reply by May 1994 when she complained to me about the Trust's failure to respond. Two months later they replied to her complaint but even then did not deal with all her concerns. I upheld the complaint and criticised the Trust for failing to monitor the handling of the complaint and the work of the staff responsible. I also criticised the chief executive for not replying personally to the woman. The Trust have improved their complaints procedure. Trust Board to monitor the new complaints procedure closely.

E.182/94–95: Calderdale Healthcare NHS Trust, West Yorkshire
I upheld aspects of a man's complaint about the Trust's investigation of complaints he made to them about their care of his brother-in-law in the months before his death in August 1993. I criticised the Trust for not having a procedure for dealing with complaints about alleged ill-treatment of patients and for failing to interview one important witness. I found maladministration in the unstructured way the complaint was considered by the Trust. Trust to introduce procedures for dealing with allegations of ill-treatment.

E.193/94–95: East Norfolk Health Authority (HA)
The proprietors of a group of residential nursing homes asked the HA in 1993 how non-prescribable incontinence supplies could be obtained free of charge for their residents, as should have been possible under new national arrangements. Despite numerous reminders and a formal complaint by solicitors acting on their behalf, they had received no substantive response when they complained to me a year later. I found that the HA took too long to answer their enquiries and that there was a complete failure in their procedures for handling complaints. After the complaint was put to me, the HA reimbursed the complainants for the cost of incontinence supplies for their residents. They agreed to keep under review new arrangements for dealing with complaints, and that board members should monitor performance.

E.212/94–95: Pontefract Hospitals NHS Trust
A complaint was sent to the Trust in November 1993. A meeting to discuss it took place on 4 November 1994 and the chief executive wrote to the complainant on 7 November 1994. I upheld the complaint of excessive delay in replying to the complaint and recommended that the Trust ensure that all complaints were dealt with and monitored under the established procedure.

E.221/94–95: London Ambulance Service (LAS) (South Thames Regional Health Authority)
I criticised the LAS for their delayed and unsatisfactory handling of a complaint made in November 1993 about the attitude of their call operators and about an error which resulted in an ambulance being sent to the wrong address. No copy was kept of a tape-recording containing important information. Staff reminded of the need to identify promptly, and to preserve securely, all relevant evidence.

E.296/94–95: Kingston Hospital NHS Trust *(see also A and E Department)*
A woman complained about a delay in admitting her father to a ward after his GP referred him to a hospital A and E department in April 1994 with a suspected heart attack. The Trust sent an inadequate reply to her letter, having failed to consult any of the staff who had attended to the man. The Trust to ensure that all complaints were investigated thoroughly.

E.359/94–95: Camden & Islington Health Authority (HA) and University College London Hospitals NHS Trust
I upheld a complaint against the Trust that in December 1993 a woman was sent copies of her hospital records, which were poorly reproduced, incomplete, partly illegible and lacking in explanation. I also upheld complaints about the way the HA and the Trust responded to the woman's concerns about her care and treatment. The HA's initial reply was almost unintelligible because clinical terms were not explained. There were unacceptable delays by the Trust and they did not identify a serious shortcoming in the handling of the woman's referral from one specialist to another. More care to be taken when sending patients copies of their records; complaints to be dealt with more speedily; clearer replies to be sent to complaints. Trust to remind staff of the procedure for handling tertiary referrals.

E.438/94–95: Leicester Royal Infirmary NHS Trust
I did not uphold a man's complaint about the arrangements for his wife's outpatient appointment in January 1994. I found fault with the Trust's handling of the man's complaint, in particular their delay in explaining how to obtain a second opinion and their failure to respond to his concern about the integrity of their investigation. Trust to remind staff of the need to reply promptly to all complaints, making sure that all aspects of a complaint had been covered, and clarify for staff and patients the procedure for obtaining a second opinion.

E.490/94–95: Dudley Health Authority and Dudley Group of Hospitals NHS Trust
I upheld a complaint made in January 1994 that the Trust's handling of complaints from a patient's family about communication with that family and the nursing care given to the patient was dilatory and unsatisfactory and recommended that the Trust amend their written complaints policy to remove inconsistencies.

E.513/94–95: Hastings and Rother NHS Trust *(b)*
In October 1993 a man wrote to the Trust expressing his concerns about the care and treatment he had received in the hospital's neurology department then complained to me that the Trust had dealt with his concerns inadequately. My investigation found that the Trust's handling of the matter had been seriously hampered by a consultant's dilatory and unhelpful

response to many requests for his comments. I recommended that the Trust remind all medical staff of the need to co-operate fully with the requirements of the local complaints procedure, and that the consultant provide an immediate and comprehensive response to the man's outstanding concerns.

E.564/94–95: West Hertfordshire Health Authority and St Albans and Hemel Hempstead NHS Trust

In May 1993 a patient's daughters complained about the treatment their mother received. They considered the initial reply unsatisfactory and, after further correspondence, a meeting was held in November 1993. A reply to the outstanding concerns was promised but by December 1994 (by which time the Trust were responsible for the hospital) no reply had been received. I fully upheld the complaint about the dilatory and unsatisfactory way in which the complaint was handled. Trust to review the operation of their complaints procedure over the previous twelve months and take urgent steps to address any remaining deficiencies identified. Where complainants are dissatified after receiving a reply, Trust to monitor progress of the resolution of the problem.

E.621/94–95: Central Manchester Healthcare NHS Trust

In October 1994 a man complained about clinical treatment he had received from April to July of that year. The letter of reply to the complainant in December 1994 included an offer of a meeting, which the complainant accepted. In January 1995 he was told that a meeting was not appropriate – there was no apology for that. I upheld the complaint to the extent that the question of the meeting was not properly considered by the Trust either when it was first offered or after a consultant had expressed his concerns about that proposal. Trust to consult staff before offering complainants meetings with them and try to provide the complainant with a more detailed reply to his complaint.

E.639/94–95: North and Mid Hampshire Health Authority (HA) and North Hampshire, Loddon Community NHS Trust *(b) and (c)*

I upheld a complaint that the HA and the Trust had not explained satisfactorily the circumstances in which a man with dementia was discharged to a private nursing home in March 1994 from a hospital where he had been a patient for four years. My investigation, which followed a local independent enquiry, established that an implementation plan for the closure of the hospital was changed only a month after it had been approved by the health and social care bodies concerned. The man's discharge from hospital was brought forward by 21 months. The meeting of the HA at which the change was approved was not open to the public, which I considered totally undemocratic. There were serious failures to apply official guidance about discharge arrangements. The man was not registered with a GP until the day before he died (a little over two weeks after the discharge) and I doubted whether a consultant's acquiescence in the move amounted to the authority needed for the discharge to go ahead. The replies to the complaint made by the man's son-in-law were unsatisfactory in some respects but much action had been taken to improve arrangements for the discharge of patients from long term care.

E.657/94–95: West Kent Health Authority (HA) Dartford and Gravesham NHS Trust *(b)*

I upheld a complaint that the HA and the successor Trust took nearly five months (from January to June 1994) to respond to a complaint made by a woman and her daughter and that when a reply was sent it was

unsatisfactory. I criticised the lack of communication with the complainants during their wait for a reply. The ambitious target times in the complaints procedure were rarely achieved. The reply was incomplete and two opportunities to check it were missed. Staff to be reminded of the importance of responding to complaints comprehensively and sensitively.

E.660/94–95: Harrow and Hillingdon NHS Trust
I was unable to make a finding on a complaint by a woman that in May 1994 her enquiries about breast screening services were not accurately or adequately answered by staff at a clinic managed by the Trust. I upheld her complaint that the response from the Trust was delayed and inadequate. The Trust responded to the complaint instead of sending it to another Trust which employed the relevant staff. Trust to remind staff of their policy on handling complaints involving other Trusts.

E.671/94–95: Central Nottinghamshire Healthcare NHS Trust
I upheld a complaint that the Trust failed to acknowledge impropriety by a consultant who referred the spouse of a patient to a consultant psychiatrist in 1992 without obtaining consent from the spouse and repeatedly refused to apologise.

E.697/94–95: Exeter District Community Health Service NHS Trust
A man complained about being obstructed in an attempt to take up the offer in March 1994 of a meeting with staff of the Trust to discuss his father's death, the delay in arranging the meeting, and the period of notice given, which deprived him of the opportunity to be accompanied by a community health council officer. My investigation found that, while there had been no unreasonable obstruction, a suggestion by the Trust that the man should first follow the clinical complaints procedure was inappropriate. I did not criticise the Trust for the period of notice given, but I criticised a secretary's failure to respond to a telephone message which had been left by the man concerning the arrangements for the meeting.

E.714/94–95: London Ambulance Service (LAS) (South Thames Regional Health Authority (RHA)) *(a)*
In October 1993 a woman complained to LAS about the service they had provided to her late father. Although telephone calls and meetings took place, a definitive reply was delayed pending the outcome of disciplinary proceedings. There was confusion about who should keep her informed about events and she was not told about some important developments. LAS to clarify responsibility for dealing with complaints when disciplinary procedures were involved. RHA to tighten up scrutiny of complaints against LAS.

E.716/94–95: Mid Kent Healthcare NHS Trust *(see also Ward conditions/ accommodation)*
The Trust at first replied promptly to a woman who complained in October 1993 about arrangements at an outpatient clinic. Later they failed to follow the proper procedures for dealing with complaints. Trust to provide as full a reply as possible to complaints and to ensure all complaints are dealt with according to the procedures.

E.743/94–95: Kensington and Chelsea and Westminster Family Health Services Authority (FHSA) now Kensington & Chelsea and Westminster Health Authority
A woman complained that the FHSA did not inform her in March 1992 or

later that she could have asked for her complaint against her GP to be dealt with under the formal complaint procedure. In September 1993 after going through the informal procedure the FHSA rejected her appeal to them to waive their time limits and to look at her complaint under the formal procedure. I found that the FHSA should have informed the woman of all her options when she first made the complaint. That became part of the FHSA's complaints policy.

E.772/94–95: Bromley Hospitals NHS Trust
A woman made oral complaints at three outpatient appointments between August and November 1993 because she believed her medical records were incorrect following an epidural procedure on 22 July. No one told her at the time that the records were correct and she eventually found out in February 1995 that there were no errors. Meantime she made a written complaint on 22 April 1994 about the incorrect records and raised concerns about her treatment since July 1993. There was a delay in answering the complaint, which was complex and covered several directorates, because there was confusion over who was to take the lead in co-ordinating the reply and the relevant directorates were not identified at the start. The final reply did not answer all the points raised and contained an error. Trust to ensure staff are aware of and follow the procedure for informal complaints; to monitor closely the effectiveness of their new complaints procedure; and remind all staff who handled complaints of their responsibilities for ensuring that replies are full and accurate.

E.809/94–95: Two Shires Ambulance NHS Trust
When the wife of a man who apparently sustained injuries during his journey by ambulance to Stoke Mandeville Hospital complained to the Trust in March 1994, the Trust's investigation was ineffectual. Trust to ensure that all complaints are fully investigated and that the details of investigations are recorded. Staff to be reminded to open doors fully and secure them safely before transporting patients through doorways.

E.810/94–95: Darlington Memorial Hospital NHS Trust
A man complained that a consultant was abrupt and rude to his wife at an outpatient appointment in June 1994 and that when he complained about the matter, the chief executive of the Trust acted unreasonably in refusing to allow a meeting with the consultant unless he agreed to the presence of a community health council representative and, when he refused, in declining to consider the complaint further. I did not uphold the first complaint but upheld the second. Trust to review and clarify its policy on inviting third parties to meetings with complainants, paying particular attention to discussion and agreement with the complainant.

E.819/94–95: North Essex Health Authority *(b) and (c)*
I upheld a woman's complaint that there were serious delays between 1992 and 1994 in answering her complaint about her treatment and the attitude of a doctor. I found that organisational problems and changes had added to delays, and that there was no effective complaints monitoring system in place. Board of the Trust now responsible for the hospital to monitor complaints.

E.863/94–95: East Surrey Healthcare NHS Trust and East Surrey Health Authority (HA) *(see also Communication with patients and relatives)*
A woman wrote to the Trust in February 1994 about the care and treatment

she had received. The complaint was investigated by the midwifery manager and the director of midwifery. The authority later held a meeting with the complainant and her husband and wrote to the Trust. I upheld complaints about the handling of the woman's complaint by the Trust and the authority. Trust also failed to tell the complainant about my office. The complainant requested an independent review of her case and, although the Trust had no objection, the authority refused. I did not see how the original investigation by the Trust's director of midwifery could be perceived as independent. However, the HA had other evidence to suggest a further review was not justified. I did not uphold that aspect of the complaint.

E.898/94–95: Havering Hospitals NHS Trust, Essex *(see also A and E Department)*
A consultant, after discussion with a colleague, provided incomplete and misleading information to a woman who raised concerns in February 1994 about the length of time her father spent in the A and E Department and the suddenness of his death. Later both consultants failed to follow the Trust's procedures for dealing with complaints. Trust to remind staff of the importance of following the complaints procedure. The prospect of resolving the complaint was hampered by the loss of the patient's records. The customer relations manager made an error of judgment in deciding that a letter was purely a request for access to medical records and removed the complaint from the complaints records system. A later letter from a health authority was overlooked or ignored by the Trust. The Trust have changed the way the handling of complaints is co-ordinated. Trust to update their written complaints procedure to take account of those changes, and to monitor closely the effectiveness of the new arrangements.

E.899/94–95: Northumberland Mental Health NHS Trust
A detailed investigation of a man's complaint made in December 1993 about the psychotherapy services provided to him was spoiled by a poor reply which failed to address all the issues raised and appeared to be unnecessarily critical and judgmental of his actions. It was also carelessly sent to the wrong address. Trust to make sure that they reply to complaints in accordance with their complaints procedure.

E.1001/94–95: North and Mid Hampshire Health Authority and Winchester and Eastleigh Healthcare NHS Trust
After the death of their daughter, in December 1992, a couple asked in November 1993 to be informed of the time of her death and the Trust's policy on the identification of bodies. I upheld their complaints that the response to their enquiries was dilatory and inadequate, and that they were not given access to, or legible copies of, their daughter's medical records which they requested in May 1994. Trust to remind staff of the importance of observing the rights of individuals under the Patient's Charter, local policies and national guidelines; chief executive to take a personal role in managing and monitoring the system; Trust to make clear who was responsible for dealing with requests for access to health records, and remind staff of the importance of providing explanations where time limits were exceeded.

E.1052/94–95: Newham Healthcare NHS Trust *(b)*
In August 1994 a man complained to the Trust about a misdiagnosis and the length of time it took for the error to come to light. His complaint letter was lost and he died before the Trust's investigation was complete. I upheld a complaint from his daughter about the loss of the letter and the delay in the investigation. She also complained that the radiology department was not

involved in the investigation before a first meeting between the family and the Trust. I upheld that complaint; Trust to review their arrangements for handling complaints.

E.1073/94–95: Rotherham Health Authority and Rotherham General Hospitals NHS Trust
A woman complained that the replies she received to her complaints about the care of her father at Rotherham District General Hospital in November 1992 were delayed and unsatisfactory. I upheld the complaint that the handling was delayed. Trust to ensure that new procedures are effective and that staff are aware of the need to deal promptly with complaints. I criticised the Trust for failing to keep the complainant informed of the progress of their enquiries: Trust to ensure that complainants are kept informed, and that letters carried the chief executive's name only when he had approved them.

E.1109/94–95: Haringey Healthcare NHS Trust
A man complained to the Trust in late 1993 about several aspects of his father's care. The complaint was answered promptly but the son was dissatisfied and had a meeting with Trust staff. There was a delay in writing to him following the meeting and the reply did not cover all the points raised.

E.1206/94–95: South Staffordshire General Hospitals NHS Trust and South Staffordshire Health Authority *(a)*
A woman whose husband died in hospital on 2 January 1993 wrote to the Trust about the care and treatment given during the final hours of his life. Despite an extensive exchange of correspondence lasting over 16 months, the woman remained dissatisfied. Although the Trust tried to address the woman's concerns conscientiously, they gave incorrect information and there were delays in providing copies of nursing and physiotherapy records and in telling the woman about the procedure for clinical complaints. Trust to consider how to improve their policies and procedures.

E.1220/94–95: Hampshire Ambulance Service NHS Trust
A couple complained about delays in replying to their requests for information about events surrounding the death of their daughter in December 1992. They asked for the times of the 999 calls made from their home on the day that she died, and for information about the services provided for their daughter. I upheld the complaint and recommended that the Trust strengthen their complaints procedure so that a full explanation is given where a substantive reply cannot be provided within four weeks.

E.1241/94–95: Central Sheffield University Hospitals NHS Trust *(b) and (c)*
I upheld a complaint that a letter written in July 1994 from a consultant to a business manager, a copy of which was sent to the complainant, was curt and dismissive and that the concerns of the complainant were not fully addressed. Staff to be reminded of the importance of collecting and recording all relevant evidence when investigating complaints and of adhering to the Trust's complaint procedure. I recommended that the Trust provide the complainant with a full reply to her outstanding concerns.

E.1244/94–95: Burnley Healthcare NHS Trust *(b)*
In August 1994 a woman applied under the Access to Health Records Act for access to her late mother's hospital records and complained about her

mother's care and treatment. The records were not released for three months and a meeting was abandoned because, on the inaccurate advice of his medical defence organisation, a consultant refused to meet the woman who was accompanied by a community health council representative, without a representative of his medical defence organisation. Trust to provide better guidance to consultants about their obligations under the Act and to remind staff of the need to communicate with each other about expected attendance at meetings with complainants.

E.1353/94–95: Camden and Islington Health Authority and University College London Hospitals NHS Trust *(c)*
I found delayed and unsatisfactory handling of a woman's complaint in August 1993 about her father's care in the private patients' unit of University College Hospital and about problems locating his personal effects after he died. The investigation was flawed, records were lost, and explanations were lacking. Trust to revise guidance to staff on handling patients' personal property; movement of records and details of searches to be recorded; arrangements for monitoring complaints to be improved.

E.1408/94–95: Queen's Medical Centre, Nottingham, University Hospital NHS Trust, Trent Regional Health Authority (RHA)
A complainant waited five months for a reply because a consultant delayed providing information needed to answer the complaint which was made in June 1993. Trust to ensure that, whenever possible, the consultant replied promptly to requests for such information. I did not uphold a complaint that the regional medical officer unreasonably refused to hold an independent professional review, but I criticised the RHA for mislaying one of the complainant's letters.

E.1421/94–95: South Birmingham Mental Health NHS Trust
An inpatient's family complained that the Trust inadequately investigated an incident in June 1994 (in which their relative was injured) and its aftermath. I upheld the complaint to the extent that the initial investigation did not adequately involve the patient and his family; the first reply did not adequately address one of the concerns raised; and insufficient response was made to additional concerns raised by the family during meetings. Trust to give the family a written reply to their additional concerns, keep records of meetings with complainants and send them a copy of those records (or a letter covering key points) when additional concerns were raised.

E.1525/94–95: Special Health Authority for the National Hospital for Neurology and Neurosurgery
A woman complained that the special health authority had not replied to her complaint made in March 1993 about treatment for her son. I found that a draft response had been prepared within seven weeks for the general manager of the authority to sign, but despite reminders from the complainant, the community health council and an officer of the district health authority the general manager did not reply until eighteen months after the complaint was put. I strongly criticised the general manager's lack of action and recommended that the authority's board ensure prompt attention to complaints and the regular provision of monitoring information.

S.40/94–95: Greater Glasgow Health Board
The Board's handling of a woman's complaint made in May 1993 about the attitude of a consultant was dilatory. Delay arose from a failure to follow existing procedures. I considered that their investigation was inadequate as

not enough effort was made to trace an independent witness at an early stage. Staff dealing with complaints to be reminded of the need to adhere strictly to procedures.

S.42/94–95: Royal Infirmary of Edinburgh NHS Trust
I found that the Trust's reply to a man's complaint about the lack of explanations before surgery in February 1994 and the lack of after-care arrangements following his discharge was inadequate in that it did not answer part of his complaint and was based on incomplete information and an assumption. I considered that the surgeon involved should not have discussed the complaint with the man at an outpatient clinic without prior arrangement. Trust to reply to the man about his after-care arrangements and to remind staff dealing with complaints of the importance of seeking comments from all those involved and the need to distinguish clearly between assumption and fact.

W.33/94–95: North Wales Health Authority *(c)*
Staff at Ysbyty Gwynedd took from 2 May until 28 August 1993 to reply to a complaint put to them in Welsh. The reply, first written in English, was inaccurate and poorly translated into Welsh. There was no proper monitoring of the complaint. The Authority apologised, introduced a new complaints procedure and appointed a qualified translator.

E.20/95-96: North Thames Regional Health Authority (RHA)
A woman's complaint was referred in July 1994 to the RHA for an independent professional review (IPR). The IPR did not take place until nearly a year later and the woman complained that there had been unreasonable delay and obstruction in the arrangements. I upheld the complaint only to the extent that the RHA could have dealt with the matter more efficiently and expeditiously in the early stages.

E.48/95-96: Swindon and Marlborough NHS Trust
A woman whose baby was stillborn complained that the Trust's handling of her complaint, made in October 1994, was unsatisfactory and that the chief executive's replies contained inaccuracies and failed to answer all of her concerns. I found some deficiencies in the handling of the complaint. I considered that the chief executive tried to answer the woman's concerns but certain explanations could have been clearer and more detailed. I was concerned that the Trust did not inform the woman about the clinical complaints procedure or about my role. Trust remind their staff of the need to comply fully with their complaints procedure.

E.230/95-96: Central Nottinghamshire Healthcare NHS Trust and North Nottinghamshire Health Authority *(see also Equipment)*
I upheld a complaint that the authority's handling of a woman's complaint made in November 1993 was unsatisfactory and dilatory. The authority to implement revised complaints procedure and to set up a robust complaints monitoring system.

E.276/95-96: Lewisham Hospital NHS Trust *(b)*
A woman complained in March 1993 about her clinical management relating to the birth of her baby. There were delays in replying to her complaints, and a promise to arrange an internal review of the clinical issues was forgotten. The woman was not told about the option of an independent

professional review of her care. The hospital did not have a written clinical complaints procedure. I upheld the complaint. Trust to prepare guidance for all staff on handling clinical complaints.

See also A and E Department – E.58/95-96; Ambulance non-urgent transport – E.961/94–95; Charges – E.1004/93–94; Communication with patients and relatives – E.56/94–95, E.430/94–95, E.637/94–95, E.990/94–95; Communication between staff – E.233/94–95; Waiting lists – E.328/94–95; Staff attitudes – E.1207/94–95; Records – S.80/94–95

Clinical Complaints Procedure

E.45/94–95: North Thames Regional Health Authority (RHA)
In November 1993 a woman was told that she had a fibroid and needed a hysterectomy but a later histopathology report showed that the diagnosis of a fibroid was wrong. She requested an independent professional review (IPR) but the RHA refused. She complained that the RHA failed to consider her concern that insufficient tests had been carried out to confirm the diagnosis. I did not uphold her complaint. The woman had not initially made that concern clear and even if she had that would not have changed the decision about an IPR.

E.123/94–95: North Thames Regional Health Authority (RHA) *(b)*
A woman complained about a delay in arranging an IPR which, although requested in 1991, was not held until 1993. She also complained of a delay of seven months in reporting the outcome to her, the fairness of a chief executive's written summary of the IPR was then provided, and about responses to correspondence from her by the hospital and the RHA. I upheld the complaint and I asked the RHA to review how complainants should be told the outcome of IPRs.

E.180/94–95: Shropshire Health Authority and West Midlands Regional Health Authority
I found that during 1993 there were unacceptable delays both in arranging an IPR, which a man had requested because of his dissatisfaction about treatment he had received, and in sending the man the assessors' report. Shropshire Health Authority failed to monitor the arrangements. I did not uphold a further complaint that the report had not done justice to the man's concerns, but I found that the man had been inadequately informed about what to expect and I recommended that the Trust produce a leaflet about that.

E.442/94–95: Anglia and Oxford Regional Health Authority
I upheld a woman's complaint that the arrangements for an IPR in 1994 were unsatisfactory. Not all relevant staff were interviewed and the assessors and RHA staff were not properly briefed. RHA to make sure that everyone concerned was fully informed of arrangements for such procedures.

E.527/94–95: South Thames Regional Health Authority
A woman whose complaint was rejected for an IPR in May 1994 complained of maladministration by the RHA's consultant in charge of clinical complaints because the consultant had taken it upon herself to investigate and reply to the complaint and had based her conclusions on inaccurate information. I found that the consultant's handling was unsatisfactory and the RHA agreed to reconsider the woman's request for an IPR.

E.590/94–95: West Midlands Regional Health Authority, South Staffordshire Health Authority, Burton Hospitals NHS Trust
A man complained in February 1993 about the care and treatment given to his late wife in hospital. I found that due to an oversight by an overworked and inexperienced complaints officer the hospital took too long to reply to the complaint. I also found that when the man's complaint subsequently went to an IPR the complaints officer was given inadequate advice and guidance and as a result the IPR took too long to arrange. Trust to review complaints procedure and, with RHA, to ensure staff involved in arranging IPRs are adequately briefed.

E.1462/94–95: Anglia and Oxford Regional Health Authority
When a woman complained about the care her late husband received in early 1993 the authority declined to respond substantively to all her concerns. I upheld the complaint. Staff to be reminded of the importance of courteous, full and prompt replies to complainants, and that replies should include advice on further action complainants may take if they remain dissatisfied. I did not uphold a complaint that the decision to refuse an IPR was not reached in a reasonable manner but recommended that the reasons for such decisions be fully recorded.

Primary care complaints

E.1199/94–95: Wirral Family Health Services Authority (FHSA) – now Wirral Health Authority
A woman's letter of complaint was copied from Wirral Health Authority to the FHSA in March 1994 as it included comments about her former GP. I upheld a complaint that the FHSA did not give the woman any information about complaints procedures but I did not uphold a further complaint that FHSA staff gave her conflicting information about how they had dealt with the matter.

E.132/95-96: Family Health Services Appeal Unit and Family Health Services Appeal Authority *(c)*
A woman complained that because the Appeal Unit were given incorrect information by a Family Health Services Authority (FHSA) to whom she made an out of time complaint about her GP in March 1995, the Unit turned down the FHSA's application for consent to investigate her concerns. She also complained that her subsequent representations to the Appeal Authority (which succeeded the Appeal Unit on 1 April 1995) were not given adequate consideration. I found that the Appeal Unit's decision was flawed but it was doubtful whether the matter could have been re-opened. Appeal Authority to obtain legal advice about that and to review the circumstances in which it would be appropriate for formal powers to be used in preference to informal enquiries such as were made in this case.

5 COMPLAINTS ABOUT ACCESS TO INFORMATION

5.1 In 1993 the Government published a White Paper, 'Open Government' (Cm 2290). The White Paper set out the Government's intention of achieving greater public access to official information through a non-statutory Code of Practice rather than by a Freedom of Information Act. The White Paper included a commitment that the NHS should have a separate Code.

5.2 The Code of Practice on Openness in the NHS in England was published in April 1995; similar Codes were introduced in Scotland and Wales. They came into effect on 1 June 1995 and the Government published guidance on interpretation of the Codes at the same time.

5.3 Before that the Secretary of State for Health, on behalf also of her colleagues in Scotland and Wales, invited me to take responsibility for investigating complaints from members of the public that their requests for information under the Codes had not been met. I accepted. As Parliamentary Commissioner for Administration I had taken on a similar responsibility to investigate complaints from those unable to obtain the information they wanted under the Code of Practice on Access to Government Information which came into effect in April 1994.

5.4 To mark the launch of the NHS Codes the Government issued a press notice and published a leaflet ('Openness in the NHS') for the general public. I understand that some 250,000 copies have been printed and distributed locally. The guidance to the NHS made clear that Ministers expected every NHS organisation to ensure that the Codes were publicised widely, with specific references to the individual to whom requests for information should be made and how to complain if requests were not met.

5.5 In July 1995 I issued a revised leaflet ('How the Health Service Ombudsman can help you') to let the public know about my powers and responsibilities. It explained that I could now investigate complaints of non-disclosure under the Codes. I and my staff have referred to this extension of my jurisdiction in articles and speeches over the last year.

5.6 The NHS Codes of Practice on Openness are non-statutory. My powers to investigate complaints under the Codes lie in the Health Service Commissioners Act 1993, as extended by the Health Service Commissioners (Amendment) Act 1996. In one respect I take a different approach in deciding whether to investigate complaints about non-disclosure of information as compared with other complaints. In other complaints I expect individuals to show some prima facie reason for their claim to have suffered some hardship or injustice. However in relation to complaints about non-disclosure under the Codes I regard a refusal to provide information to which the complainant believed that there was an entitlement under the Codes as of itself grounds on which to claim injustice or hardship. This mirrors my practice as Parliamentary Ombudsman in responding to complaints about non-disclosure of information.

5.7 I wrote to the Chief Executives of Health Authorities, Boards and Trusts in England, Scotland and Wales, and to other health bodies in my jurisdiction, when the guidance to the Codes was published in order to

explain how I intended to handle complaints about non-disclosure. Copies of my letter were sent to Community Health Councils and Local Health Councils.

5.8 At that stage, although the Codes of Practice extended also to cover information held by practitioners providing NHS family health services, the practitioners were outside my statutory jurisdiction so there was no need for me to explain my new responsibilities to them. From 1 April 1996 my jurisdiction has been extended to them. Just after the end of the year covered by this Annual Report I informed all family health service practitioners of my responsibilities for investigating complaints against them, including those relating to non-disclosure under the Codes.

5.9 The NHS Codes are modelled closely on the Government Code published in 1994. The underlying principle of the Codes is that information (not necessarily the documents in which the information is found) will be made available unless it can be shown to fall within one or more of the nine exemptions set out in the Codes. The exemptions are similar in kind, though fewer, to those in the Code of 1994 applying to bodies within my jurisdiction as Parliamentary Commissioner.

5.10 In respect of some, but not all, exemptions health bodies are required to consider whether, in the public interest, information which would otherwise be exempt should be disclosed. In this regard the 1995 NHS Codes differ from the 1994 Code where the preamble makes it clear that, if non-disclosure under any of the exemptions is contemplated because it could cause harm (eg to the organisation concerned), this 'harm test' should be considered in relation to any possible public interest that might be served through disclosure. The scope for disclosures in the public interest may accordingly appear greater under the 1994 Code than under the 1995 NHS Codes. So far my experience does not enable me to say whether this is borne out in practice.

Experience so far

5.11 The Codes require that (i) each health body must publish the name of an individual responsible for the operation of the Code and (ii) how to request information through that individual should be publicised locally. Complaints about non disclosure, or about delays in disclosure, or charges for information, should be made to that individual. The Codes provide that if complainants are dissatisfied with the response they receive they should write to the Chief Executive of the health body concerned. Time limits are set for each stage.

5.12 Complainants still dissatisfied after receiving a reply from the Chief Executive should, under the Codes, be told how they can complain to me.

5.13 In the first ten months I have received very few complaints or enquiries about access to information. Ten written inquiries were received and fifteen specific complaints. Of these, I declined to investigate nine either because the complainant had not exhausted the procedure in the Codes for local investigation or because I judged that an investigation would be inappropriate (for example where the complaint was about the content of information already disclosed). In two other cases preliminary inquiries of the NHS body by my staff led to the information being made available without the need for a formal investigation by me. In four cases I have begun a formal investigation, none being completed by the end of the year covered by this Report. In one of these cases I discontinued my investigation

when I discovered that the complainant was proposing to take legal action against the body in question. The information sought was likely to be disclosed as a part of that action.

5.14 The paucity of complaints reaching me is just like the position in respect of my experience as Parliamentary Ombudsman of complaints under the 1994 Code. The small numbers may reflect the lack of any substantial and continuing efforts on the part of Government and the NHS to publicise the Codes after their launch. Some complainants may have been put off by the procedures they must go through before they can complain to me. I understand that informal inquiries by the NHS Executive in England suggest that relatively few complaints have been made to NHS bodies locally under the Codes. Maybe the appetite of the public for information – whether about the NHS or Government Departments – is less than had been supposed. It would be rash to underestimate the force of apathy.

5.15 Of those complaints made to me about non-disclosure not all referred to the Codes. It is evident that NHS staff have sometimes dealt with requests for information without recognising that they should be considered as requests under the Codes. Refusals to disclose have as a result not been linked to the Codes. Some of these cases related to information first asked for before the Codes came into force. Sometimes information was requested as one aspect of a wider complaint about care or treatment. My impression – on the very limited cases I have so far seen – is that knowledge of the Codes and how complaints about non-disclosure should be handled is not yet sufficiently widespread among NHS staff; and that NHS bodies need to give more attention to ensuring that staff know about the change. In the early months I have not criticised any NHS body for failing to consider a complaint under the Codes or to inform a complainant about the Codes but I shall not condone such omissions in future.

Access to Personal Health Records

5.16 I have it in mind to prepare in the autumn a report on the first full year of the Codes. However, there is one aspect on which it would be helpful for me to comment now. It concerns access to personal health records.

5.17 Patients normally have a right to see their own health records. The Codes refer to the statutory rights provided by the Data Protection Act 1984 (for records held on computer) and by the Access to Health Records Act 1990. The 1990 Act provides a specific recourse to the courts where the holder of the record wishes to deny access to records made after 1 November 1991 when the Act came into force.

5.18 The Codes do not add to these statutory rights. However, when the Codes were published I regarded personal health records as information held by the NHS and hence within the ambit of the Codes. Health Ministers subsequently decided that an individual refused access to his or her personal health records could complain through the new NHS complaints procedure operating from 1 April 1996, without prejudice to any statutory right to a determination in the courts. The guidance on the new NHS complaints procedure issued by the NHS Executives in March 1996 reflected that decision. That guidance also stated that complaints about non-disclosure of other information should be dealt with under the Codes and not go through the NHS complaints procedure.

5.19 In the light of the NHS Executives' guidance I now tell those who complain to me that they have been refused access to their health records that, if they have not already done so, they can complain through the NHS complaints procedure, without prejudice to any right they may have under the 1990 Act to a determination in the courts.

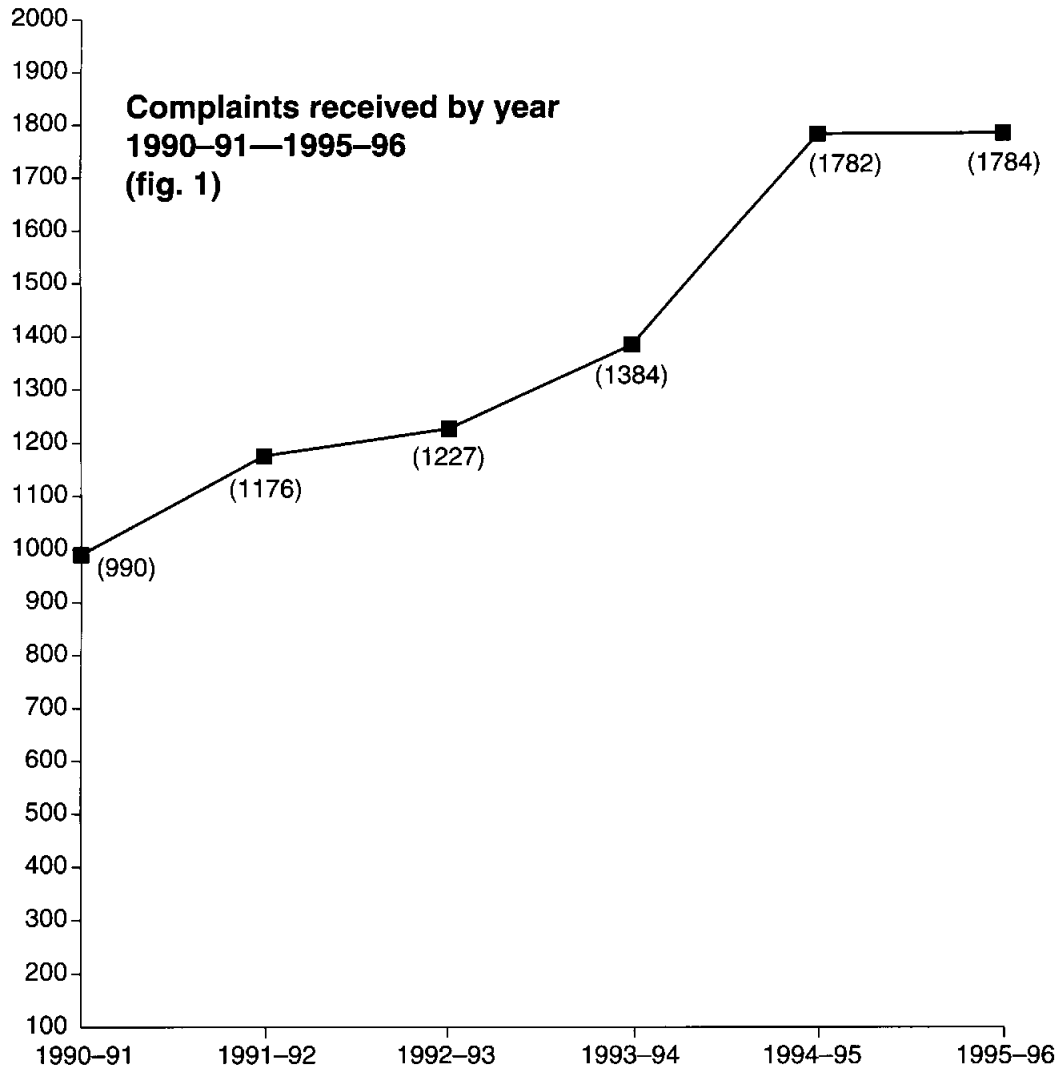
5.20 Those who remain dissatisfied with the outcome of an investigation through the NHS complaints procedure can then complain to me. Where they have a remedy in the courts under the 1990 Act I can, however, only investigate if in the circumstances of the case I consider it would be unreasonable for the complainant to exercise that right.

6 STATISTICS

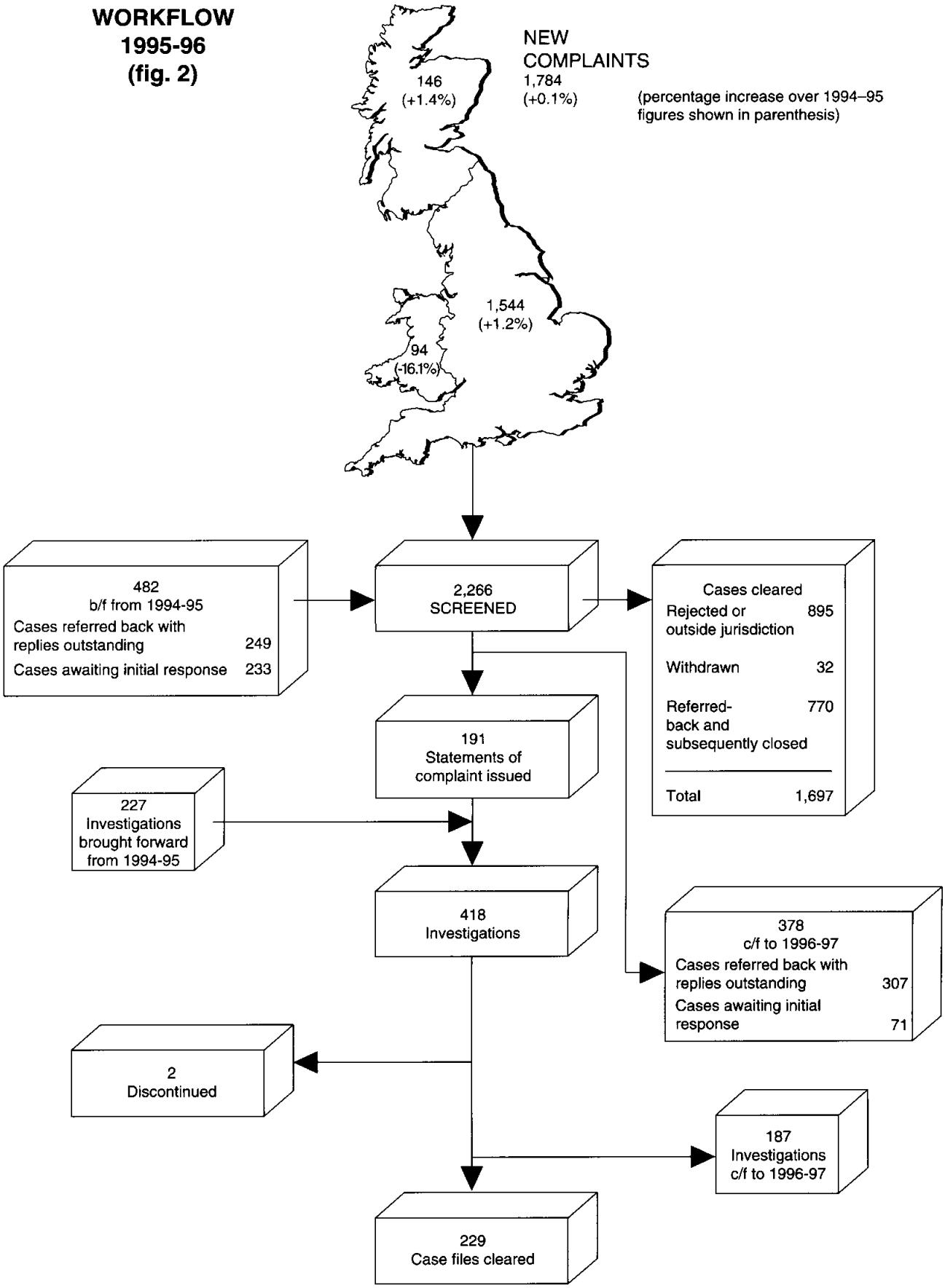
6.1 The total number of complaints received in 1995–96 (1784) was almost the same as the number received in 1994–95 (1782). Figure 1 shows the number of complaints received each year since 1990–91. It clearly shows that the number of complaints has risen significantly over those years but it would be wrong to conclude, on the basis of one year's figures, that the rising trend has stopped. (Indeed, in the first three months of 1996–97 there is evidence of further growth.) Moreover, the recent introduction of new complaints procedures in the NHS and the extension to my jurisdiction mean that it is impossible to draw conclusions about the future level of complaints to the Health Service Commissioner. During the last year my office has made significant progress in clearing the backlog of work to which I referred in my last report. The decks are now clearer to deal with a likely future increase in the workload under the extended jurisdiction.

6.2 Figure 2 gives information about the number of complaints received from England, Scotland and Wales during 1995–96. There were small increases in England and Scotland. There was a fall of some 16% in the number of complaints in Wales. Figure 2 also indicates the flow of work load with within the organisation. The tables at Figure 3 and Appendix B provide summarised information.

6.3 Although the number of new complaints was steady in comparison with 1994–95, the number of cases brought forward from 1994–95 was significantly higher than in previous years. (The backlog represented an increase of 60% over the number of cases brought forward to 1994–95.) The total workload for the year was 2,493 cases. By the end of the year 71 cases were awaiting an initial response. A large number of those cases arrived in the office in the last few days of the reporting year. This contrasts with 233 cases which awaited an initial response at the end of 1994–95 (see figure 3). The backlog of work which resulted in some complainants waiting several months for an initial response to their complaint has been eliminated


Complaints received by year
1990–91—1995–96
(fig. 1)
2000
1900
1800
1700
1600
1500
1400
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
(990)
(1176)
(1227)
(1384)
(1782)
(1784)
1990–91
1991–92
1992–93
1993–94
1994–95
1995–96

WORKFLOW
1995-96
(fig. 2)



Workload and Disposal (fig. 3)

Workload

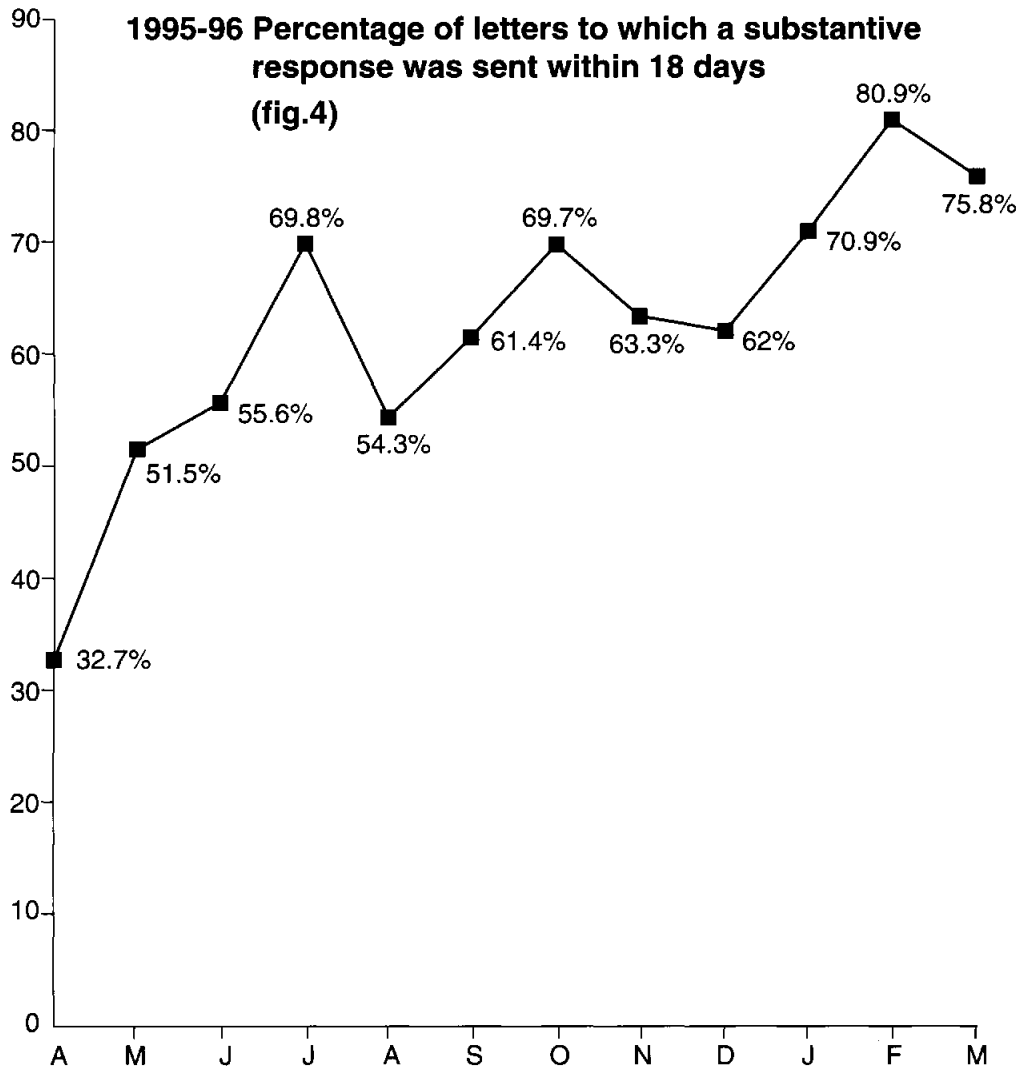
Cases brought forward from 1994-95	709
Consisting of:	
Cases referred back with replies outstanding	249
Cases awaiting initial response	233
Cases under investigation	227
Cases received in 1995-96	1,784
Total	2,493

Disposal

Investigations completed	229
Cases rejected	736
Cases outside jurisdiction	159
Cases discontinued (or withdrawn)	34
Cases referred back and subsequently closed	770
Cases carried forward to 1996-97	565
Consisting of:	
Cases referred back with replies outstanding	307
Cases awaiting initial response	71
Cases under investigation	187
Total	2,493

6.4 A further 1702 items of supplementary correspondence were received in my screening directorate. This correspondence included, for example, responses to requests from my staff for additional information and objections from complainants to the rejection of a complaint. There was an increase of 254 (18%) in such items of correspondence over 1994–95. The total volume of work dealt with by my screening directorate increased by 17.3%. My staff also handle a large number of telephone enquiries. Since November 1995 I have recorded the numbers of such enquiries dealt with in the screening directorate. During the second half of the reporting year my screeners received an average of 300 telephone enquiries per month. Most were general enquiries including requests for advice or requests for copies of the leaflet about my work.

6.5 In my last report I noted, with some disappointment, that in 1994–95 only 42% of letters received a definitive reply within of 18 days. In last year's report I forecast that 45% of all correspondents should be replied to within 18 days in 1995–96. I am pleased to report that 63.4% of all correspondence was dealt with within 18 days. That average figure hides the steady progress which was made throughout the year. The number of letters dealt with within 18 days rose from 32.7% in April 1995 to 80.7% in February 1996 (see figure 4). The average number of days taken to reply to correspondence received in 1995–96 was 22 days – a significant reduction on the average of 40 days taken in 1994–95.



6.6 Of the 565 cases carried forward at 31 March (709 in 1994–95) 187 were under investigation (227 in 1994–95), 307 had been referred back and were awaiting a reply (249 in 1994–95) and 71 were awaiting an initial response (233 in 1994–95) (see Figures 2 and 3). I accepted 191 cases for investigation. This represents some 11% of the complaints which I received in 1995–96. That does not mean that 89% were rejected outright. Within the figure of 89% are many complaints which were referred back for further information (sometimes more than once).

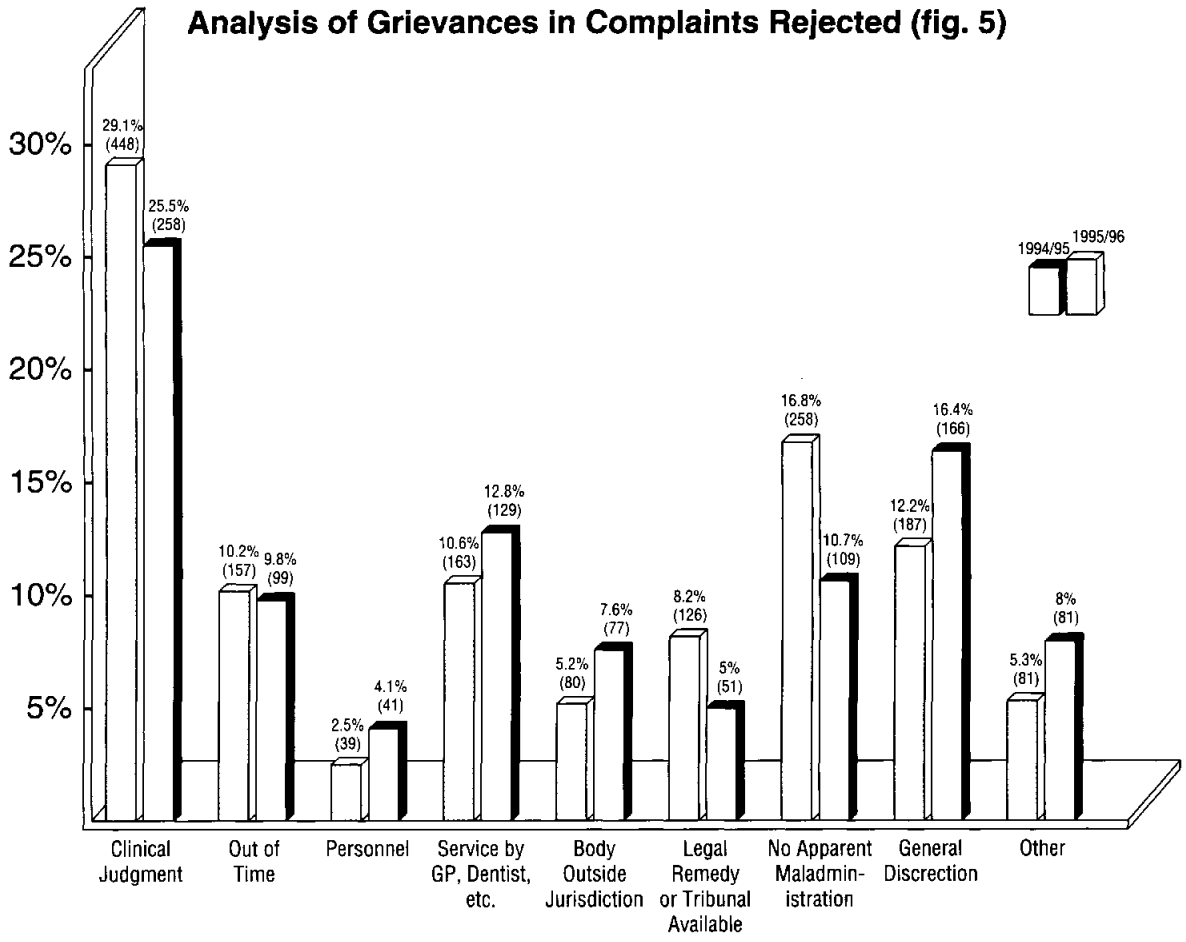
6.7 The need to refer back to a complainant can arise for a number of reasons. For example, the law requires that before I can consider a complaint, the health authority (or other NHS body concerned) must be given an opportunity to look into the complaint and reply. The complainant may then refer the complaint to me with an explanation of why he or she is dissatisfied with the health authority's attempts to resolve the matter. If this procedure has not been followed, I refer the complaint back to the sender with guidance on how to proceed. Complaints may also be referred back if all the necessary papers have not been provided, if more information is required, or if it is not clear what the complainant is asking me to do. In 1995–96 some 55% of new complaints were referred back (58% in 1994–95). Of the replies received to letters referring back to the complainant, some

39% required to be referred back again (compared with 47% in 1994–95). Of those complainants to whom I referred back, 770 did not respond within 3 months, and in accordance with my practice those cases were closed, representing 45% of all cases which were not investigated. The equivalent figure was 690 (52%) in 1994–95.

6.8 My powers are set by Parliament. I have the power to decide whether or not to investigate any complaint put to me which falls within my jurisdiction. I have, for example, the discretion to waive the time limit of one year – within which complaints should reach me – where I consider the circumstances of a complaint warrant it. I can also decide not to investigate a valid if I believe that an investigation by me would achieve little for the complainant that has not already been achieved through the NHS complaints procedures. In 1995–96 I rejected 895 cases either because the complaints were beyond my jurisdiction (for example, the complaints were about care, treatment or decisions based on the clinical judgment of a doctor or nurse, or involved a general practitioner) or because I did not consider an investigation would be productive. A further 32 cases were withdrawn by complainants before I had reached a decision about whether or not to investigate.

6.9 Many complaints which I receive are complex, involving a large number of different grievances. The rejected cases included a total 1,539 separate grievances – this represents 895 cases with an average of 1.72 grievances per rejected case. The equivalent figures for 1994–95 were 1,011 rejected grievances and 1.65 grievances per rejected case. An analysis of the main reasons for rejection is at figure 5 with further information given at Appendix C. Details of the principal subjects of complaint, together with the related NHS service areas and the professions of the staff involved in the complaints are provided at Appendices D and E. Equivalent information about investigated grievances is at Appendices F and G. This is only the third year that I have been able to present this information in this way. As a result I cannot be certain about trends. However, the largest category of grievance in rejected complaints (Figure 5) remain matters of clinical judgment (25% in 1995–1996 and 29% in 1996–97). That will gradually become less common as a reason for rejection, as the recent extension of my jurisdiction allows me to investigate clinical matters which relate to investigations after 31 March 1996.

Analysis of Grievances in Complaints Rejected (fig. 5)



Resolution of complaints without investigation

6.10 It has been my practice to try to obtain a satisfactory solution for a justified complaint. There are cases where a complainant has waited an unreasonable time for a reply from a health service body. Then I encourage my staff to contact the health service body on behalf of the complainant. In many cases such action results in a satisfactory conclusion for the complainant. Since I have not investigated the case, the success hitherto did not feature in the statistics even though it represented great use of my staff's time and satisfied the complainant.

6.11 My Office has now set up a system which attempts to identify such cases and they may feature in future reports. This year I draw attention to instances where an intervention by my staff helped to achieve a satisfactory solution for the complainant.

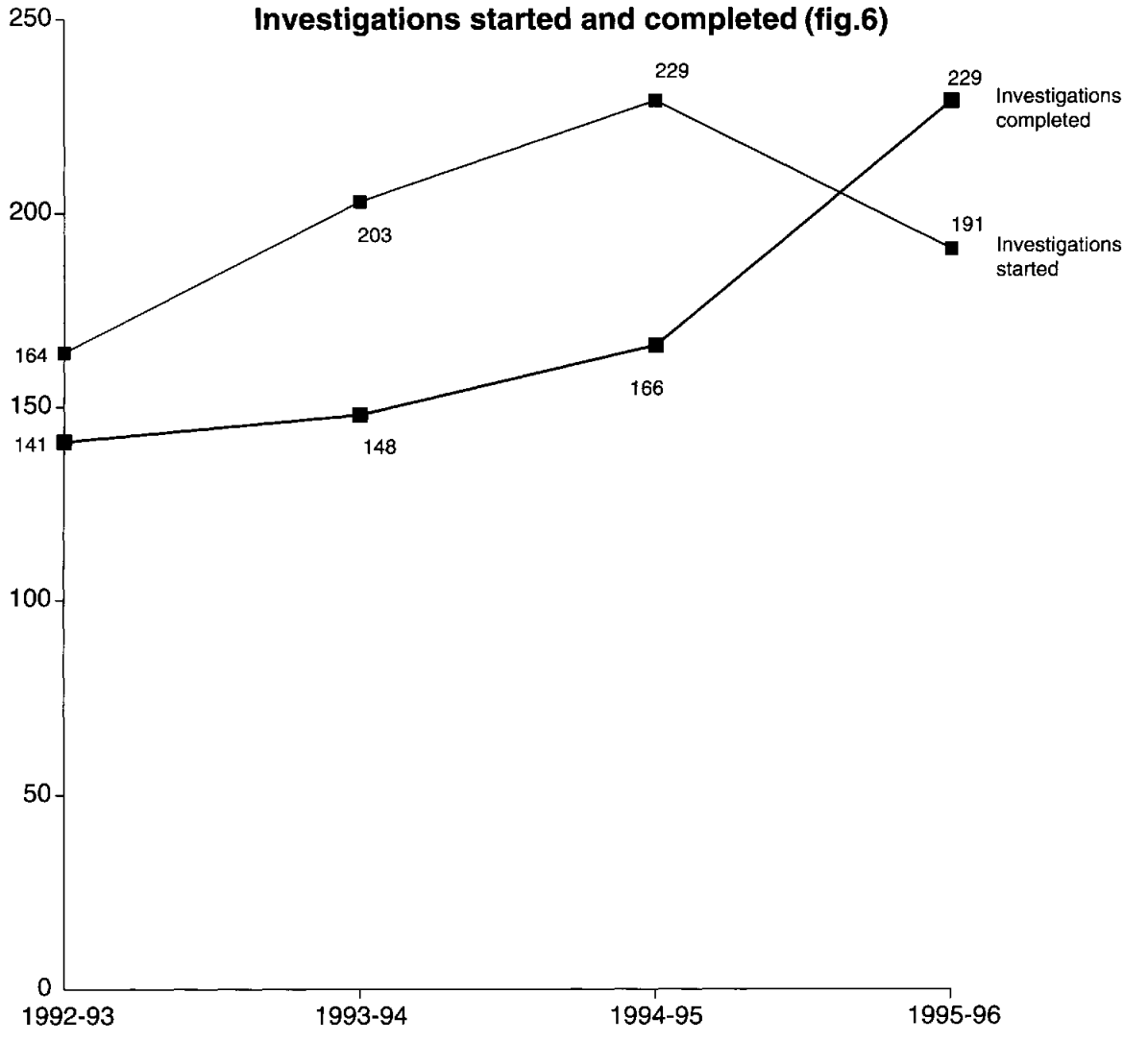
(1) A man had made a complaint to a Trust on 18 July 1995 and had received no reply when he wrote to me on 3 December 1995. One of my staff wrote to the Trust on 8 December and received a reply from the Trust on 22 December to the effect that a reply to the complainant would be sent without delay. The complainant wrote on 12 January 1996 to say that the Trust had replied on 9 January and to thank me for the prompt and helpful way in which the problem had been resolved.

(2) In a similar case a Community Health Council wrote to a Trust on 7 December 1994. No reply had been received by the time they wrote to me on 1 December 1995. One of my staff wrote to the Trust on 8 December 1995 and received a reply dated 22 December saying that a reply had been sent to the complainant that day.

(3) A complainant wrote to me on 1 November 1995 about the refusal of a Health Authority to provide funds for treatment through an extra-contractual referral, despite the support of the patient's general practitioner. One of my staff discussed with the Health Authority the possibility of the complainant appealing against the decision to refuse funding. He was told that there was no appeal mechanism but that the case would be reconsidered. The Health Authority then wrote to tell the complainant on 14 December 1995 that they would fund the necessary treatment for 18 months.

Reports issued on completed investigations

6.12 During the year 229 investigations were completed, a significant increase on last year (166), which was in itself a record. This figure exceeds the forecast, set in my last Annual Report, of 210. About half the increase in reports produced represents the effect of staffing increases (see paragraph 1.18); the remainder is the result of a sustained effort by staff to conclude investigations more quickly without any sacrifice of quality. I accepted 191 cases for investigation during the year, adding to the 227 cases carried forward from 1994–95. This is substantially fewer than predicted in my last Annual Report where I expected that the upward trend of complaints received in my office would continue. The graph at figure 1 shows that this did not prove to be the case. As a consequence, for the first time in many years investigations completed have exceeded investigations started (see Figure 6).



6.13 Towards the end of 1995 I became increasingly concerned at the number of cases which had been in the office for more than a year. By the end of December they had reached 93, but that figure was brought down to 41 by the end of the reporting year. I intend that by the end of 1996 none of the cases held in the office will be more than a year old. This backlog, which had its roots in the problems experienced screening the large numbers of complaints received in 1994–95, has adversely affected the average time taken to complete investigations, which stood at 66 weeks at the end of the year. Nine investigations were begun and concluded in 1995–96 in an average time of 39 weeks. I completed 113 investigations (49% of all completed investigations) within the 65 weeks forecast in last year's report. Figure 7 analyses the throughput of time of the cases completed this year.

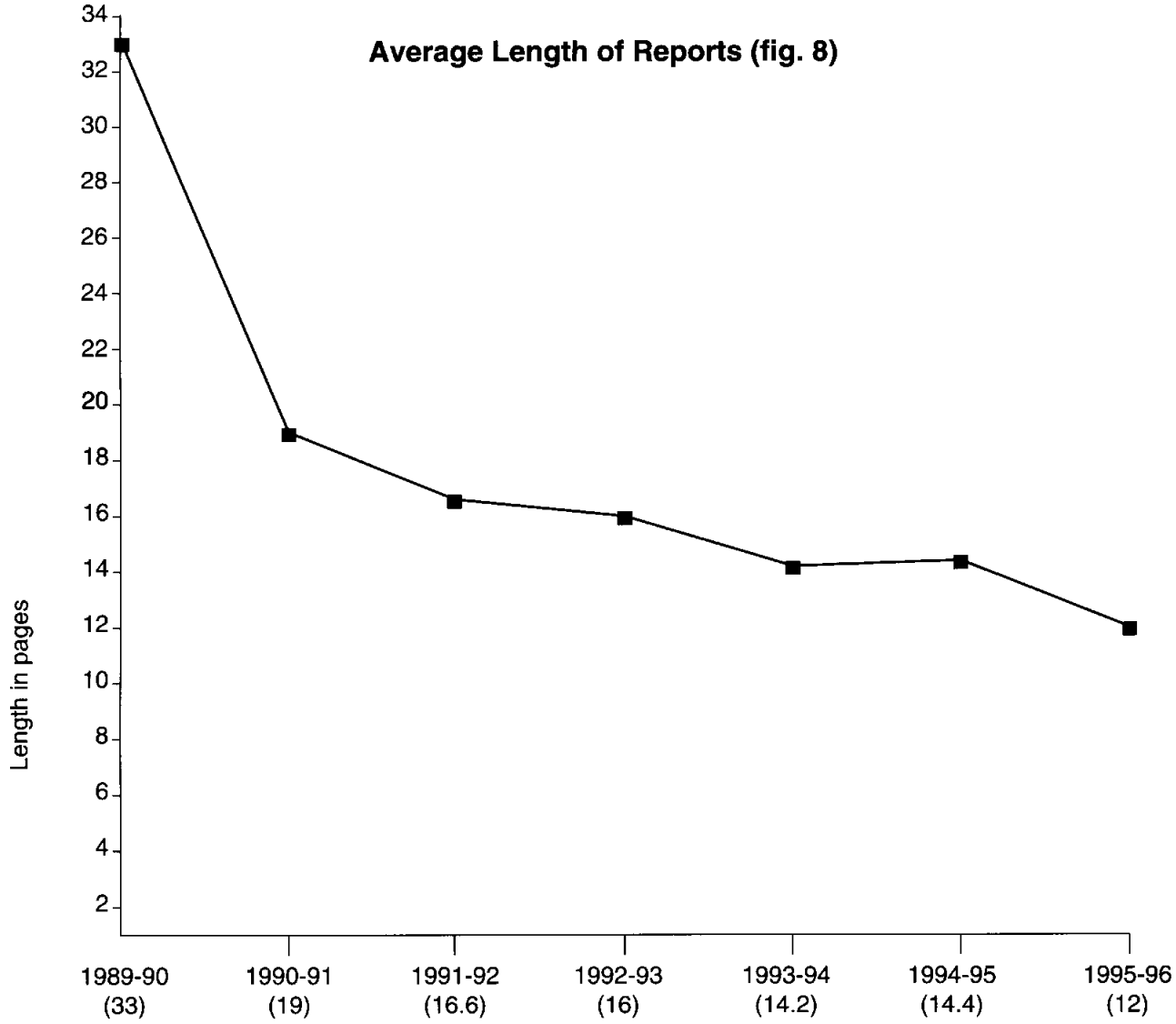
Time Bands for Investigations (fig. 7)

Time band	Proportion of investigations concluded		
	1994-95	1995-96	Cumulative
Under 45 weeks	29 (17.5%)	35 (15.3%)	15.3%
46 – 55 weeks	31 (18.7%)	29 (12.7%)	28%
56 – 65 weeks	49 (29.5%)	49 (21.4%)	49.4%
66 – 75 weeks	35 (21.1%)	45 (19.7%)	69.1%
76 – 85 weeks	16 (9.6%)	40 (17.5%)	86.6%
86 – 95 weeks	6 (3.6%)	22 (9.6%)	96.2%
more than 95 weeks	—	9 (3.9%)	100%*

(Figures in brackets = % of total)

*Total is greater than 100% as figures have been rounded to one decimal place

6.14 The average length of reports of investigations has continued to go down because of efforts made to produce clear and concise reports. Figure 8 shows the changes in report length since I took post in 1990. Clarity in the presentation of reports is a very important objective; reports must deal with the complainants' concerns in a way they are able to understand. I have found investigation of a small number of well defined and focussed grievances to be an effective approach. This is reflected in the figures for the average number of grievances per investigated complaint; 2.4 this year, with a total of 546 grievances investigated, and is a continuation of the decreasing trend seen in past years, which is illustrated in Appendix H. Of the grievances reported upon this year, I upheld 62%.



6.15 Appendices F and G analyse the grievance figures into subject matter, the NHS area complained about and the staff involved. The most frequent subjects of complaints investigated are: care and treatment; communication (including consent to treatment and counselling); and complaint handling. These three categories account for some two thirds of the grievances investigated (21.8%, 15.4% and 27% respectively). This differs little from last year (26%, 18% and 26% respectively). I have frequently highlighted the issue of complaints handling in Annual Reports and Selected Case volumes. Since I upheld 90% of such grievances investigated in 1995–96, I am disappointed that there has been no real improvement in this area.

6.16 Hospital acute services were the focus most of the grievances I investigated; 354 (69.8%) against 324 (64%) last year. Grievances about administrative issues, including complaints about FHSAs were the next most common area; 120 (22%). However, there is a slight improvement here on last year's figures as this year I upheld 82% of the grievances about administrative issues, as against 87% the previous year.

6.17 The number of grievances about clinical staff increased this year: 142 (26%) against 116 (23%) last year, but the proportion upheld fell to 49% this year from 57% last year. The number of grievances about nurses fell slightly: 182 (33%) against 197 (34%) last year, although the proportion upheld increased from 42% to 47%. The number of grievances against administrative staff was 210 (39%) against 177 (35%) last year. I upheld 84% of the grievances – almost exactly the same proportion as last year.

Staffing

6.18 I have planned to have trained staff in place soon enough to meet the demands resulting from the extension of my jurisdiction, unpredictable though those demands may be. To deal with an increasing workload I recruited extra staff to form an additional investigation directorate which started work at the beginning of the year. My screening unit was strengthened in April by the recruitment of a director. In September I recruited three more unit leaders, five screening officers and eight investigating officer to prepare for the extension of my jurisdiction in April 1996. All these staff were in post by January 1996. A further thirteen investigation staff have been recruited and will start work in the summer of 1996. Because of the extension of my jurisdiction into clinical matters I have recently recruited internal clinical advisers: three medical practitioners (of whom one has a background in general practice) and one nurse. They too will arrive in the summer of 1996.

HSC OUTPUT AND PERFORMANCE TARGETS

Note: Forecast figures are given for one year only, as it is not possible to estimate the effect, year by year, on workload of the recent jurisdictional changes, although preparations have been informed by the Department of Health's estimate of an eventual increase of some 150%.

		Forecast 1994–95	*Actual 1994–95*	*Forecast 1995–96*	*Actual 1995–96*	*Forecast 1996–97*
1	Complaints received	1,550	1,782	2,100	1,784	2,200
2	Percentage accepted for investigation	15	12.9	13	10.7	12
3	New investigations begun	230	229	293	191	264
4	Average time taken (weeks) to complete investigations	45	59.9	65	66.2	56
5	Percentage of replies sent within 18 days	75	42	45	63	70
6	Investigations completed	196	166	210	229	240
7	Average length of reports (pages)	15	14.5	14	11.8	11
8	Staff in post:					
	(i) All investigative staff	36	40.58	45	56.35	95
	(ii) Investigating officers	23	26.58	30	36.81	52
	(iii) Screening staff	4.5	4.88	7	8.12	13
9	Investigations/total investigative staff	5.4	4.12	4.6	*	*
10	Investigations/investigating officers	8.5	6.28	7	*	*
11	Cases received/screening staff in post	344	365	300	220	169

*These ratios have not been included, as the staffing figures at 8 include staff recruited in the light of the jurisdictional changes, while these considerations have not affected the actual output figures for 1995–96 and only marginally affect the forecast figures for 1996–97.

Summary of workload

England		Scotland		Wales		Totals		
1994-95	1995-96	1994-95	1995-96	1994-95	1995-96	1994-95	1995-96	
384	619	31	54	29	36	444	709	Brought forward from previous year
1526	1544	144	146	112	94	1782	1784	**Add** received in current year
1910	2163	175	200	141	130	2226	2493	Total considered
556	792	42	87	51	50	649	929*	Complaints rejected, discontinued or withdrawn
572	667	72	57	46	46	690	770	Complaints 'referred back' and subsequently closed
163	200	7	15	8	14	178	229	Results reports issued
1291	1659	121	159	105	110	1517	1928	Concluded (including discontinued)
619	594	54	41	36	20	709	565	**Deduct** carried forward to next year
163	187	17	12	11	9	191	208	Written enquiries/advice sought

*There were 32 cases withdrawn by the complainant before a decision was taken on whether or not to investigate and 2 cases where the complainant asked for the investigation to be discontinued.

Analysis of grievances in rejected complaints 1995–96 — by reference to powers and jurisdiction.

England		Scotland		Wales		Totals		% change	
1994-95	1995-96	1994-95	1995-96	1994-95	1995-96	1994-95	1995-96	(1995-96 against 1994-95)	
66	65	5	10	6	5	77	80	−2.4%	Body complained of outside jurisdiction
109	134	10	20	10	9	129	163	−2.2%	Complaint against GP, dentist, pharmacist, optician
39	29	1	6	2	3	42	38	−1.7%	Service Committees and Tribunal Regulations
217	401	21	30	20	17	258	448	+3.6%	Clinical judgment
43	112	3	12	3	2	49	126	+3.2%	Legal remedy available
37	36	1	1	3	2	41	39	−1.6%	Personnel matter
85	143	5	11	9	3	99	157	+0.4%	Out of time
2	—	—	—	—	—	2	—	−0.2%	Right to appeal to tribunal
—	—	2	6	—	—	2	6	+0.2%	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
92	217	12	21	5	20	109	258	+6.1%	No prima facie failure/maladministration
12	13	—	2	3	2	15	17	−0.4%	Contractual/commercial transaction
147	160	6	19	13	8	166	187	−4.2%	General discretion
15	14	—	3	4	2	19	19	−0.7%	Complainant not aggrieved or acceptable as complainant
2	—	—	—	1	1	3	1	−0.2%	Complaints from local authority, other public body or nationalised industry
866	1,324	66	141	79	74	1,011	1,539		Totals

Analysis of grievances in rejected complaints 1995–96 — by service areas and subjects

Service Areas	Subjects of complaint																Totals	
	Admission, Discharge and Transfer arrangements (incl. transport)	Aids Equipment Premises and Environment	Appointments Waiting Lists and Delay	Attitude	All Aspects of Care and Treatment	Communication Consultation Consent and Counselling	FHSAs complaints and admin.	IPR Administration	NHS Contractors	Non-NHS duties and Non-relevant body	Patients' Property, Compensation and Expenses	Personnel and Terms of Service matters	Policy decisions ECRs and Commercial	Records, Breach of confidence Test results	Appeals and Hospital complaints handling	Others	1995–96	1994–95
Hospital acute — In patient	39	2	6	9	297	35	—	—	1	—	3	3	5	7	5	13	425	211
— Out patient	—	3	26	11	108	20	—	—	—	4	2	—	1	10	5	3	193	121
A & E	3	—	—	3	19	2	—	—	—	—	—	—	—	2	—	—	29	23
Geriatric	1	—	—	—	4	1	—	—	—	—	—	—	—	—	—	1	7	12
Mental Health	8	—	—	5	56	7	—	—	—	2	2	—	1	13	5	6	105	58
Maternity	—	—	—	—	11	2	—	—	—	1	1	—	—	2	—	—	17	23
Ambulance	10	—	2	3	2	—	—	—	—	—	—	—	—	—	2	—	19	6
Other Community Health	1	—	—	3	13	4	—	—	—	—	—	1	1	—	1	4	28	26
Administrative (excl. FHSAs)	6	2	11	4	3	10	3	18	2	9	22	22	26	46	153	12	349	237
Family Health Services+FHSAU	—	—	1	—	4	10	47	—	164	—	1	7	3	11	18	—	266	215
Not specified	—	—	—	—	6	—	—	—	—	1	—	—	—	4	—	1	12	2
None	—	1	—	—	2	1	1	2	1	54	3	—	2	—	—	22	89	77
Totals 1995–96	68	8	46	38	525	92	51	20	168	71	34	33	39	95	189	62	1539	
Totals 1994–95	27	7	20	31	291	61	59	7	132	74	25	27	21	59	138	32		1011

Analysis of grievances in rejected complaints 1995–96 — by professions and subjects

NHS Professions involved in complaints	Subjects of complaint																Totals	
	Admission, Discharge and Transfer arrangements (incl. transport)	Aids Equipment Premises and Environment	Appointments Waiting Lists and Delay	Attitude	All Aspects of Care and Treatment	Communication Consultation Consent and Counselling	FHSAs complaints and admin.	IPR Administration	NHS Contractors	Non-NHS duties and Non-relevant body	Patients' Property, Compensation and Expenses	Personnel and Terms of Service matters	Policy decisions ECRs and Commercial	Records, Breach of confidence Test results	Appeals and Hospital complaints handling	Others	1995–96	1994–95
Medical and Dental	41	1	22	20	442	54	—	7	8	5	3	—	2	27	1	9	642	359
Professions allied to medicine	—	—	—	2	4	1	—	—	—	—	—	—	—	—	—	2	9	3
Nursing, midwifery and health visiting	6	1	—	9	66	15	—	—	—	—	2	4	—	5	—	10	118	84
Scientific, technical and professional	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0	2
Ambulance crews	7	—	2	2	2	—	—	—	—	—	—	—	—	—	1	—	14	5
Maintenance and auxiliary staff	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	1	3	2
Health authority administrative staff/members	13	3	21	4	4	21	33	13	1	13	27	28	34	58	187	16	476	306
FHSA Service Committees	—	—	—	—	—	—	16	—	—	—	—	—	—	—	—	—	16	41
FHSA lay conciliators	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
NHS contractors	—	—	—	—	3	—	1	—	158	—	—	1	—	1	—	—	164	132
Not specified	1	—	1	1	3	1	—	—	—	—	—	—	1	4	—	2	14	4
None	—	1	—	—	1	—	1	—	1	53	2	—	2	—	—	22	83	71
Totals 1995–96	68	8	46	38	525	92	51	20	168	71	34	33	39	95	189	62	1539	
Totals 1994–95	27	7	20	31	291	61	59	7	132	74	25	27	21	59	138	32		1011

Analysis of grievances in investigations completed in 1995–96 — by service areas and subjects

Service Areas	Subjects of complaint													Totals	
	Admission, Discharge and Transfer arrangements (incl. transport)	Equipment and Aids	Appointments Waiting Lists and Delay	Attitude	Care and Treatment	Communication Consent and Counselling	IPR Administration	Policy decisions and ECRs	Patients' Property, and Expenses	Privacy Breach of confidence	Records Medical Certificates	Hospital complaints handling	Other	1995/96 Upheld wholly or in part / Not upheld	1994/95 Upheld wholly or in part / Not upheld
Hospital acute — In patient	16	1	4	5	39	25	—	—	1	1	5	33	14	144	120
	12	4	2	5	62	25	2	1	—	—	3	3	8	127	126
— Out patient	—	—	7	1	2	7	—	—	1	1	3	16	2	40	30
	—	—	2	9	—	6	—	—	—	—	2	—	—	19	15
A & E	6	—	—	—	2	2	—	—	—	—	1	1	—	12	22
	2	—	1	1	5	1	—	—	—	—	—	1	1	12	11
Geriatric	3	1	—	—	1	—	—	—	—	—	—	—	1	6	3
	1	—	—	—	1	—	—	2	1	—	—	—	1	6	11
Mental Health	—	—	—	—	2	5	—	—	3	—	1	2	1	14	15
	—	—	—	1	3	4	—	—	—	1	—	2	—	11	17
Maternity	—	—	1	—	—	1	—	—	—	—	1	2	2	7	6
	—	1	—	1	2	2	—	—	—	1	—	—	—	7	1
Ambulance	4	—	—	—	1	1	—	—	—	—	—	8	—	14	8
	1	—	1	—	1	—	—	—	—	—	—	1	—	4	21
Other Community Health	—	—	1	—	—	—	—	—	—	—	—	—	1	2	—
	—	—	1	—	—	—	—	—	—	—	—	—	—	1	4
Administrative (inc. FHS service)	1	1	—	1	—	1	10	2	—	—	7	70	6	99	102
	1	—	1	2	—	3	2	2	1	—	—	8	1	21	15
Totals Upheld	30	3	13	7	47	42	10	2	5	2	18	132	27	338	306
Not Upheld	17	5	8	19	74	41	4	5	2	2	5	15	11	208	202

Analysis of grievances in investigations completed in 1995–96 — by professions and subject

Professions involved in complaints	Subjects of complaint													Totals	
	Admission, Discharge and Transfer arrangements (incl. transport)	Equipment and Aids	Appointments Waiting Lists and Delay	Attitude	Care and Treatment	Communication Consent and Counselling	IPR Administration	Policy decisions and ECRs	Patients' Property, and Expenses	Privacy Breach of confidence	Records Medical Certificates	Hospital complaints handling	Other	1995/96 Upheld wholly or in part / Not upheld	1994/95 Upheld wholly or in part / Not upheld
Medical and Dental	6	—	9	6	16	18	3	—	1	2	1	4	4	70	66
	5	2	5	15	12	24	3	—	—	1	3	1	1	72	50
Professions allied to medicine	—	—	—	—	—	—	—	—	—	—	—	1	1	2	5
	—	1	—	1	—	—	—	—	—	—	—	—	1	3	3
Nursing midwifery and health visiting	16	2	2	1	28	22	—	—	—	—	5	3	7	86	83
	8	2	—	3	61	12	—	—	1	1	1	—	7	36	114
Scientific, technical and professional	—	—	—	—	—	—	—	—	—	—	—	—	1	1	2
	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Ambulance crews	1	—	—	—	1	—	—	—	—	—	—	—	—	2	2
	—	—	1	—	1	—	—	—	—	—	—	—	—	2	3
Maintenance and auxiliary staff	—	—	—	—	—	—	—	—	—	—	—	1	1	1	—
	—	—	—	—	—	—	—	—	—	—	—	—	1	1	3
Health authority administrative staff	7	1	2	—	2	2	7	2	4	—	12	124	13	176	148
	4	—	2	—	—	5	1	5	1	—	1	14	1	34	29
Totals Upheld	30	3	13	7	47	42	10	2	5	2	18	132	27	338	306
Not Upheld	17	5	8	19	74	41	4	5	2	2	5	15	11	208	202

Number of grievances investigated and upheld, 1986–87 to 1995–96

Number investigated	Number upheld

Year	Total	No. of grievances per report issued	No.	% of (ii)
(i)	(ii)	(iii)	(iv)	(v)
1986–87	483	3.7	290	60.0
1987–88	525	3.9	321	61.1
1988–89	556	4.0	322	57.9
1989–90	345	3.9	177	51.3
1990–91	487	3.5	236	48.5
1991–92	442	3.4	243	55.0
1992–93	476	3.1	287	60.3
1993–94	436	2.6	275	63.1
1994–95	508	2.7	306	60.2
1995–96	546	2.4	338	61.9

Appendix I

Geographical distribution of complaints received.

1995–96

Region of Origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint
Northern & Yorkshire	166	9.3	6,663	40
Northwest	173	9.7	6,629	38
Trent	95	5.3	4,800	51
West Midlands	130	7.3	5,307	41
Anglia & Oxford	127	7.1	5,322	42
South & West	190	10.6	6,555	35
North Thames	395	22.1	6,844	17
South Thames	268	15.0	6,756	25
Totals for England	1,544	86.5	48,876	32
Scotland	146	8.2	5,145	35
Wales	94	5.3	2,918	31
Overall Totals	1,784	100.0	56,939	32

1994–95

Region of Origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint
Northern & Yorkshire	176	9.9	6,044	34
Northwest	191	10.7	6,603	34
Trent	92	5.2	4,673	51
West Midlands	109	6.1	5,215	48
Anglia & Oxford	112	6.3	5,211	46
South & West	174	9.7	6,300	36
North Thames	356	20.0	6,812	19
South Thames	316	17.7	6,699	21
Totals for England	1,525	85.6	47,557	31
Scotland	144	8.1	5,099	35
Wales	112	6.3	2,898	26
Overall Totals	1,782	100.0	55,554	31

RECRUITMENT

The Office abides by the Civil Service Order in Council 1995 which states that all departments and agencies should recruit on the principles of fair and open competition on selection on merit in accordance with the guidelines issued by the Civil Service Commissioners. The Principal Establishment Officer and his staff ensure that all recruitment is conducted on this basis and that certain laid down permitted exceptions to this are legitimate deviations from the norm. All recruitment is subject to internal audit and review by the Civil Service Commissioners.

The statistics for the campaigns held for HSC Investigation and Support staff during the 1 April 1995 and 31 March 1996 period are:

HEALTH SERVICE COMMISSIONER STAFF

HSC HEO INVESTIGATING OFFICERS – June 1995 (inter-departmental trawl, Health Service Journal (HSJ) advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	27	18	10	14	6	2
Non-White	—	—	—	—	—	—
Other (no form returned)	7	6	3	3	2	2
Total	34 (59%)	24 (41%)	13 (43%)	17 (57%)	8 (67%)	4 (33%)

Number of applicants: 58.

Monitoring forms returned: 45 (78%).

Of the 45 applicants who completed the monitoring form, none was non-white.

HSC HEO INVESTIGATING OFFICER (Wales) – June 1995 (inter-departmental trawl, HSJ advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	38	20	3	6	—	2
Non-White	—	—	—	—	—	—
Other (no form returned)	12	8	—	1	—	1
Total	50 (64%)	28 (36%)	3 (30%)	7 (70%)	—	3 (100%)

Number of applicants: 78.

Monitoring forms returned: 58 (74%).

Of the 58 applicants who completed the monitoring form, none was non-white.

HSC GRADE 7 UNIT LEADERS – June 1995 (inter-departmental trawl, HSJ advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	43	21	9	4	3	1
Non-White	—	—	—	—	—	—
Other (no form returned)	21	4	1	1	—	1
Total	64 (72%)	25 (28%)	10 (67%)	5 (33%)	3 (60%)	2 (40%)

Number of applicants: 89.

Monitoring forms returned: 64 (72%).

Of the 64 applicants who completed the monitoring form, none was non-white.

HSC HEO INVESTIGATING OFFICER – January 1996 (inter-departmental trawl, HSJ and press adverts)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	523	252	35	26	4	7
Non-White	80	51	2	3	—	—
Other (no form returned)	78	39	1	3	—	1
Total	681 (67%)	342 (33%)	38 (54%)	32 (46%)	4 (33%)	8 (67%)

Number of applicants: 1,023.

Monitoring forms returned: 906 (89%).

Of the 906 applicants who completed the monitoring form, 131 were non-white (14%) and of the 12 that were successful none was non-white.

HSC GRADE 7 UNIT LEADERS – January 1996 (inter-departmental trawl, HSJ and press adverts)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	51	39	11	12	1	1
Non-White	2	2	—	—	—	—
Other (no form returned)	6	—	1	—	—	—
Total	59 (59%)	41 (41%)	12 (50%)	12 (50%)	1 (50%)	1 (50%)

Number of applicants: 100.

Monitoring forms returned: 94 (94%).

Of the 94 applicants who completed the monitoring form, 4 were non-white (4%) and of the 2 that were successful none was non-white.

PCA/HSC SUPPORT STAFF

ADMINISTRATIVE ASSISTANTS (Job Centre advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Total	33 (60%)	22 (40%)	9 (64%)	5 (36%)	2 (100%)	—

Number of applicants: 55.

ADMINISTRATIVE ASSISTANTS (Recruitment & Assessment Services (RAS) instant recruitment)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Total	4 (50%)	4 (50%)	4 (50%)	4 (50%)	1 (50%)	1 (50%)

Number of applicants: 8.

ADMINISTRATIVE OFFICERS (internal trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	4	7	4	7	4	6
Non-White	2	1	2	1	2	1
Total	6 (43%)	8 (57%)	6 (43%)	8 (57%)	6 (46%)	7 (54%)

Number of applicants: 14.

Of the 14 applicants, 3 were non-white (22%) and of the 13 that were successful 3 were non-white (22%).

MESSENGERS (Job Centre advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Total	50 (89%)	6 (11%)	10 (91%)	1 (9%)	2 (100%)	—

Number of applicants: 56.

MESSENGERS (Job Centre advert)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Total	36 (100%)	—	9 (100%)	—	2 (100%)	—

Number of applicants: 36.

SENIOR MESSENGER (internal trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	1	—	1	—	1	—
Non-White	1	—	1	—	—	—
Total	2 (100%)	—	2 (100%)	—	1 (100%)	—

Number of applicants: 2.

Of the 2 applicants, 1 was non-white (50%) and the one successful was white.

PERSONAL SECRETARIES (inter-departmental trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	—	22	—	16	—	4
Non-White	—	—	—	—	—	—
Total	—	22 (100%)	—	16 (100%)	—	4 (100%)

Number of applicants: 22.

Of the 22 applicants who applied for the positions, none was non-white.

EXECUTIVE OFFICERS (internal trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	—	3	—	3	—	2
Non-White	—	—	—	—	—	—
Total	—	3 (100%)	—	3 (100%)	—	2 (100%)

Number of applicants: 3.

Of the 3 applicants, none was non-white.

SEO FINANCE MANAGER (inter-departmental trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Total	39 (80%)	10 (20%)	4 (57%)	3 (43%)	1 (100%)	—

Number of applicants: 49.

SEO DATA MANAGERS (internal trawl)

	Applications		*Interview*		*Appointed*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
White	4	2	4	2	1	1
Non-White	—	—	—	—	—	—
Total	4 (67%)	2 (33%)	4 (67%)	2 (33%)	1 (50%)	1 (50%)

Number of applicants: 6.

Of the 6 applicants none was non-white.

Overall statistics

Of the 1,599 applications that were received for the above schemes, 537 were from women (34%). Amongst the 239 invited for interview 115 were women (48%) and of the 65 that were successful 33 were women (51%). In relation to ethnic monitoring 1,167 (73%) monitoring forms were returned for external competitions (although not all competitions had monitoring forms issued), while for internal competitions ethnic data were drawn from other sources. 139 applications were from non-white candidates (9%). Amongst the 239 invited for interview (some of whom did not return monitoring forms) 9 were non-white (4%) and of the 65 that were successful 3 were non-white (5%).

No monitoring forms were received from registered disabled people for any of these posts.

In order to increase the level of ethnic and disabled monitoring for some inter-departmental trawls the Office is considering issuing its own application forms rather than allow departments to submit the civil service standard form. Similar action will be considered for Job Centre adverts. The Recruitment and Assessment Services accounts for the monitoring of its Instant Recruitment schemes centrally.,

Consultancy staff

In addition to the above, one short term appointment of a retired former member of staff was made on a consultancy basis at Director (Grade 5) level.

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