HEALTH SERVICE COMMISSIONER

FOR ENGLAND, FOR SCOTLAND AND FOR WALES

ANNUAL REPORT FOR 1993–94

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Health Service Commissioner

FOURTH REPORT FOR SESSION 1993–94

ANNUAL REPORT FOR 1993–94

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"You slip in and out of my room, give me medications and check my blood pressure .... Please believe me, if you care, you can't go wrong. Just admit that you care. That is really for what we search."

(American Journal of Nursing 1970).

1 INTRODUCTION

1.1 Almost every Ombudsman has found in recent years an increase in the complaints referred. We live in a querulous and questioning age; but it is noteworthy that the level of complaint against the NHS is still remarkably low when judged against the enormous numbers of admissions to hospitals for in-patient or day treatment. In 1993–94 more complaints were sent to me than in any year since the Health Service Commissioner was called into being. The Health Departments now provide more systematic statistics about complaints. Whether there is a correlation between the number of complaints and the general standard of care provided by the NHS is a judgment which I am content to leave to others. I find that many NHS staff are increasingly aware of the value of complaints as indicators of quality: however I still find room for improvement in handling complaints. My office enables me to see poor complaints handling, staff resentful of complainants, inadequate service, ignorance of procedures designed to help patients and words rather than actions in defining and delivering a quality service.

1.2 The year 1993–94 was an important one for complaints procedures in the National Health Service and more widely. The Select Committee on the Parliamentary Commissioner for Administration, which looks after my actions both as Parliamentary Commissioner and as Health Service Commissioner, produced a report in January 1994 on the scope and jurisdiction of the two offices I hold. In 1993 the Government set up a Review Committee under the Chairmanship of Professor Alan Wilson, Vice Chancellor of the University of Leeds, which was asked

> "to review the procedures for the making and handling of complaints by NHS patients and their families in the United Kingdom, and the costs and benefits of alternatives to current procedures, and to make recommendations to the Secretary of State for Health and other Health Ministers."

That report was published under the title "Being Heard" in May 1994. The responses of the Government to both those reports will clearly affect the way in which I discharge my duties in the future and the scope of my remit.

1.3 In my annual report as Parliamentary Commissioner for Administration for 1993 I set out some examples of what I considered to be maladministration. The term was described by those who took legislation through Parliament in 1966 when the Parliamentary Commissioner Bill was being enacted. The term maladministration is not defined in statute. I therefore felt that it was useful to give examples of what I regard as maladministration in my annual report and I now repeat that in this annual report.

1.4 The terms given by Mr Richard Crossman in 1966 were " bias, neglect, inattention, delay, incompetence, ineptitude, perversity, turpitude, arbitrariness and so on." I have added

rudeness (though that is a matter of degree);
unwillingness to treat the complainant as a person with rights;
refusal to answer reasonable questions;
neglecting to inform a complainant on request of his or her rights or entitlement;
knowingly giving advice which is misleading or inadequate;
ignoring valid advice or overruling considerations which would produce an uncomfortable result for the overruler;
offering no redress or manifestly disproportionate redress;
showing bias whether because of colour, sex, or any other grounds;
omission to notify those who thereby lose a right of appeal;
refusal to inform adequately of the right of appeal;
faulty procedures;
failure by management to monitor compliance with adequate procedures;
cavalier disregard of guidance which is intended to be followed in the interest of equitable treatment of those who use a service;
partiality; and
failure to mitigate the effects of rigid adherence to the letter of the law where that produces manifestly inequitable treatment.

1.5 As Health Service Commissioner I am able to look at failures in service. Because of that I judged it right to publish a special report, the first of an individual case ever so published by a Health Service Commissioner, in February 1994. The events which I examined occurred before the introduction of the new approach to care in the community which started in April 1993. They were in my view so important that I thought it right to inform Parliament and the public of my findings which were that Leeds Health Authority had failed to provide care for a man who was left highly dependent after a stroke. After 20 months of acute care the hospital discharged him to a nursing home, but long term nursing care should in my view have continued to be provided by the NHS. As it was not provided by the NHS I invited the Health Authority to reimburse the man's wife for the costs she had incurred since his discharge from the NHS. They accepted my recommendation. They also undertook at my suggestion to review the whole of their policy in relation to the provision of continuing care for such patients.

1.6 I welcome the fact that in January 1994 the Government issued a consultative paper on Codes of Conduct and Accountability in the NHS and subsequently issued it in definitive form. In addition to the need for openness and fairness not only to complainants but also to the staff directly involved in dealing with complaints there is a role for the members of NHS Authorities, Boards and Trusts to play in monitoring the way in which complaints are handled. Quarterly reports to the members were a requirement laid down under the Hospital Complaints Procedure Act 1985. All too often my investigations show that such a provision is absent from local procedures or that, even though it is there, it is being ignored. A quality service is about devoting personal attention to individual patients. Policies and procedures are useless if that essential human element is missing.

1.7 In 1993 I introduced an innovation. I decided that when I published a selection of completed investigations in anonymised form I would no longer

withhold the identity of the NHS Authority, Board or Trust concerned. That change is consistent with what I do as Parliamentary Commissioner for Administration. It accords with the principle of accountability. Ministers, representatives of the Opposition, and the NHS Management Executives all welcomed that change. I still withhold the identity of the complainants for reasons of confidentiality and in order to avoid making them distressed once more.

1.8 In this annual report I have for the first time in Chapter 4 included a brief summary of all the cases completed during the year with the names of the NHS Authorities concerned. By no means all complaints were upheld by me. I do not look upon the list as a league table of performance. The fact that a particular health authority may appear more than once could simply mean that it is open and helpful in letting those who want to complain know that they may approach me. If they give advice, they should get it right. It is incompetent for health authorities or community health council staff to give the address of another Ombudsman instead of mine. It does not help the complainant if he or she is advised to put to me a grievance which is clearly outside my jurisdiction. Such local unhelpfulness is bound to make the complainant disillusioned and disappointed.

1.9 In many of the cases which I investigated I was obliged to criticise what can only be regarded as an abrogation of responsibility and neglect of management. Far too often I have to deplore the treatment of patients which shows disregard for the needs and care of fellow humans. Far too often nothing has been done to manage patient care properly until I have completed an investigation. In cases such as that those responsible should feel a sense of shame.

1.10 Many of the complaints put to me have been caused by failures in communication. Some of those failures have been aggravated by splitting health care into many more separate organisations whose staff need more training for their responsibilities. Often staff are ignorant of the advice given by Health Departments about how to admit patients, how to give them adequate care and how to discharge them at the end of their period in hospital. Ignorance or an omission to put into practice well thought out guidance can lead to failures to provide the standards of care to which patients are entitled.

1.11 The cases which I publish provide lessons to the NHS about pitfalls to avoid. Members of the public are entitled to expect that the NHS will pay heed to lessons to be learnt from my investigations. The summaries of selected cases are widely circulated and I welcome the initiative of the West Midlands Regional Health Authority in 1993 when it issued focused guidance to NHS authorities within its area on what they should do to avoid the failures highlighted by my published cases.

1.12 In the past year I received 1384 new complaints. That was 12.8% up on the previous year and was the highest number so far. The increase in the proportion of investigable complaints has also continued. I accepted 203 for investigation as against 164 in 1992/93. The increase in work has been matched – but with a time-lag – by some increase in my staff. As a result the average time taken to complete an investigation rose from 45.3 weeks to 48.6 weeks. The proportion of cases given a full reply within 18 days on being screened has dropped to 50%. Despite that I pay a warm tribute to my staff for coping with a heavier caseload and for their efforts to keep delays to the

minimum consistent with thorough investigations. A detailed statistical analysis is given in Chapter 5 and the Appendices.

W K REID
Health Service Commissioner July 1994

(i) Discharge procedures

2.1 In my Annual Report for 1990–91 I observed that the Department of Health guidance in circular HC(89)5 'Discharge of Patients from Hospital' was capable of different interpretations. That was particularly important in respect of whether a relative could veto the discharge of a patient to a private nursing home, if the fees there would not be paid by the NHS. That unfortunate lack of clarity has featured in several discharge cases which I have investigated, though the view of the Health Departments is that NHS authorities do not have an inalienable duty to provide hospital care for a person who is judged not to need it. That is not the same as maintaining that they can reasonably choose not to provide full-time continuing nursing care under the NHS in every case where acute care in hospital is no longer needed.

2.2 The Departmental guidance requires that patients who are being discharged to private nursing homes, or their relatives, should be told in writing and in good time whether the fees will be paid by the NHS; and that patients should not be placed in a private nursing home against their wishes if it means that they or their relatives will be personally responsible for the home's charges. In my experience that policy guidance is not adequately known or observed. In some instances patients or their relatives have simply not been properly told about the financial implications of discharge to a private nursing home. Three of the cases in this section deal with these aspects of discharge procedures.

W.256/92–93 on pages 44–55 of HC 498

2.3 A woman complained about the discharge of her elderly aunt to a private nursing home from a long stay hospital which was about to close. After initially agreeing to the move, the woman withdrew her consent saying that she had not realised, until a month before the planned discharge date, that her aunt would be responsible for paying the home's fees. She afterwards agreed 'with the greatest reluctance' that the move should go ahead. My investigation showed that the woman had known for some time that the move might have financial implications, so she could have taken some steps herself to find out the facts. I did not regard the Department's guidance as giving the woman the right to prevent her aunt from being discharged when the consultant responsible considered that her needs could be met at the home. I criticised the Health Authority's failure to observe the Department's guidance in respect of written notification about the nursing home's fees and I found that more could have been done earlier to provide information about what was planned and the possible financial consequences.

E.62/93–94 on pages 1–9 of HC 197

2.4 This case focused on issues of such wide public interest about the provision of long term nursing care for patients who are severely brain damaged and incapacitated that I made a separate report about it. A 55 year old man suffered a stroke, for which he received surgery. After 20 months in a neuro-surgical ward nothing further could be done, although he remained seriously incapacitated. His wife agreed reluctantly to find a suitable nursing home for him and he was discharged in September 1991. The next year the man's wife complained to the Health Authority that they had not met their responsibilities towards her husband and that she had been obliged to pay for his continuing nursing care. The Authority's policy was to make no provision for the continuing care of patients with neurological conditions. I regarded

that as a failure in service in this case. Aspects of the discharge arrangements had also been unsatisfactory, particularly in that the man's wife had not been told in writing that the Health Authority would not pay the nursing home fees. As a result of my report they agreed to make an *ex gratia* payment in respect of the nursing home costs; to provide the man's future nursing care at NHS expense; to review the provision of services for such patients; and to remind those providing a service of the need to follow departmental guidance on discharge procedures.

W.524/92–93 on pages 86–91 of HC 498

2.5 An elderly woman, who had had a fall and lived alone, was taken to an accident and emergency (A and E) department where her leg was put in plaster. A casualty doctor decided that she did not have a fracture but was suffering from blood in the knee joint and did not need to be kept in hospital – although several days later a fracture was diagnosed. When the nurses found that the woman could not walk, the casualty doctor telephoned a general practitioner (GP) and arrangements were made to admit the woman to a private home. I found no evidence that enquiries had been made about the availability of a hospital bed, or whether there was a shortage of beds. None of the staff told the woman about fees for the home and they did not follow departmental or local guidance on discharge procedures. The outcome of my investigation was that the relevant NHS Trust made an *ex gratia* payment of £928 to the woman. They agreed to ensure that staff knew what was required of them under national and local guidance on discharge arrangements, and to advise patients before any transfer to a private home.

W.929/91–92 on pages 40–49 of HC 30

2.6 There was a tragic outcome to the events in the last case in this section. A GP persuaded an elderly woman, who was suffering from serious depression, that she needed hospital treatment. At the hospital a registrar decided that, although it would have been desirable to admit the woman, she was not actively suicidal. Believing there was no suitable bed available, the registrar sent her home. The registrar did not contact the GP before doing so and, despite a request from the woman's husband, declined to assist in arranging transport. The woman returned home by taxi and shortly afterwards took her own life. I found that beds had been available but that the registrar had failed to follow correct procedures to identify them. I found that poor relationships between A and E and psychiatric staff had not helped. The GP should have been consulted before the patient was discharged and more thought should have been given to her transport needs. After the woman's death the Health Authority conducted their own enquiry which made various recommendations for change which they agreed to check and monitor. They also agreed to carry out a critical evaluation of the adequacy of the arrangements for emergency psychiatric patients and of staff relationships.

(ii) Records and communications

2.7 Careful attention to record keeping is an essential part not just of the provision and continuity of treatment and care, but also of communications with patients and their families. Many of my investigations show a wide difference of understanding between doctors and nurses and patients and their relatives about the care and treatment which is being, or has been, given. Some individuals have unrealistic expectations of treatment or, in their anxiety and distress, find it difficult to accept what they are being told, but I occasionally encounter utterly conflicting and irreconcilable accounts of what has been taken place. Why should it be necessary to stress yet again that exchanges with patients and their families should be handled in a sensitive and caring way, that explanations be given clearly and unambiguously, and that

such matters be adequately documented? The cases in this section illustrate how repeated failures in service can result from poor communication and record-keeping.

W.966/91–92 and W.114/92–93 on pages 49–59 of HC 30

2.8 Availability of medical records can be crucial to the investigation of a complaint. A man who complained about his wife's care was told that his concerns could not be taken forward under the clinical complaints procedure because certain of her medical records had been lost. The loss of his wife's records was also likely to affect adversely the outcome of my enquiries into the man's complaints. I therefore pressed the chief executive of the Health Authority to satisfy himself that everything possible had been done to find the missing documents; they then turned up. The main folder, which was very worn, had no means of securing documents, although the hospital concerned has since begun to use plastic clips in medical records folders and has also introduced controls to limit the number of staff with access to patients' records. As a result of my investigation the Health Authority agreed to review arrangements for recording the movement of records, and ensuring that they were complete. They also agreed to check and record the contents when records have to be sent to external recipients. The late provision of the records meant that my investigation was delayed but not frustrated.

W.214/92–93 and W.454/92–93 on pages 21–30 of HC 498

2.9 After a routine operation an elderly man's post-operative recovery was slow but his son was reassured by nurses. They were not aware that the patient's consultant suspected cancer but had decided against pursuing tests to provide a definitive diagnosis. The consultant did nothing to inform the patient or his son. When the patient died, his son was shocked to discover from reading the post mortem report the extent of the cancer. He complained that the consultant had not spoken to him about his suspicions. I criticised as wrong in principle the consultant's expectation that the nurses could deduce a diagnosis from the clinical records and that they should convey that to the patient or his family. The Trust agreed to set down in writing what was expected of medical and nursing staff in terms of communicating a potentially worrying diagnosis.

W.306/92–93 on pages 55–60 of HC 498

2.10 An elderly man admitted to hospital for respite care was vulnerable to mouth infections because of his medication but neither that risk nor the family's concern about his sore mouth was recorded. Indeed, the records were so fragmented as to make it impossible to see whether there was a general and continuous appraisal of the patient's condition and care. The man was attacked by another patient. His relatives were caused unnecessary distress by not being told of that before they visited. Later the man's condition deteriorated and a doctor thought he might die at any time, but a nurse did not consider the deterioration sufficiently serious to merit being mentioned to the family. It was also not mentioned when they visited the next day, and a few hours after that visit the man died. I criticised the failures in communications between staff and with the patient and his family. The Trust agreed to take action to improve (a) the recording of the assessment and care given to patients and (b) the safeguarding of records. The Trust also agreed to consider what guidance should be given to staff about contacting relatives when a patient is injured while in the hospital's care, and about the allocation of responsibility for ensuring that next-of-kin are informed of any significant deterioration in a patient's condition.

W.547/92–93 on pages 101–110 of HC 30

2.11 A woman seriously disabled for 30 years was admitted to hospital for an operation. Her condition meant she was at high risk of developing pressures sores, but no record was made of factors relevant to that when she was

admitted. Plans for her care were not completed. Nursing records for the early part of her stay were seriously deficient and those for the later part had been lost. The Trust agreed to institute a local policy for the safeguarding of records and to remind staff of the importance of making adequate records of patient assessment and the care given.

SW.75/92–93 on pages 202–210 of HC 498

2.12 A woman who had accompanied her husband when he was admitted to hospital as an emergency was asked to wait outside the ward because she was told that a doctor would wish to speak to her. After she had waited for several hours a nurse, who had made no effort to contact a doctor, told her that she should go home. I accepted that in a busy ward receiving emergency patients there might be some delay before a doctor became free to speak to a relative, but in this case the staff had simply forgotten that the woman was waiting. After her husband's death, the woman had been told by her GP of an autopsy report which apparently contradicted what she had been told by the hospital clinician about her husband's condition. She did not appreciate that that report was based only on an initial naked-eye examination and that it would be followed by a further report after histology had been carried out. The subsequent histology report confirmed the original diagnosis. I suggested that where, as happened here to the confusion of the widow, macroscopic findings were known to be a variance with a hospital clinician's diagnosis, some discussion would be prudent between pathologist and clinician before communicating with a third party. The Trust agreed to review their policy in that respect.

(iii) Care and supervision

2.13 Every year I investigate cases about the circumstances in which decisions by doctors and nurses about a patient's care and treatment were made, whether those staff who needed to know were told and whether the decisions were carried out and recorded. The clinical decisions about what the treatment and care should be are not matters for me. The next two cases illustrate how failure to follow good practice and basic deficiencies in giving care and in observing a patient's condition caused needless distress and anxiety.

W.706/91–92 and 865/91–92 on pages 17–27 of HC 30

2.14 An elderly man had to wait over four months for tests to establish whether he had cancer. He was admitted to hospital for an examination but was discharged before a bank holiday weekend without any proper steps being taken to establish whether he would be able to cope at home where he lived alone. Later he suffered kidney failure and was re-admitted as an emergency. He was transferred to another hospital. There he suffered debilitating delays of up to four hours before being taken daily by ambulance to the radiotherapy centre, less than half a mile away, for treatment which took only 10 minutes. On one occasion he was wheeled along a public street in the rain for other treatment. My investigation revealed serious shortcomings in the patient's clinical and nursing records, ambiguous and illegible instructions, and inadequate discharge arrangements. The hospital Trusts and the ambulance Trust concerned agreed to put right what was wrong, including the provision of non-urgent transport arrangements for patients being moved between hospitals.

W.242/92–93 on pages 30–41 of HC 498

2.15 A man suffering from sickness, lack of appetite and jaundice was admitted to hospital as an emergency on a Friday. A scan requested then was not carried out for four days. Two further examinations were carried out during the 20 days he spent in the hospital before being transferred to another

hospital where he died two days later. The man had been admitted to the first hospital under the care of a consultant who was on leave, as were another two of the five consultant surgeons at the hospital and three of the four permanent radiologists. Weekends and a lack of team work contributed to a failure to decide a treatment strategy with any sense of urgency. Nobody took action to ensure that the man received the fat free diet he needed. His food and fluid intake were not monitored. Nurses did not refer the problems of poor appetite or diet to the doctors or the dietitians. Nurses did not understand that the high fat content of many food supplements made them inappropriate for a jaundiced patient. I was as concerned at the nurses' lack of knowledge about a matter of such basic importance as I was about awareness of correct technique for lifting a patient in a report which I published in the volume of selected cases for April – September 1993 (HC 30 pages 155 to 162).

(iv) Ambulance services

2.16 In 1993–94 several complaints were about ambulance services, both for emergency calls and for booked journeys. Some resulted from the deficiencies over a long period in the London Ambulance Service, which was overwhelmed by complaints. Others arose because established procedures and practice were not followed. I describe four bad cases.

W.380/92–93 on pages 67–72 of HC 30

2.17 A woman aged 93 fell from the tail-lift of an ambulance while being taken home from a day hospital. Evidence was conflicting about exactly how it happened, but there was no dispute that the ambulance attendant was not standing on the tail-lift with the patient when she fell. That was contrary to a requirement specified in the Ambulance Service's Training Instructions but not included in Service Guidelines. The Ambulance Service agreed to incorporate it in the latter and to place a prominent safety warning notice in each vehicle.

W.624/92–93 on pages 103–107 of HC 498

2.18 In another case involving the same Ambulance Service a man was knocked from his motorcycle when a car door was opened in front of him. An ambulance came and took him to hospital. The police were not involved because the ambulance crew had not reported the accident to them at the time. I found that a memorandum setting out a revised procedure for reporting road traffic accidents to the police had been issued in 1986, but the control instructions had not been amended at the same time. As a result of the crew's failure to follow established procedure there was little prospect that the motorcyclist could secure redress against the person who had caused the accident. These omissions by the Ambulance Service constituted a serious failure in service. Even more disturbing was the fact that I received no proof that the staff had been given any written reminder, as a result of this complaint, about what they should do in reporting road traffic accidents to the police. Putting right what went wrong should be an integral part of the response made to any substantiated complaint.

E.309/93–94 on pages 187–192 of HC 498

2.19 A private ambulance company contracted to carry out work for the local NHS ambulance service. A woman complained that when her late husband, who suffered from heart and breathing problems, was discharged from hospital he was allowed to walk from the ward to the ambulance and then had to wait for the ambulance doors to be opened. The proprietor of the private ambulance company, who went into the ward, alleged that the man had set off walking on his own before he could stop him. From the weight of evidence about the patient's condition and capabilities, and his own awareness

of them, I did not believe the proprietor's story. I found that there had been a failure in care. Ambulance crew should always make contact with the ward staff before going to the patient.

WW.51/92–93 on pages 210–215 of HC 498

2.20 A 90 year old woman with a fractured pelvis waited nearly seven hours on a trolley in an A and E department for an ambulance to return her from hospital to the nursing home where she lived. The woman needed either an emergency ambulance or a vehicle with an attendant, which could accommodate a stretcher. Staff at ambulance control did not note but 'remembered' requests for non-urgent transport – for that was how the request was regarded – even though the woman had special requirements. The Health Authority's said that there had been no opportunity to take the woman home earlier because it had been an extremely busy day but that was not borne out by my officer's analysis of the facts. There had been opportunities to take the woman home earlier. I criticised the failure to record requests and to monitor non-urgent transport and I asked the Health Authority to do something about those and other shortcomings.

(v) Handling of complaints

2.21 All NHS authorities, including Trusts, should have complaints procedures in place, appoint a designated officer to handle complaints and ensure that the correct action is taken where potential criminal offences, untoward incidents or disciplinary matters are involved. Too often I find that these procedures have not been followed, that there has been undue delay, that not all the staff involved have been questioned during local investigation and that the local replies leave unanswered many of the concerns expressed by complainants. It is not surprising that when this happens patients and their relatives are left very dissatisfied. They do not accept the sincerity of any apologies. They distrust assurances about what is being done to put matters right. I continue to find similar failures in the handling of complaints by family health services authorities (FHSAs) under the informal procedure for their investigation of complaints against the actions of GPs and other family practitioners (investigations under the statutory or formal procedure are still outside my jurisdiction). The following cases are disturbing.

W.582/92–93 on pages 91–103 of HC 498

2.22 I was appalled at how badly a Health Authority dealt with a woman's complaint that a male nurse had had a sexual relationship with her while she was a patient in a psychiatric unit. The woman had complained first to her doctors and then to the general manager of the unit. The doctors promised to take action but did nothing until the woman put her complaint in writing. I recognised the need to discourage spurious or mischievous complaints but I found it unreasonable in the circumstances to expect a woman to write formally about such a sensitive and worrying complaint before they would take any action. I discovered that the Authority had waited four months before reporting to the police an alleged criminal offence. The Authority's argument that it was for them first to establish whether there had been professional misconduct I found to be flawed. The nurse was dismissed for gross misconduct but not until six months later did the Authority fulfil their duty to inform the regulatory body for nursing – the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) – of their action. That meant that the nurse remained working elsewhere. I severely criticised the Authority which agreed to issue guidance to all staff, without delay, about the actions to be taken in respect of complaints relating to possible criminal offences.

W.828/92–93 on pages 126–138 of HC 498

2.23 In another case I found that a woman's complaint about a registrar's conduct and behaviour at an outpatient clinic had been handled insensitively. She had been interviewed twice about a particularly sensitive matter and asked to sign two statements, and would have had to go through that again had she not declined an invitation to appear before a panel, mainly of consultants, who were to deliberate upon the matter. Since the complaint was about what the woman saw as unacceptable behaviour by the registrar during a clinical examination, it seemed to me that that should have been raised with the chairman of the Authority as an allegation of professional misconduct and dealt with under the provisions of the appropriate Department of Health circular.

W.842/92–93 on pages 122–128 of HC 30

2.24 After a woman complained about a consultant's attitude during an outpatient consultation, the consultant wrote that he was not prepared to see her again. I found that the consultant's response had been hasty and ill-judged and based on a misinterpretation of what the woman had written. I said that the Health Authority should consider whether they should refer to the relevant professional body the consultant's action in dismissing the woman summarily from his care in the middle of a course of treatment without ensuring that arrangements were put in hand for her to be referred to another consultant. It took the Health Authority well over three months to investigate and reply to the woman's complaint, because poor communication among those involved caused confusion about who was dealing with the matter.

E.305/93–94 on pages 182–187 of HC 498

2.25 In the case mentioned in paragraph 2.9 the involvement of legal advisers in dealing with the complainant's requests for information led to considerable delay and he was not told of the options available for pursuing his clinical complaint. Similar issues arose in the case of a woman whose baby died after undergoing three operations. The mother asked for a post mortem. When she did not receive the results, she asked her solicitors to obtain the information. At about the same time, the surgeon sent a short letter to the woman and a detailed one to her GP. The woman felt that the letter sent to her contained contradictions and she did not understand the one to the GP. The solicitors received no adequate response to letters sent to the hospital manager and the general manager of the Health Authority. The hospital manager had assumed that she was dealing with a medical negligence case. Even so, had the complaints procedure or that in respect of potential litigation been followed properly the woman's concerns might have been considered earlier and the misunderstanding about litigation avoided. After the matter had been referred to me the solicitors were sent a reply in terms similar to the surgeon's original letter to the GP. That response fell far short of the hospital's requirement to avoid technical jargon when writing to complainants and it did not mention the clinical complaints procedure. The Authority apologised unreservedly and agreed to implement measures for monitoring complaints work and to remind staff of the provisions of the clinical complaints procedure. The medical records also went missing for a time, and the Authority agreed to review their procedures for the safeguarding of medical records required for litigation or the investigation of a complaint.

W.828/92–93 on pages 126–138 of HC 498

2.26 A man complained to me that, because of maladministration in the way in which a FHSA handled his complaint before invoking the formal procedure, there was delay in dealing properly with his concerns. He also considered the Authority to be at fault for not telling him earlier about the statutory 13 weeks time limit. I found the Authority's handling of the complaint deficient. I considered it unlikely that the options for dealing with

the complaint were explained when the man first complained. As a result he did not know that they were treating his complaint as a minor grievance, he was given no opportunity to have it dealt with through the informal conciliation process, and he was not told of his right to ask for a formal investigation at an early stage. In upholding the complaint I noted with approval that the Authority had put in hand arrangements to ensure that their complaints leaflet was sent to all complainants with their first response. They also agreed to remind staff of the need to follow the Department of Health's guidance.

W.873/92–93 on pages 138–141 of HC 498

2.27 A FHSA failed to give adequate consideration to a complaint because they followed a poorly worded Department of Health leaflet rather than the provisions of the regulations. That led them to give a woman, who had complained about her mother's GP prescribing drugs which her mother abused, the clear impression that the patient's consent was required in all third party complaints, except where the patient had died or was under age. When her mother died the woman wrote again to the Authority. She was not told until some two months later that her letter had not been accepted as a complaint and that she should write again. When she did so her complaint was ruled out of time, and her subsequent appeal to the Family Health Services Appeal Unit was rejected. I found that the Authority had been wrong in ruling the matter out of time. They undertook to see whether that injustice could be remedied by a further approach to the Appeal Unit and to write to the Department about the wording of its guidance.

(vi) Clinical complaints procedure

2.28 An independent professional review by two assessors is the last stage of the clinical complaints procedure, which was introduced in 1981 for handling clinical complaints against hospital medical and dental staff. Although I may not investigate matters which I consider involve the exercise of clinical judgment I can, and do, investigate the handling of clinical complaints and the conduct of reviews. It is a matter of regret that I find too often that the principles of good administration have not been followed. The following cases illustrate the delays and injustice which can then result.

W.280/92–93 on pages 59–63 of HC 30

2.29 An independent professional review considered the clinical care of a young man detained under the Mental Health Act 1983 who was allowed out of hospital without his parents being told and died. The registrar who permitted the leave gave differing accounts of his actions to a Coroner's Court and to the review hearing. The patient's father expressed concern to the Regional Health Authority about the outcome of the review and the failure of the assessors to take account of the conflict in the registrar's evidence. He was told that the work of the assessors was concluded and that nothing further could be done. The Authority should have given more thought to what could be done about the father's concerns. After I had made my report, the review was reconvened.

W.496/92–93 on pages 87–94 of HC 30

2.30 A man complained to me that the arrangements made by a Regional Health Authority for an independent professional review of his wife's clinical management were unsatisfactory: the assessors had not had all the relevant records relating to her treatment and had not interviewed one of three consultants responsible for her care. The woman had been cared for by a consultant cardiologist at one hospital and by a consultant cardiac surgeon and a consultant cardiologist at another. The hospitals were managed by separate health authorities within the same Region. I considered that the

regional consultant responsible for arranging the review had taken too narrow a view of the scope of the complaint and only the records from the first hospital had been made available to the assessors. If the Authority as part of their preparation had sent the complainant a summary of the case and terms of reference for the review – a practice followed in some regions – the difficulties might have been avoided. I would consider it unsatisfactory if, when there is evidence that a review had been undertaken on incomplete factual information, nothing can be done to review the assessors' findings short of seeking leave to have a judicial review. I recommended that the Authority should consider further what action might be taken to deal with the complainant's assertion that the findings had been reached without knowledge of all the relevant facts. I also made specific recommendations for them to review their procedures.

W.502/92–93 on pages 83–86 of HC 498

2.31 In paragraph 37 of my Annual Report for 1990–91 I mentioned a case where a consultant unreasonably objected to a man being accompanied by a Community Health Council (CHC) representative in a meeting under the first stage of the clinical complaints procedure. This year I investigated a similar complaint in relation to the third stage of the procedure. A woman and her husband wished a CHC officer to accompany them as complainant's friend. The Regional Health Authority told the independent consultants who were to undertake the review that the CHC officer would be present but omitted to mention the woman's husband. On the day the assessors said that they would see the woman in the company either of her husband or of the CHC officer, but not of both. I found that the assessors acted unfairly in not being prepared to accept the woman and her husband as joint complainants and that they had placed too narrow an interpretation on the term 'personal friend' in the Department of Health guidance about the conduct of meetings with complainants. I invited the Department to consider whether regional directors of public health and the Joint Consultants Committee should be reminded of the right of complainants to decide who should be present as a friend at any meeting under the clinical complaints procedure.

W.908/92–93 and W.1019/92–93 on pages 157–167 of HC 498

2.32 A woman who had her appendix out considered that on two occasions a surgical registrar deliberately carried out treatment in a manner which caused unnecessary pain. The registrar was a foreign doctor, holding a limited registration certificate, who had been working in the hospital while on a university training programme. Dissatisfied with the response from the hospital and the Health Authority, the woman and her fiancé asked for an independent professional review but were told that that was not possible as the surgical registrar was no longer employed in the NHS and had returned to the United States. I found that the registrar had been without a contract in respect of his employment for most of the time he was at the hospital. Until the complainants sought an independent professional review no steps were taken to take forward matters under the clinical complaints procedure, the consultant concerned having decided he would not deal further with the matter. I found that the regional medical officer had regard to irrelevant considerations in deciding against a review. The health authorities concerned apologised and agreed to tighten their complaints procedures, and to review arrangements for supervising the work of visiting doctors.

3 CASES OF SPECIAL INTEREST

3.1 The cases which I have selected for this chapter include the application of the standards in the Patient's Charter, extra-contractual referrals, and health authorities' responsibilities for ensuring the safe keeping of patients' property.

W.351/92–93 on pages 68–83 of HC 498

3.2 When patients with challenging behaviour were re-settled from another district into a mental handicap unit, a young man with severe learning disabilities who lived in a bungalow at the unit was moved to share another bungalow with other residents, one of whom attacked him frequently. That known risk was considered less dangerous than housing the young man with the patients with challenging behaviour. Eventually, he had to be kept apart from other residents for his own safety. I found that some years earlier a proposal had been made to release space for those being re-settled by moving patients from the unit to new housing at a different location, but the man's mother had raised objections to that at a public meeting. The man was not offered a place in the new housing but stayed on instead at the unit even though its use was being changed. A case conference failed to identify a long-term solution and there was a lack of will in tackling the problem. There were failures to follow Department of Health guidance about the resettlement of patients from other areas when the alternative local arrangements for the man were inadequate and there was no plan to meet his needs. The Health Authority apologised and said that they would agreed with the man's mother a detailed, long-term care plan to meet her son's needs.

W.381/92–93 on pages 72–78 of HC 30

3.3 Under the National Health Service and Community Care Act 1990 it is the function of district health authorities to provide for the medical needs of those living in their area mainly by purchasing treatment on a contract basis. It is still open to a GP to make an extra-contractual referral – that is, to refer a patient to a hospital with which the local health authority does not have a contract – but problems can arise. A man suffering from a long-standing and painful neurological condition was referred by his GP to a specialist hospital from which he was referred to another specialist and then to a neurologist at yet another hospital, who decided to admit him for further investigation. The man's Health Authority, after consulting his GP but not the specialist who had made the subsequent referral, declined to fund that admission. The Authority apologised for not having followed proper procedures in making, recording and notifying the decision, and they agreed to consider any further request for an extra-contractual referral which the man's GP might make on his behalf. In a case (W.693/92–93, which I did not publish in a selected case volume) involving a different health authority I found a further example of failure to adhere to proper procedures. The complaint was about refusal to pay for a woman's eye operation at a hospital in Belgium, and I found maladministration in the failure to take clinical advice before the decision was made. Both of these cases show how important it is that procedures and policy guidance are understood and observed, and that clear reasons are given to the person affected.

SW.81/92–93 on pages 141–146 of HC 30

3.4 A woman, who had understood from what she was told at an outpatient clinic that she would have her knee replacement operation in about three months, wrote to the hospital when that time had passed to check the position. She was told that she could not be given a definite date for admission. The hospital administrator argued that it would not have been

helpful to have told the woman about the maximum waiting time of 51 weeks as set out in the hospital's Patient's Charter, when she had apparently already been given a specified six months earlier. I found that decision mistaken and said that the woman was entitled to be given or have explained to her such information as the Health Board had available. I upheld the complaint, even though the woman eventually had her operation within the 51 weeks waiting time. I also invited the Board to rewrite their local Charter to conform with the Patient's Charter for Scotland.

WW.54/92–93 and WW.59/92–93 on pages 215–228 of HC 498

3.5 A man suffered fatal injuries in a fall while giving instruction. Three years later his father asked me to investigate why his son's property had been given by hospital staff to a third party. The property – including clothing and climbing equipment – might have been of evidential value at the two inquests which had taken place into the circumstances of his son's death. The patient had been taken by ambulance to a small hospital and then to a larger hospital in another district. Both hospitals denied removing the man's property. My investigation looked at all the possible opportunities there would have been to remove the clothing and equipment – at the scene of the fall, during two ambulance journeys and at both hospitals. I found that some property had been removed at the first hospital; no signature or receipt was obtained. Most of the clothing and an abseiling harness had been removed at the second hospital and handed over before the patient's mother and father arrived at that hospital. Both hospitals apologised for having failed to follow patient's property procedures and agreed to review those procedures with regard to items which might have evidential value. I suggested that clearly marked patient's property bags should be provided for use by the ambulance service and that clearer guidance be given to nurses on what property should be recorded as valuable. I also recommended that medical staff should be reminded to record the date, time and circumstances of the notification of a death to a coroner.

W.314/92–93 on pages 60–68 of HC 498

3.6 A man attended a NHS hospital as a private outpatient and was admitted urgently for immediate exploratory surgery. Neither he nor his wife was told that he could choose to be admitted as a private or NHS patient, nor were they told that the standards of amenity were the same for all patients in the hospital and that there were no special facilities for private patients. There were only six single rooms in the hospital. The man spent two days in a single room. Then he was nursed in a general ward for five weeks before being moved to a private hospital shortly before his death. His widow was charged £7,020 for his stay at the NHS hospital and, although her insurers paid the bill, she questioned the amount. Her letter was passed from one official to another; her concerns about standards of food and nursing care were never answered; and a letter which her Member of Parliament sent to the hospital was lost. The staff thought, erroneously, that the hospital complaints procedures did not apply to private patients. The Department of Health guidance issued in 1986 about managing private practice and rendering accounts was not followed. The woman's complaint was, essentially, ignored. The Trust apologised to the woman. They agreed to ensure that potential fee-paying patients have explained to them what is covered by daily charges; to follow Department of Health guidance; to deal with private patients complaints in accordance with written complaints procedures; and to make arrangements for the effective monitoring of all complaints.

W.1026/92–93 and W.710/93–94 on pages 167–174 of HC 498

3.7 A woman complained that staff in an A and E department made insufficient effort to arrange for her to receive emergency dental treatment locally. The woman had had an accident while visiting the town. After a doctor had attended to her facial injuries she was told that she needed

treatment for a broken tooth. Arrangements were then made for her to see a clinical assistant in oral surgery at his practice in another town, 20 miles away. The woman arranged her own transport. My investigation was concerned with the actions of the hospital staff and not with the adequacy or otherwise of the local emergency dental services provided by general dental practitioners (though it was available only to persons registered with a local dentist). The doctor who made the appointment with the clinical assistant considered that the woman needed the skills of an oral surgeon. That was a decision which she took in the exercise of clinical judgment and in accordance with the hospital's usual practice when – as in the woman's case – a nerve was exposed. She considered the woman fit to travel, and the journey was necessary if the tooth was to be saved; the clinical assistant could not have carried out restorative work at the hospital because they did not have the necessary equipment. I did not uphold the complaint but I observed that it might not have been made if the situation had been made clear at the time. The Trust now responsible for the hospital accepted that the woman should have been offered more help in arranging transport.

W.711/92–93 on pages 111–116 HC 498

3.8 A woman complained that a health authority's refusal to fund any further *in vitro* fertilisation (IVF) treatment was at variance with their approved policy, which stated that patients in their area who were already receiving IVF treatment would be limited to two cycles of treatment, each paid for by the Authority. The woman, who had been receiving IVF treatment in a hospital outside the area and paid for from non-NHS sources, was told that they no longer had the funds to treat non fee-paying patients. When she approached her Health Authority for funding she was deemed ineligible because she had already had more than two cycles of treatment. My investigation was confined to establishing the Authority's intentions when approving the policy, and to considering whether there had been maladministration in arriving at or implementing their decision in the woman's case. I found that the Authority intended that patients who had already had two or more cycles of IVF treatment should not be eligible for more, regardless of how the treatment had been funded. However, the wording of the recommendation approved by the Authority was capable of being interpreted in more than one way. I criticised the Authority for mislaying some of the woman's correspondence. But for that she would have been sent a letter, which the Authority sent to other patients receiving or awaiting IVF treatment, explaining their decision in terms which left no doubt about the position.

4 REMEDIES

4.1 Because my main purpose in referring to individual cases is to provide pointers to where shortcomings can arise and what can be done to put matters right, I decided that, for my annual report for 1992–93, the information in the 'Remedies' chapter should be presented under the main topics or categories of complaint. That innovation seems to have been welcomed by those who make use of my reports, and it also reflected as far as possible the new classification system set out, in this report, in appendices D and E. I have developed that approach further this year. In Chapter 1 I referred to my decision in 1993–94 to give, in my selected case volumes, the identity of the NHS authority involved and to refer in my annual report to *all* the cases completed during the year – regardless of whether I upheld all or any of the heads of complaint. This chapter therefore summarises, or includes a brief reference to, each case and gives the name of the relevant NHS authority.

Implementing my recommendations

4.2 Many of my investigations result in action to improve services, facilities or procedures, and my staff always check that my recommendations are carried out. Where I make a recommendation in respect of any part of a complaint I regard it as a duty of the Authority, Board or Trust to tell the complainant promptly what has been done as a result. I expect chairmen and non-executive members, as part of their monitoring role, to satisfy themselves that my reports are acted upon.

Financial remedies

4.3 If what the complainant is seeking above all is compensation, I regard that as a matter for the courts. Some ombudsmen include in their remedies a 'time and trouble' – or botheration – payment. Unless in a particular case I regarded financial redress as appropriate for the maladministration at issue, or there was perhaps a culpable persistence in error, I would not normally consider a compensatory payment to be appropriate for grievances about NHS care. The circumstances would have to be exceptional for me to do so.

4.4 I do recommend financial redress where there has been an identifiable loss or cost as a direct result of maladministration. In 1993–94 some such payments were relatively small, covering the cost of transport home (E.366/93–94) or the loss of personal items – a man's suit (W.294/92–93) or a necklace (W.447/92–93). In one case an *ex-gratia* payment of £750 was made to a man whose claim for attendance allowance was delayed because he had not been told of a terminal diagnosis (W.804/92–93 page ...). I have already referred in Chapter 2 to the financial remedy in the Leeds nursing home case (E.62/93–94), and to £928 paid in another case to cover the fees of a private home because A and E staff did not follow Department of Health guidance on discharge procedures (W.545/92–93).

Other outcomes

4.5 Many cases have more than one aspect of concern and I may not uphold all – or indeed any – of them. In the interests of brevity, I have summarised in this chapter only that part of each complaint which I upheld, or only the most significant aspect. In a few cases it was not possible to make a finding, or I decided to remit the case for further reconsideration by the NHS authority concerned (such as case W.693/92–93). In some cases, because I considered that the degree of injustice or hardship suffered was slight, I did not uphold the complaint. Occasionally a NHS authority will itself volunteer an apology and take local action without waiting for my report. I welcome that, although I will usually continue my investigation in

case there are matters which need to be brought to light and put right. NHS authorities are invariably very willing to act on my recommendations in those circumstances.

Categories of complaint

4.6 The summaries which follow are grouped under two main headings. Part A relates to the *substance* of complaints to me and covers a wide range of topics, whereas part B deals with the *handling* of complaints by the NHS authorities concerned. Many cases could have been placed under several headings, so I have provided a limited number of cross references.

4.7 Poor handling of complaints locally continues to be a significant, and largely avoidable, problem. Usually complainants seek no more than a timely, accurate, and sensitive explanation and apology and action to prevent the same problems being experienced by others. All too often they experience delay, confusing replies, or even obstruction. Occasionally local procedures are sloppy or even non-existent. That is unacceptable. Where there are adequate procedures, there is a duty upon the chief executive to see that they are acted upon and that staff are trained in how to operate them – and that those dealing with complaints have the seniority and authority to carry out a thorough local investigation.

Fuller texts of case reports

4.8 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 1993, HC 30.

(b) – as above, but in the volume for October 1993 – March 1994, HC 498

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

(s) – special report published, 2 February 1994, HC 197

PART A

4.9 The cases summarised in this part relate to the *substance* of the original complaints. Unless there there is a statement to the contrary, I upheld the complaint at least in part.

A and E department

W.929/91–92 (a) (c): Bloomsbury & Islington HA

A depressed, suicidal, woman died a few hours after being refused emergency hospital admission. Her GP was not consulted about the discharge, nor was transport home arranged. Staff to be reminded of discharge and transport procedures, and how to find a bed for an emergency admission.

WW.48/92–93: Mid Glamorgan HA

I did not uphold a complaint that a very elderly man should have been admitted after a fall – he had refused admission and neither his sons nor a casualty doctor could persuade him to stay – there was no A and E discharge procedure and I also called for arrangements for the attendance of social workers to be remedied. Regarding alleged inaccuracies in heart and blood pressure readings, I said an electrical interference screening test should be undertaken.

W.728/92–93: Tunbridge Wells HA
A man who thought his condition needed emergency treatment waited nearly three hours before a doctor saw him and decided not to treat him but suggested he should see his GP. I did not uphold his complaint about that, but the nurse who had referred the patient to the doctor had not made a full record of her decision. Staff reminded of need for full and attributable records.

W.739/92–93: St Helens and Knowsley Hospitals NHS Trust
A GP referred a woman to the A and E department saying she would not have to wait long to be seen and admitted. She was admitted six hours later and died the next day. Staff and GPs reminded about admission procedures.

W.843/92–93: West Dorset Hospitals NHS Trust
I did not uphold a complaint that A and E staff had been uncaring but a man had overheard conversations between staff about another person. Doctors to use telephones in privacy and locums to wear name badges.

A and E discharge

See: Nursing and Residential Homes – W.524/92–93

Agency and locum staff, medical students and visiting doctors

See: Diagnosis – W.242/92–93; Clinical complaints procedure – W.908/92–93; Lack of care – SW.60/92–93

Ambulance emergency transport

W.303/92–93: London Ambulance Service (SW Thames RHA)
A reply about delays in sending an emergency ambulance to a man's home and taking him to hospital was inaccurate and, unacceptably, implied that the man's wife might have been partly to blame. Tape recordings of the telephone calls were not provided to the family and a request for a meeting with the chief executive went unheeded. Review of policy on tape recordings and the decision in this case.

W.587/92–93: London Ambulance Service (SW Thames RHA)
Emergency telephone calls were held in a queuing system, and an emergency ambulance was delayed – the crew had been given an incorrect map reference. Action to be taken to ensure staff know which maps to use, and queuing problems to be monitored when technically possible.

See also: Clinical complaints procedure – W966/91–92

Ambulance Non-urgent transport

WW.51/92–93 (b) (c): Gwynedd HA
A 90 year old woman with a fractured femur, who had to be carried by stretcher, waited seven hours on a trolley for an ambulance to return her to the nursing home where she lived. Emergency and other suitable ambulances had been available. When discharging vulnerable patients, medical staff to make clear the time by which that should happen. Ambulance service to record all requests for transport; introduce standards for non-urgent transport; undertake a sample survey to measure performance of non-urgent transport, and to issue guidance on the retention of control room tapes.

W.448/92–93: London Ambulance Service (SW Thames RHA) and Riverside Health Authority
An ambulance failed to collect a man for two outpatient appointments. I did not uphold the complaint against the hospital, but did uphold it against the ambulance service. The failures arose from inaccuracies in transposing messages and in recording the man's address.

W.795/92–93: North Tees Health NHS Trust, South Tees Acute Hospitals NHS Trust
A woman was taken from one hospital to another for a scan. I did not uphold a complaint that she was inadequately clothed for the ambulance journey. I did find that, because of inadequate communication between staff, she had an unacceptably long wait for return transport and was not offered a meal. Reminders about timely notice of, and checking, transport requirements.

W.853/92–93: London Ambulance Service (SW Thames RHA)
A man, who had to be carried by stretcher, waited over eight hours for an ambulance to collect him after a scan. An emergency ambulance was needed because there were no other vehicles capable of taking a stretcher. New patient transport vehicles being acquired will accommodate stretchers.

E.309/93–94 (b) (c): Preston HA
I found it highly unlikely that an elderly man suffering from heart and breathing problems would have attempted to walk from the ward to a private ambulance unless encouraged to do so. The ambulance service's reply had not accurately reflected their own findings about the complaint. The ambulance service later dispensed with the services of the private ambulance company involved.

See also: Diagnosis – W.706/91–92; Discharge– W.904/91–92; Patients Property – WW.51/92–93.

Ambulance Equipment and procedures

W.380/92–93 (a) (c): London Ambulance Service (SW Thames RHA)
A woman aged 93 fell from an ambulance tail-lift platform. Instruction that the attendant should accompany patient on the platform to be included in 'service guidelines'. Safety warning notices and audible warning devices installed in similar ambulances.

W.624/92–93 (b) (c): London Ambulance Service (SW Thames RHA)
Because the ambulance service did not inform the police of an accident an injured motorcyclist was denied the possibility of taking legal action against the car driver involved. Revised instructions to be issued about notifying road traffic accidents.

Appointments, waiting lists

SW.36/92–93: Tayside HB
A woman's outpatient appointment was made by telephone; her name was not on the appointment list, her records were not to hand. Overbooking at the clinic also caused considerable delays. I made no finding about the attitude of the consultant and was satisfied that a nurse had asked about the husband accompanying his wife at her consultation. The consultant's report was sent to the wrong GP probably because a standard check had not been done. Reminder about checks, and Board to arrange sensible appointment times.

W.101/92–93: Camberwell HA
A man would have been given an earlier appointment if test results had been received by his consultant. After his admittance, plans were made for his discharge without consulting his family. System introduced for checking that originators receive test results. Reminders about discharge planning and adequate records.

W.583/92–93: Chichester HA
I found no maladministration in a clinical decision not to admit a man after an outpatient appointment, but the reply to his complaint which said that he

had been told that he would be placed on an urgent waiting list was misleading and not based on the information available.

W.688/92–93 (b): Bloomsbury and Islington HA
I did not uphold a complaint that a woman had not been told that her first hip replacement had to heal before a decision was made about operating on her other hip, or that placing her name on a second waiting list for that had delayed her treatment.

W.722/92–93: Northern Devon Healthcare NHS Trust
After a nose and throat operation a child's parents were told an outpatient appointment would be posted to them. The mother wrote to the hospital but received no reply. She telephoned and was told the appointment was that morning. Arriving on time, her daughter was kept waiting for an hour. Monitoring of outpatient appointments and local Patient's Charter standards to be reviewed.

W.944/92–93: Royal Free Hampstead NHS Trust
Telephone enquiries about an urgent gynaecological outpatient appointment were mishandled. Tracing obstetric and gynaecological records, and staff cover, to be reviewed.

See also: Diagnosis – W.706/91–92, W.753/92–93

Bed management

See: A and E – W.929/91–93; W.627/92–93 (page 29 this Chapter); Private patients – W314/92–93

Care plans, computer generated

See: Diagnosis – W.242/92–93

Clothing, bed linen, patient dignity

See: Lack of care and treatment – W.387/92–93, WW.9/92–93, WW20/92–93

Cot sides

See: Lack of care – WW.53/92–93; Communications/ Relatives – SW.106/92–93

Drugs and prescribing

See: Discharge – W.910/91–92; Lack of care/treatment – W.630/92–93

Communications with patients and relatives

W.880/91–92: Weston Area NHS Trust
A woman admitted with suspected cancer died the same night. There were several misunderstandings between the admitting doctor and the patient's daughter about communicating a diagnosis, drugs given, and the certification of death. Review of training for doctors on procedures following a death; mortuary records to include the time when a body is moved to the mortuary.

SW.75/92–93 (b) (c): Grampian HB
A man's wife waited in vain for several hours to see a doctor. I concluded that staff had forgotten about her. After her husband's death she had been misinformed and distressed by two different autopsy reports. I found an avoidable delay of seven weeks between the issue of a pathologist's initial report and a histology report which reached a different conclusion. The replies to the woman lacked accuracy. Reminder about dealing with relatives; and review of policy on communicating results of autopsy reports.

SW.106/92–93: Greater Glasgow HB
A woman complained that use of cot sides would have prevented her mother's fall from bed, but I found use of cot sides to be a matter of

professional judgment. I upheld complaints that a ward sister had delayed contacting the family about the fall and failed to ensure a nurse spoke to the family before they entered the ward on their next visit. Communications suffered further when staff reacted defensively as relationships became strained. Issue of guidance on use of cot sides; written guidance to be considered on action to ensure staff are available to speak to relatives.

W.116/92–93: Hillingdon Hospital NHS Trust
I did not uphold a man's complaint that his wife had been transferred to an intensive care unit against her wishes, because the decision about that stemmed from professional judgment. I did find that she had a five hour wait while a bed was found. Communications were poor. She expected to be discharged home but was transferred to another hospital. To a limited extent, I upheld a complaint that lavatories and the ward were dirty. Reminder about need for prompt action to deal with failures in cleanliness; and for medical staff to record at the time what a patient has been told about a diagnosis or prognosis.

W.214/92–93 (b) (c): Walsall Hospitals NHS Trust
An elderly man died in hospital a few weeks after a routine operation. His consultant had not pursued tests to confirm – or informed the patient, the nurses or the man's son about – a suspected cancer. I upheld complaints about lack of communication and failures to provide the son's solicitor with information or deal properly with the complaint. I did not uphold a complaint about a transfer of the patient's records. Written policy to set out what is expected of medical and nursing staff in communicating with relatives about a serious diagnosis; action to resolve the clinical complaint; and to ensure legal advisers understand departmental guidance and local complaints procedures.

W.511/92–93: Exeter RHA
I did not uphold a man's complaint that in a telephone conversation a maternity sister who had told him that his daughter (recovering from a caesarian operation a few hours before) was well refused to give more detailed information or obtain his daughter's consent to do so.

W.627/92–93: South Lincolnshire HA
A woman's nursing care had not been inadequate but communications about local nursing policies and practice were. She had been moved too often between different wards, and examined, inappropriately, in a bathroom. Her husband had not been told about the seriousness of her condition. Too much reliance was put on meetings and a consultant was defensive and exculpatory in his reply to the man's complaint. Review of admissions and bed allocation policies. Action to ensure privacy and dignity during examinations. Reminders about care in dealing with relatives and need for detailed replies to complaints.

W.680/92–93: Northern General Hospital NHS Trust, South Yorkshire Metropolitan Ambulance and Paramedic Service NHS Trust
I did not uphold a complaint that the ambulance service had taken inadequate steps to obtain next-of-kin details about an elderly woman, or that the hospital had given misleading information about her condition. I did find that ward staff had been dilatory in obtaining details and had not recorded them correctly. Investigation of the complaint was poor; reply delayed. Before my investigation new complaints procedures and training had been introduced.

W.820/92–93: Redbridge HA
The day before her death a woman's family were told about the seriousness of her condition, but her husband's telephone calls the following morning were unanswered. He arrived at the hospital after her death. Reminder about record keeping. Check of the telephone answering system.

W.986/92–93: Tunbridge Wells HA
On the morning a woman's seven year old son was to have an operation involving two surgeons, one of them told her that he thought his part of the procedure was inappropriate. Apology for lack of sensitivity.

Communications between staff

W.75/92–93: Royal Free Hampstead NHS Trust
A cancer patient was upset by a doctor's remarks which revealed a difference of opinion between medical teams about his treatment. Deficient record keeping added to the problem. The Trust could not confirm which of several doctors had attended the patient. Reminder about record keeping.

SW.94/92–93: Aberdeen Royal Hospitals NHS Trust
A young boy was fasted unnecessarily for a biopsy which did not take place and his parents were given conflicting information about when it would be done. Poor communication between staff had led to avoidable confusion and the parents were not given a clear explanation in reply to their complaint. Reminder about importance of good communications.

Community care and treatment

W.918/91–92: East Dorset HA
An elderly woman being cared for at home had difficulty in attending to her own hygiene. Patients, and when appropriate their carers, to be told in writing when permanent supplies of incontinence aids are to be arranged.

W.312/92–93: Bloomsbury & Islington HA
A wheelchair user had to have all repairs including punctures carried out by calling out an approved repairer in a different county. I did not uphold the complaint but review undertaken of what constitutes an urgent repair.

W.317/92–93: Worcester and District HA
I did not uphold a cystic fibrosis sufferer's complaint that he should receive a domiciliary physiotherapy service. For some years such a service, originally intended as a short term measure until he had learnt to perform his own physiotherapy, had been provided. He was able to drive to work and to hospital and to travel abroad. Decisions about the location of and a reduction in the hospital service provided were taken properly, but inadequate explanations had been given.

W.677/92–93: Bromley HA
In December 1990 a GP asked district nurses to provide a bathing service for a frail, elderly woman but in early 1991 the service was restricted to those also receiving nursing care. Complaint partially upheld. Review and clarification of policy on bathing.

W.824/92–93: Parkside HA
A woman suffering from agoraphobia was offered treatment after much delay but there had been failures in communication with her and within the Authority. Review of arrangements for supervision of community nurses, lines of communication and responsibility.

W.893/92–93 (b) (c): Grimsby HA
A specialist unit in London recommended continuing therapy for a severely disabled young man but a local consultant who examined him at home decided a hospital assessment was needed. That was not done, and a case conference was not held. Action to be taken to expedite the clinical care required.

W.1032/92–93: South Lincolnshire HA
I did not uphold a complaint that a man had not been provided with an appropriate chiropody service. I found that he had not accepted what he saw as a limited form of treatment which did not meet his expectations.

See also: Learning disability service – W.351/92–93; surgery delay – W.850/92–93 (page 41)

Consent

W.271/92–93: Greenwich HA
I found that it was regarded as acceptable practice, in cases of suspected non-accidental injury to children, that a parent's consent was not obtained to skeletal survey tests but no one had explained to the mother what the tests involved. Staff refused to discharge the child before the mother was seen by a social worker. Guidelines about skeletal surveys to be reviewed; discharge procedures to be clarified.

W.716/92–93: Leeds HA
I did not uphold complaints about lack of explanation about surgery, or a clinical decision not to replace a woman's pacemaker. I did find that she had been pressurised when signing an ambiguous consent form, and charged incorrectly as a private patient. Explanations to be given and consent forms signed well before surgery takes place. Consent forms to be clarified; correct procedure to be followed to identify and charge private patients.

See also: Maternity care – SW.87/92–93; Primary care complaints – W.873/92–93

Dental treatment

W.1026/92–93 (b) (c): Scarborough HA and North East Yorkshire Healthcare NHS Trust
I did not uphold a complaint that A and E staff had made insufficient effort to arrange for a woman to receive emergency dental treatment locally. Treatment was arranged but no transport provided and the woman had to go 20 miles to see the oral surgeon. The reply to her complaint was delayed and superficial.

Diagnosis: delay

W.706/91–92 (a) (c): Weston Area Health NHS Trust and United Bristol Healthcare NHS Trust
An elderly man with suspected cancer waited four months for tests. Staff did not understand the consultant's handwritten instructions. After an inpatient examination the man was sent home, where he lived alone, without adequate aftercare arrangements being made. When he was readmitted with kidney failure, his relatives were not told about his transfer to another hospital. Inadequate transport arrangement resulted in delays and on one occasion the man was wheeled through the streets in rain to attend a treatment centre. Staff reminded of the need for clear records. Discharge and ambulance procedures to be reviewed.

W.242/92–93 (b) (c): Basildon and Thurrock HA
A man with lack of appetite and jaundice was admitted as an emergency but a scan and other tests were delayed by the absence on leave of consultant

radiological and surgical staff. The hospital could not name some of the locum staff who had seen the patient. A fat free diet was prescribed but not provided, nor was the man's food intake monitored. After 20 days the man was moved to another hospital where a gallstone, not the suspected cancer, was diagnosed. He died two days later. Reviews of arrangements for consultant cover, monitoring and meeting the nutritional needs of patients, and the phasing out of inadequate computer-generated care plans.

W.753/92–93: Salisbury HA
A woman suffering from internal bleeding was referred by one consultant to another. There were considerable delays of several months. She did not meet the second consultant until her third appointment and then only after waiting two hours. At the first two appointments her records had not been available. Consultants to see and advise on the urgency of all referrals and ensure a satisfactory service to patients.

W.804/92–93: Aylesbury Vale HA
Doctors did not inform a patient or his wife of a diagnosis of terminal cancer, and the man's claim for attendance allowance was delayed. Ex-gratia payment of £750; steps to be taken to improve awareness of attendance allowance.

See also: Appointments – W.101/92–93

Discharge arrangements

W.904/91–92: Barking, Havering and Brentwood HA, and London Ambulance Service.
I did not uphold a complaint that an elderly woman with lodgers at home, one of whom had said that he would keep an eye on her, was discharged inadequately dressed and without aftercare being considered. I made no finding on whether the ambulance service left her at home in a safe and comfortable condition.

W.598/92–93: Great Yarmouth and Waveney HA, and Royal National Orthopaedic Hospital NHS Trust
A man was discharged by the Trust with his knee sutured and in plaster. His GP could not remove the sutures and referred him to the local hospital. There the consultant who had treated the man before felt unable to remove the sutures without knowledge of the Trust's treatment. I criticised the Trust for the failure to arrange removal of the sutures and both hospitals for lack of communication. Trust to review guidance about removal of sutures.

W.761/92–93: Burnley Health Care NHS Trust, and Airedale NHS Trust
After treatment for a heart attack a man spent two weeks in a convalescent hospital. He died the day after discharge. Both Trusts had made the necessary discharge arrangements but the man had declined social services help. I upheld the complaint to the extent that the first Trust had not considered whether a home assessment was needed. Staff to be made aware of occupational therapy services.

W.790/92–93: South Lincolnshire HA
Because of conflicting evidence I made no finding on a complaint about remarks said to have been made about a woman's son, but staff were reminded of need for sensitivity. I did find an unreasonable (and not uncommon) delay in provision of medication to take home and of a medical certificate. Review of procedures.

W.910/91–92: Guy's and Lewisham NHS Trust, and Brighton HA
On a woman's discharge from Guy's confusion arose about what drugs had been prescribed and what arrangements should be made for radiotherapy. The discharge letter lacked specific instructions and she was not seen by a consultant radiotherapist during two weeks as a patient in Brighton. Part of the complaint, about ambulance services, was not referred by the Health Authority to the relevant authority. Reminder about legal requirements in respect of controlled drugs, and prescribing in good time before discharge; review of discharge procedures and reminder about need for detail in discharge letters; review of complaints procedures.

See also: Diagnosis: delay – W.706/91–92

Equipment

W.537/92–93: Croydon HA
I did not uphold a disabled woman's complaint that she had to discharge herself from hospital because a special type of adjustable bed had not been provided and that staff had not indicated that they would try to obtain one.

W.565/92–93: Heatherwood & Wexham Park Hospitals NHS Trust
I made no finding about whether oxygen and ventolin face masks had been used by more than one patient, but upheld a complaint that a woman had not been told that she could visit her husband at any time. Trust to mark face masks with patients' names and to issue an updated information handbook to patients admitted as emergencies.

See also: A and E department – WW.48/92–93

Funding/expenses/ charges

W.300/92–93 (a): West Lambeth HA
I did not uphold a complaint that a man was asked to pay for a preparation used to treat baldness. I found that the fact that the preparation cannot be prescribed under NHS regulations had probably been explained to him.

W.381/92–93 (a) (c): West Berkshire HA
A GP referred a neurological patient to a specialist hospital. From there he was referred to another hospital and then to another where the neurologist decided to admit him for tests. The HA refused to fund that referral but had failed to consult properly or tell the man what other treatment options were available. HA to consider any further referral made on the man's behalf by his GP.

W.693/92–93: City and Hackney HA
A woman who had been on a local waiting list for a cataract operation was given conflicting advice about how to apply for reimbursement of the cost of having it done overseas. Reimbursement refused for surgery done in Brussels. Decision to be reviewed with full clinical advice and all other relevant factors.

W.711/92–93: Bexley HA
Funding was refused for continuation of *in vitro* fertilisation treatment for a woman who had (but not at the Authority's expense) already received such treatment. I found the decision had been made in accordance with the intentions of the Authority's approved policy, but the policy was ambiguously worded. Mislaying of correspondence, and failure to write to the woman, meant she had not received a clear explanation.

Hygiene

See: Communications – W.116/92–93, Lack of care W.387/92–93

Lack of care/ treatment

WW.53/91–92: East Dyfed HA
I did not uphold a complaint that staff had failed to use cot sides, and did not know where to find emergency resuscitation equipment when a man suffered a fall from his bed and then a fatal heart attack, but some routine checks had not been done. Reminder about following care plans; reviews of guidance about cover for staff leave.

WW.9/92–93: Gwent HA
A diabetic patient had been walking barefoot although her legs and feet were very swollen. She was given a painkiller although her son told staff she felt she reacted adversely to it. Communication had been poor because of inadequate nursing arrangements. Dayroom call bells to be installed; wider range, and larger sizes, of women's footwear to be obtained.

WW.20/92–93: Gwent HA
I made no finding on whether a terminally ill, confused patient's dignity had not been protected by clothing him in ill-fitting hospital pyjamas, but I recommended that a supply of more suitable pyjamas be obtained. Given meteorological evidence, I did not uphold a complaint that the man had been cold because his bed had been too near a window, but draught tests needed to be done on the windows. An inadequate reply had been given to the question why the man had been admitted under the care of a consultant other than the one who had treated him before.

SW.60/92–93 (a): Tayside HB
After admission a terminally ill man made his own way to the ward. That caused him distress and he arrived in a state of collapse. Two days later a medical student, not realising how ill the man was, wrongly conducted a two hour examination of him. Revised guidance notes issued to students also to be brought to the attention of ward staff.

W.304/92–93: Barnet HA
I upheld a complaint about a four hour wait before a woman was admitted to a ward. There was inadequate communication about her nursing needs and not enough discussion with her daughter about her care. The woman's skin was accidentally damaged by poor handling – there was insufficient use of available specialist expertise in treating the woman's pressure sores. Reminders about accurate A and E record keeping and issue of procedures to safeguard accident report forms.

W.306/92–93 (b) (c): Southend Healthcare NHS Trust
A respite care patient developed mouth problems but, despite expressions of concern by his relatives and his own complaint, he was not treated for some days during which he was unable to eat or then take fluids. His family were not told of an attack on him by another patient, or informed of the seriousness of his condition. Records were poor and fragmented, and communication between staff inadequate. Action to be taken on patient assessment, mouth care, nutrition, contacting relatives when a patient is injured, and informing relatives about a patient's deterioration.

W.363/92–93: South Lincolnshire HA
I did not uphold woman's complaint about the attitude of a ward sister, or about an examination by a doctor which would have been painful and for which she might not have been fully prepared. I did find there had been confusion about monitoring her fluid balance because a student nurse had wrongly included that as a requirement in her care plan. Reminder to qualified

staff to monitor care plans prepared by inexperienced nurses and the action recorded therein.

W.387/92–93: Walsall Hospitals NHS Trust
There were shortcomings in ward hygiene practices, and in care taken to protect the dignity of a man being nursed without clothing and to prevent pressure sores developing. The records were poor. Issue of simplified instructions about cleaning and disinfection in the ward; guidance on protecting dignity of patients; and reminders about pressure sore assessment and treatment, and record keeping.

W.517/92–93: Brent and Harrow HA
In the light of conflicting evidence I did not uphold a complaint that a woman was left in a debilitated and humiliating condition for over 20 hours before being treated for diarrhoea. I found there had been a three day delay before sample was taken. Reminder about obtaining samples promptly and that adequate information should be given to patients about the sampling process.

W.547/92–93 (a) (c): The Royal London NHS Trust
After an operation a very disabled woman developed a pressure sore. Nursing records were deficient, and some lost. Review pressure sore risk assessment. Introduction of a policy for safeguarding records.

W.592/92–93: Bristol and District HA
Throughout an afternoon an elderly woman was distressed and coughing but despite requests by relatives no doctor attended until after her death at 8.45pm. Her family had not been told of the seriousness of her condition, and a nurse felt unable to explain why a doctor had not attended. Nursing records were deficient. Reminders about explanations to relatives; record keeping and staffing levels to be reviewed.

W.630/92–93: Medway HA
I did not find that a man's nutrition had been overlooked but staff did not involve his wife when he was too ill to choose his own meals and her request for fresh milk for him went unheeded. There were serious record keeping failures in respect of his medication and a deplorable delay in alerting a doctor when the man repeatedly refused medication. A clinical decision to persevere with oral, rather than intravenous, anti-biotics had not been explained. I did not uphold the woman's complaint that she had not been told of her husband's poor prognosis. Action on record keeping and communication with relatives.

W.687/92–93: Blackburn, Hyndburn and Ribble Valley HA
Apart from finding that a man was sent home without a walking frame I did not uphold any aspects of a woman's complaint about her husband's care including weight loss and insufficient help with meals; of being taken outside on a wet day in pyjamas; of development of pressure sores; and about arrangements for home trials. I did criticise poor record keeping. Improved home trial arrangements, and issue of guidance on weighing patients, to be considered; review of procedures for pressure sore assessment; reminder about completing care plans.

W.837/92–93: Leeds HA
There was a lengthy delay before a general practitioner, who provided services as a clinical assistant to a local hospital, attended to see a patient who was very ill. The nurses had not explained to the patient's wife that they

did not think her husband was in need of urgent medical attention. Later, when the woman complained the doctor suggested, inappropriately, that the woman discuss her complaint with a member of a CHC rather than him. Nurses to be instructed to record details of requests to doctors to attend patients. Issue of guidance about dealing with complaints.

W.940/92–93: Bexley HA
I did not uphold a complaint about administration of eye drops containing lignocaine but I found that the records were incomplete and procedures had not been followed correctly. Issue of guidance about identifying and recording known allergies.

E.196/93–94: North Tees Health NHS Trust
A man was told that his wife who was in hospital was to have a scan. I found that doctors had intended that but no effective arrangements had been made. I did not uphold a complaint that a nurse had dropped the woman causing an old wound to reopen, or that a doctor had failed to attend the patient. I did find that a doctor was insensitive in being too forceful in attempts to persuade the woman to move to a ward she disliked. I was satisfied that a decision to change the woman's medication from intravenous to oral administration had been taken on clinical grounds. Revised procedures to be introduced for arranging scans.

Learning disability services

W.351/92–93 (b) (c): Wolverhampton HA
A defenceless man with severe learning difficulties and physical infirmities who lived and had become settled at a mental handicap unit was moved and inappropriately accommodated with other residents who frequently attacked him. For much of the time he was segregated from other residents for his own safety. Patients with 'challenging behaviour' were resettled at the unit from a hospital in another area but there was no suitable accommodation or plans to provide any for the man. Department of Health guidance in respect of making adequate local provision *before* resettling patients from psychiatric hospitals had not been observed. Detailed long term care plan to be drawn up and agreed with the man's mother.

Lifting, and mobility, of patients

WW.55/91–92 (a) (b): Gwynedd HA
An elderly stroke patient on respite care was being moved by one nurse from his wheelchair to his bed. Both ended up on the floor. A fracture of the man's femur was not diagnosed for three days. Inadequate pain relief was given and his wife was not contacted. Action to be taken on insufficient record keeping, information at staff handover, and informing relatives of accidents; an organised nurse training programme to be implemented by a physiotherapist.

W.870/91–92 (a): The United Leeds Teaching Hospitals NHS Trust
I did not uphold a complaint of insufficient attention to a woman's pain and difficulty in walking after she had been treated for a fractured femur, but I did find that the action of one member of staff had gone beyond the bounds of acceptable encouragement. I was unable to make a finding on whether a wound dressing had been neglected. Reminder to staff about the correct procedure when a patient's medication is changed; nurses to record information about wound care.

W.897/91–92: Southampton and S W Hants HA
An elderly woman admitted after a fall died eight days later. I did not uphold her daughter's complaint that her mother had felt she had been pushed and upset by being told to help herself but I did find that the problems had

probably occurred during walking practice. Reviews of nurse training in lifting and moving patients, and communicating with relatives about a patient's condition.

W.126/92–93: Oxfordshire HA
Relatives of an elderly woman thought she had been dragged on a blanket, naked and wet, from a bathroom to her bed. She had been moved fully clothed by means of a blanket lift. I did not uphold a complaint that she had been left unaccompanied for too long on a commode. Nurses to explain incidents which might cause relatives distress; training of nurses to cover the importance of correct lifting techniques.

S.8/93–94: Lanarkshire HB
I did not uphold a complaint that a long stay patient had fallen from a commode because of inadequate supervision. The woman had not been left unattended but the nurse had turned away to remove a chair to make way for a lifting hoist. I did find uncertainty among staff about procedures. Reminder about guidance on moving and handling patients.

Maternity care

SW.87/92–93: Lanarkshire HB
A woman complained that having been told that she had miscarried she was given little support from staff during a four hour wait before being taken to the operating theatre. I found staff had given the woman as much support as they could, but delay in a registrar arriving meant she had been denied an explanation from medical staff. In the operating theatre she also waited 45 minutes. I found it unacceptable that she was asked to sign a consent form while lying on the operating table, and any explanations given to her must have been rushed. I criticised a lack of procedure which resulted in community midwives not being informed and then, later, contacting the woman about her pregnancy. Maternity and community midwifery services have now been co-located.

W.525/92–93: Leicestershire HA
A woman complained that her baby's safety had been compromised and she had suffered pain and distress because of inadequate monitoring during labour. There were conflicting professional views about the care needed. The woman had received the care considered necessary by her midwife which was a matter of professional judgment not open to question by me. I found a lack of written information for mothers and the woman's request for a copy of relevant records had not been met. Written guidance for mothers to be issued; the records to be made available.

Mobility

See: Lifting

Nutrition and diet

See: Lack of care/treatment – W.306/92–93, W.630/92–93, W.687/92–93; diagnosis: delayed – W.242/92–93.

Nursing and residential homes

W.256/92–93 (b) (c): Bromley HA, Ravensbourne NHS Trust
A woman had been aware for some time that there might be financial implications if her aunt was discharged from hospital to a private nursing home. Department of Health guidance had not been followed on making clear at the earliest opportunity in writing whether the Health Authority would pay the fees. Review of discharge arrangements.

W.524/92–93 (b) (c): Royal Cornwall Hospitals NHS Trust
An elderly woman had her leg put in plaster but could not walk or be

discharged home where she lived alone. She was moved the same day from the A and E department to a private nursing home but was not told about the fees payable. At my suggestion the Trust made an *ex gratia* payment of £928 to cover the bill. Reminder about Department of Health discharge guidance.

W.850/92–93 (a): Eastbourne HA
A charity was unable to continue to help with the fees of a private home for a severely disabled almost paralysed man. He was admitted to hospital care. A consultant's view was that care in a geriatric ward or in a rehabilitation ward would be inappropriate and would not meet the man's need for mental stimulation. The consultant's views and his opinion that a single room should be provided (which was not done) were misrepresented. After six months the problem was resolved; after a community care assessment the man was re-admitted at no cost to him to the private home.

W.1006/92–93: South East Kent HA
I did not uphold a complaint that a 91 year old woman who had damaged her knee had been discharged from an A and E department to a private home, rather than back to warden assisted accommodation, without ascertaining her financial position or consulting her son. I found that staff believed they were acting in accordance with her wishes and those of her son. Issue of local guidance on discharge procedures for A and E patients, and on how staff should respond when patients or their relatives enquire about fees.

E.62/93–94 (s) (c) Leeds HA
A woman was obliged to pay nursing home fees after her husband who needed full-time nursing care had been discharged from a neurosurgical ward. At my suggestion an ex-gratia payment made to cover the costs incurred, and the man's future nursing care to be provided at NHS expense. Review of future provision for such patients; reminder about following Department of Health discharge guidance.

See also: Discharge arrangements

Patient's charters

See: Appointments – W.722/92–93, Surgery; delay – SW.81/92–93

Patients property

WW.51/92–93 (b) (c): Gwynedd HA and East Dyfed HA
A seriously injured instructor in outdoor activities was taken by ambulance to a small local hospital and then on to a district hospital. Neither hospital had followed patient's property procedures and I upheld the complaint against both. A harness of potential evidential value at inquests into the man's death had been given, with some clothing, to the man's employer but no record made. A patient's property book was lost. There was no record of the coroner being informed of the man's death – reminder to doctors about that. Clearly marked property bags to be provided for use in ambulances; reviews of guidance about property procedures.

W.294/92–93: Epsom Healthcare NHS Trust
Relatives complained about aspects of a man's nursing care and loss of his suit. Patient's property records lost; nursing records inadequate. Reviews of procedures and action to improve nursing record keeping; at my suggestion *ex gratia* payment made for lost suit.

W.447/92–93: Greenwich HA
An elderly woman undergoing x-rays lost a necklace. Guidelines on the security of patient's property to be issued to staff and given to patients;

apology for not explaining the involvement of the Authority's solicitors; at my suggestion an *ex gratia* payment made to cover the loss.

Private patients

W.314/92–93 (b) (c) Barking and Havering HA
A widow was charged £7020 for her late husband's stay which included two days in a single room. His insurers paid the bill. Her requests for an explanation from the hospital were ignored. Department of Health guidance about management of private practice to be followed; potentially fee paying patients to be informed in advance about daily charges; complaints dealt with in accordance with written guidance.

See also: Consent W.716/92–93

Psychiatric and psychological care

W.410/92–93: South Derbyshire HA
I did not uphold a complaint that a voluntary patient had not been seen by a doctor for two months. The woman had been seen as often as doctors considered necessary and there was no evidence of hardship. There had not been enough discussion with her about her nursing care and I upheld a complaint that she had been made to perform an exercise which had been withdrawn from treatment programmes. I made no finding about whether she had been ignored on return from weekend leave. I did not uphold a complaint about the imposition of smoking rules or her removal from a single room. Exercise programmes to be approved and undertaken by qualified staff.

W.449/92–93 (a): Leicestershire HA
I did not uphold complaints about arrangements for a woman's psychology appointments or her care being stopped without acceptable alternative NHS treatment being offered. Because of a prospective job change a psychologist had stopped offering blocks of appointments. The woman refused any of the other options offered and was properly discharged back to her GP's care. There was delay in dealing with her complaint and no formal complaints procedure, and replies purporting to come from the chief executive were signed by someone else using his name – that practice to be reviewed.

W.572/92–93: South East Kent HA
A woman complained that she and her husband had been led to believe that she was being compulsorily detained. I found no intention to mislead but the woman's rights as an informal patient had not been explained. Measures taken to ensure that on admission patients were made aware of their status.

W.898/92–93: West Essex HA
After a weekend leave a young man was moved, without warning, to a different ward. The next day he was reported missing and a few days later took his own life. The consultant had not contacted the family; supervision was inadequate; reply to the complaint was delayed. Transfer and supervision of patients to be reviewed.

See also: A and E department – W.929/91–92; Clinical complaints procedure – WW.55/92–93; Independent Professional Review – W.228/92–93, W.280/92–93

Records

W.150/92–93: St Helens and Knowsley Hospitals NHS Trust
A woman needed information about her previous treatment but received no reply to three letters. The medical records department had been disorganised and was being relocated. Before I finished my investigation the system had been overhauled and the woman's records found. Written instructions issued to medical records staff.

E.354/93–94: Royal Hull Hospitals NHS Trust
I did not uphold a complaint that completion of a form about a man's eligibility for registration as partially sighted had not been dealt with; but no details had been recorded about searches for some missing records. Reminder about making records of searches, and accurate replies to complainants.

See also: Communications between staff – W.75/92–93; Clinical complaints procedure – W.966/91-92

Staff attitudes

SW.68/92–93: Lanarkshire HB
I did not uphold a man's complaint that staff involved in carrying out his x-rays had been rude, inconsiderate and aggressive, and his complaint had not been answered. I found that it was his behaviour which had been unacceptable. His initial complaint had not been concluded properly but when he elaborated on it considerable efforts were made to reassure him and answer his complaints.

W.455/92–93: Bath District HA
I did not uphold a complaint that a consultant obstetrician was rude, I made no finding that another doctor told a woman wrongly that she had a growth retarded baby; but I upheld her complaint that the reply to her original grievance was delayed and unsatisfactory.

W.548/92–93: Dudley HA
There was conflicting evidence about a man's complaint that a consultant had been rude to him and it was not possible to determine what had been said. Insufficient effort had been made to resolve the complaint. Review of delegated authority for dealing with complaints.

W.842/92–93 (a) (b): North Manchester HA
A consultant had made an ill-judged remark during a consultation but I did not otherwise uphold a woman's complaint about his attitude or delay in carrying out a scan. I did find the reply to her original complaint had been badly handled. I criticised the consultant for hasty action when he withdrew from the woman's care, because of a mis-interpretation of what the woman had said in her complaint, without ensuring that she was referred to another consultant.

E.366/93–94: Royal Liverpool University Hospital NHS Trust
A woman was called in for surgery but no bed was available and she was sent home. I upheld her complaint about the attitude of a surgical registrar. At my suggestion *ex gratia* payment made for cost of her transport home.

See also: Discharge W.790/92–93

Surgery: delay

SW.61/92–93: Forth Valley HB, and Lothian HB
Because junior doctors were not sure about their role and responsibilities, and there were poor communications between medical and secretarial staff, there was delay in recalling a man for an echocardiogram, misleading information was given about waiting time for an angiogram, and his name was not put on a waiting list for cardiac surgery. Review of induction procedures for house officers; clarification of discharge arrangements; revised discharge summary form; formal procedures for dealing with mail and records in cardiology department; and action to improve communications.

SW.81/92–93 (a) (c): Lothian HB
A woman referred for an opinion about whether she needed knee replacement surgery was seen at a clinic of a consultant who did not carry out such surgery. She was then referred to another consultant. Because he backdated her place on the waiting list she did not suffer additional delay, but her attendance at the first clinic could have been avoided had there been an effective system for informing GPs about specialist services. The woman was not told how long she might have to wait before admission. Review of information provided to GPs; action to improve communication between clinical teams; local Patient's Charter to be rewritten.

W.86/92–93: South Birmingham HA
A woman with a fractured hip waited three days for an operation. I noted an absence of any pre-operative assessment in the clinical notes. I found the timing of the operation to be a matter of clinical judgment. A doctor's ambiguous handwriting resulted in doubt as to what traction weight had been applied. Some prescribed painkillers were not given. After her operation the woman died in the intensive care unit. I made no finding about non-attachment of an oxygen mask. An observations chart had been lost. There was a misguided belief by the hospital's chief executive that a meeting with the consultant was a pre-requisite of the clinical complaints procedure. Reminder about recording essential assessments and nursing care information; reviews of codes used to denote patient refusal of drugs; action to safeguard records; issue of simple guidance on traction weights; the clinical complaint to be taken forward.

W.166/92–93: South Birmingham HA and North Birmingham HA
A man complained that after his wife received chemotherapy at one hospital there was an unacceptable delay before she was referred back to be seen at another hospital for a mastectomy. I did not uphold the complaint as put because there had been no delay in referring the woman back and the decision as to how quickly she should be seen was a matter of clinical judgment. I criticised a failure to ensure that medical staff at outpatient clinics were in possession of all relevant correspondence. Review of correspondence handling procedures by North Birmingham HA.

W.844/92–93: Hastings and Rother NHS Trust
I did not find a lack of concern, but a woman whose operation was postponed should, and could, have been given a date for re-admission before she left the hospital. Re-booking arrangements to be reviewed.

W.850/91–92: York HA
Surgery to a woman's arthritic hand cancelled after pre-medication given. Promise that surgery would be done in another hospital within two months was not fulfilled. Review of arrangements with providers; at my suggestion woman's out of pocket expenses reimbursed.

See also: Diagnosis, W.804/92–93

Waiting lists See: Appointments, waiting lists

Ward conditions/ accommodation See: Lack of Care – WW.20/92–93; Nursing and residential homes – W.850/92–93; Learning disability – W.351/92–93; Private Patient – W.314/92–93

Complaints handling

W.711/91-92: York Health Services NHS Trust
I did not uphold a man's complaint that replies to his complaint about his wife's psychiatric care were inaccurate, but some were unduly delayed and the man should have been kept better informed. Reminder about established procedures.

W.246/92–93: Dudley HA
Although there was a willingness to try to resolve a man's concerns about discomfort arising from surgery, there were lapses and delays in dealing with the complaint. Reminder about need for accuracy and thoroughness. Meeting arranged between the complainant and his consultant.

W.503/92–93 (a): Wandsworth HA
A woman made a serious complaint about an intimate examination by a doctor. When told that such examinations were not normally done she thought that the man must have been an impostor. She described him to her consultant but was told the man could not be identified. The consultant had adopted an informal approach to the complaint, the general manager had not realised the seriousness of the allegation, and a proposed meeting had not been held. Review of local procedures and reminder to staff.

W.522/92–93: Canterbury and Thanet HA
When dealing with what they regarded as the more important aspects of a complaint, staff did not explain why a man had been sent two appointments to see a consultant who had already told him that he could do nothing to treat his condition. Clarification to be obtained about whether the man should attend any further appointments.

W.582/92–93 (b) (c): Wandsworth HA
A woman who was a patient at a psychiatric unit complained that a male nurse had initiated a sexual relationship with her. I considered it unreasonable that nothing had been done by the Authority until her complaint had been put in writing. Reference to the police was wrongly delayed until months after, on completion of a local investigation. Guidance to be issued about action if a complainant alleges a criminal offence has been committed. I also criticised a delay in reporting the matter to the relevant regulatory body.

W.590/92–93 (a): Mental Health Act Commission
I did not uphold a complaint that the Commission had been unfair in investigating a complaint about the circumstances of a man's admission to hospital. I did criticise some aspects of how they dealt with the complaint. The Commission to discuss with the Department of Health the gap between their statutory duty and their ability, within their remit, to investigate complaints.

W.725/92–93: Swindon HA
A reply was delayed because of a general manager's absence and confusion about who was responsible for dealing with the complaint. Further, without the complainant's permission, the comments of a consultant in another authority were sought. A vague reply aimed at not upsetting the patient simply compounded dissatisfaction. An officer to be designated to deal with complaints; review of complaints procedures.

W.760/92-93: South Essex HA
A reply was delayed when legal advice was sought. The Authority also misdirected itself in taking a decision, contrary to Department of Health guidance, not to provide a woman with specific answers to the issues she raised about her elderly mother's care.

W.828/92-93 (b) (c): Lancaster Acute Hospitals NHS Trust
A woman's complaint about the conduct of a doctor during her outpatient examination was dealt with insensitively and without the national procedures for dealing with allegations of professional misconduct. Review of local policy for dealing with such complaints.

E.246/93-94, E.434/93-94, E.435/93-94, E.437/93-94, E.571/93-94: Luton and Dunstable Hospital NHS Trust
In each of these five cases there was delay and lack of reply. There was undue delay in appointing a new member of staff while the officer who usually dealt with complaints was on maternity leave. The chief executive's assistant had, in addition to her normal duties, been given responsibility for complaints work. No action had been taken, and that fact had been concealed. Review of procedures.

In each of the following cases the reply was inadequate or insensitive or dismissive, and in most an unacceptable delay had occurred.

W.148/92-93 and E.158/93-94: West Lambeth Health Authority, Guy's and St Thomas' Hospital NHS Trust; S.33/93-94: Argyll and Clyde HB; E200/93-94: Greenwich HA and Greenwich Healthcare NHS Trust

Clinical Complaints Procedure

W.966/91-92 (a): Hastings HA, Eastbourne HA and East Sussex Ambulance Service
A man complained about attempts by an ambulance crew to bandage his wife's suspected skull fracture, lack of consultation about her treatment, and a decision to discontinue active treatment two days before her death. He was told his complaints could not be dealt with because of the loss of some her records. During my investigation those records were found. Clinical aspects of the complaint to be considered further. Review of arrangements for recording movement of records.

WW.55/92-93: Gwent HA
I did not uphold a man's complaint that he had been wrongly refused information about his estranged wife's voluntary psychiatric treatment. The Authority declined to refer the complaint for consideration under the clinical complaints procedure unless he provided proof that his wife supported the complaint. The woman's consultant said she was competent to give or withhold support. The procedure clearly requires, where a person is capable, that consent be obtained. There was no duty on the Authority themselves to obtain the patient's consent and they had acted correctly within the terms of Welsh Office guidance.

W.228/92-93: Oxfordshire HA and Oxford RHA
A voluntary psychiatric patient died a few days after a dispute over his discharge. It took far too long to deal with his relative's complaint and resulted in delayed submission to the relevant regulatory body of her complaint about the professional conduct of a nurse. Arrangements made for

the local review of her complaint were defective. Time limits to be included in revised complaints procedure.

W.280/92-93 (a) (c): North East Thames RHA
A review was held into the care and treatment of a young man, detained under the Mental Health Act, who had died while absent from the hospital without his parents' knowledge. I found the assessors had failed to take into account conflicting evidence and did not study a coroner's transcript. A reconvened review or one with new assessors was offered.

W.320/92-93: North Western RHA
Contrary to Department of Health guidance, the patient's consultant was present during the assessors' meeting with the complainant, and afterwards one of the assessors continued a discussion with the consultant. That cast doubt on the assessors' impartiality and in that respect I upheld a woman's complaint that the review had been conducted unfairly. Departmental guidance to be made available to all assessors.

W.496/92-93 (a) (c): South West Thames RHA
A review of a woman's treatment was unsatisfactory because the assessors had not seen all the relevant records and did not interview one of three consultants responsible for her care. Local procedures did not cover cases where treatment had been provided in more than one hospital and too narrow a view had been taken of the complaint. Procedural changes to be considered. Review of complainant's view that assessors' findings were made without full knowledge of the facts.

W.502/92-93 (b) (c): Wessex RHA
Assessors reviewing the circumstances of a birth told a woman that they would see her in the presence of her husband or the CHC secretary but not both. The assessors had taken too narrow a view of Department of Health guidance about the right of a complainant to decide who should accompany as friend at a review.

W.757/92-93: Swindon HA
A hospital had not involved the consultant in charge of the A and E department in the original investigation of a man's complaint. That delayed the consideration of the man's request for an independent professional review and there was a failure to keep him informed. Reminder about Department of Health guidance.

W.907/92-93: Scunthorpe HA and Yorkshire RHA
I upheld two limited aspects of a woman's complaint about the way in which her complaint about a clinical examination had been conducted. Clearer communication between the district general manager and the regional director of public health might have reduced the need for the woman to repeat her complaint in detail, and the RHA should not have allowed one of their officers himself to have answered a letter complaining about him.

W.908/92-93 (b) (c): Oxfordshire HA and Oxford RHA
A woman and her fiancé were told that their complaint that a foreign doctor deliberately caused her pain could not be dealt with under the clinical complaints procedure because the doctor had left the country. The doctor had been employed, during the large part of a six month university post graduate training course, without a contract. Consultants to be reminded of their responsibilities in the clinical complaints procedure, and review of contractual arrangements for, and supervision of, visiting doctors.

W.935/92-93: South West Thames RHA
and
W.994/92-93: South West Thames RHA, The Royal Surrey County and St Luke's NHS Trust
In both cases there were easily avoidable administrative failures.

E.51/93-94: Camberwell HA
Delays arose when medical records were temporarily mislaid and there were difficulties in finding a convenient date when the consultants concerned could meet the complainant. A manager's correspondence after the meeting was inadequate.

E.122/93-94: Bradford Hospitals NHS Trust
A consultant offered a man an informal review in respect of his late wife's care. I found that was not an acceptable alternative to the clinical complaints procedure, which should have been followed much earlier. One reply contained careless errors.

E.218/93-94: Royal County and St Luke's Hospitals NHS Trust
A CHC asked, on behalf of a complainant, for a meeting with a consultant. A year later no reply had been sent primarily because the Trust had not funded a post to deal with complaints. Before I completed my investigation they had done so and resolved the man's concerns.

E.305/93-94 (b) (c): Hospitals for Sick Children SHA
A request for information, put by a woman's solicitor, about the cause of her baby's death was treated wrongly as a potential medical negligence claim. Whereabouts of records not recorded. Review of procedures for complaints handling and for the safeguarding of records.

Primary care complaints

W.705/92-93: Cumbria FHSA
I did not uphold a man's complaint that he was without access to a GP's services because the FHSA had refused to register him with a GP outside his home area. I did not find it unreasonable that the FHSA had tried to persuade the man to register with a local GP. He was without a GP because he had asked to be removed from the register, having said that he intended to seek private treatment.

W.823/92-93 (a) (c): Liverpool FHSA
A man had not been told soon enough of the 13 week time limit for the submission of FHSA complaints, or of the right to ask for a formal investigation.

W.873/92-93 (b) (c): Salford FHSA
A woman complained that the FHSA had not given due consideration to accepting her complaint, without her mother's consent, about the prescribing of drugs for her mother who abused prescribed drugs. After her mother died she wrote again but the FHSA delayed and told her that her complaint was out of time. I found that the FHSA had followed misleading guidance in a Department of Health leaflet and had acted wrongly on the second complaint. FHSA to approach the Appeal Unit to see whether the injustice could be remedied.

W.878/92-93: Hertfordshire FHSA
The informal procedure had been invoked inappropriately. A man had not been told about the formal procedure or that the CHC could help him.

Incorrect information had been given at a meeting. In both this case and the next one changes had already been put in hand as a result of my recommendations in another case (see W.778/91-92 on pages 53-59 of HC704).

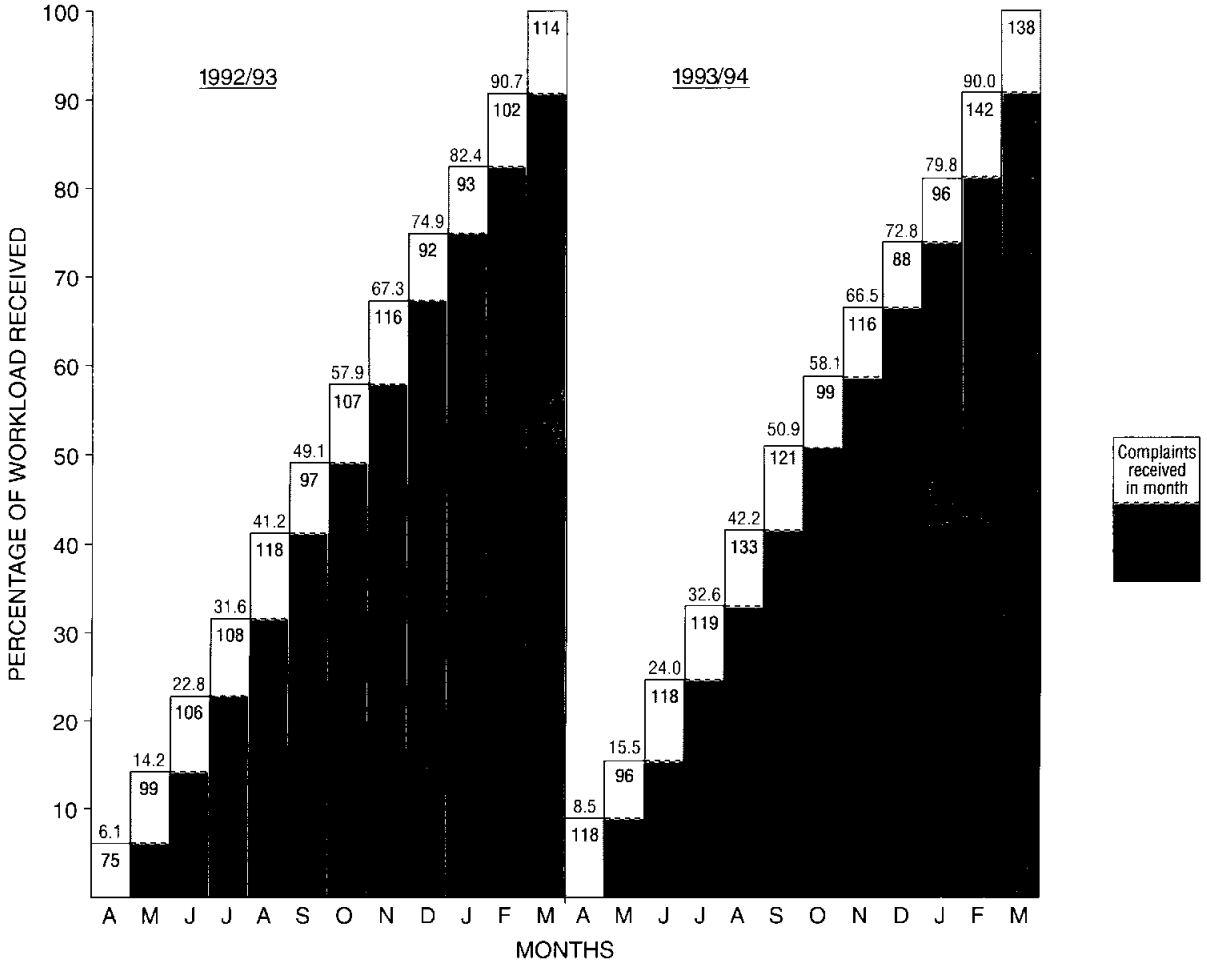
W.979/92-93: Hertfordshire FHSA
After an unsatisfactory informal review a man was told, contrary to his earlier understanding, that he could not invoke the formal procedure because his complaint was out of time. He had not been given any help or told about time limits or that the CHC could help him.

W.987/92-93: Bromley FHSA
After some delay a woman had been helped to put her complaint about her GP, but the FHSA had not responded to her complaint about a member of their staff.

E.46/93-94: North Yorkshire FHSA
Insufficient effort made to find some of a man's missing GP records. Guidance to be issued to local GPs about preservation and destruction of records.

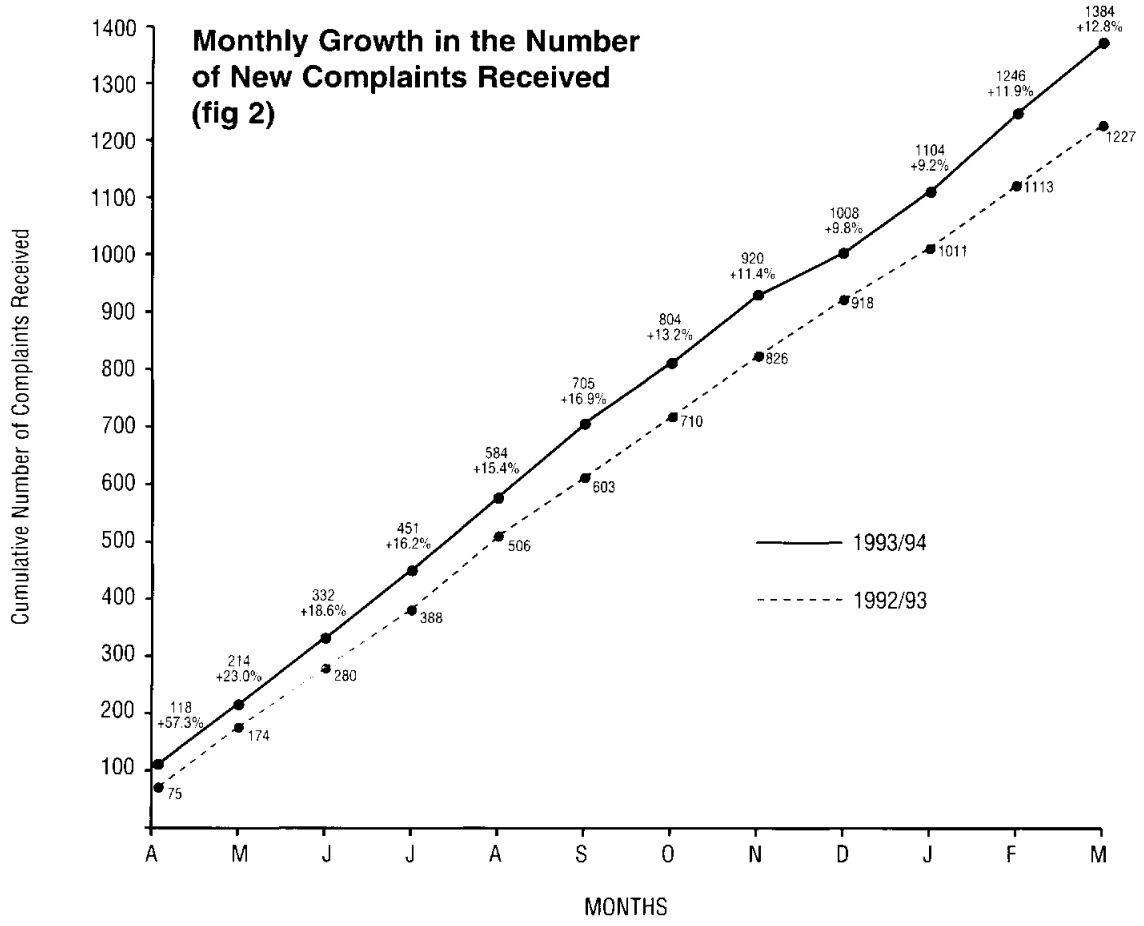
Workload 5.1 The number of complaints made to me continued to grow throughout 1993-94, the total for the year amounting to 1384. This was 12.8% more than in 1992-93. The diagram at figure 1 shows that the monthly pattern of referrals to me was like that in previous years, and figure 2 (next page) illustrates the actual month by month growth in new complaints compared with 1992-93.

Monthly inflow of new complaints (fig. 1)



5.2 Figure 3 (page 48) gives information about the number of complaints received for England, for Scotland and for Wales during 1993-94 and shows how the total workload for the year was handled. After a slight, and surprising, fall in the numbers of complaints from Scotland and Wales in 1992-93 all three countries returned to substantial growth and produced new record levels of work for 1993-94. This information is summarised in figure 4 and at Appendix B.

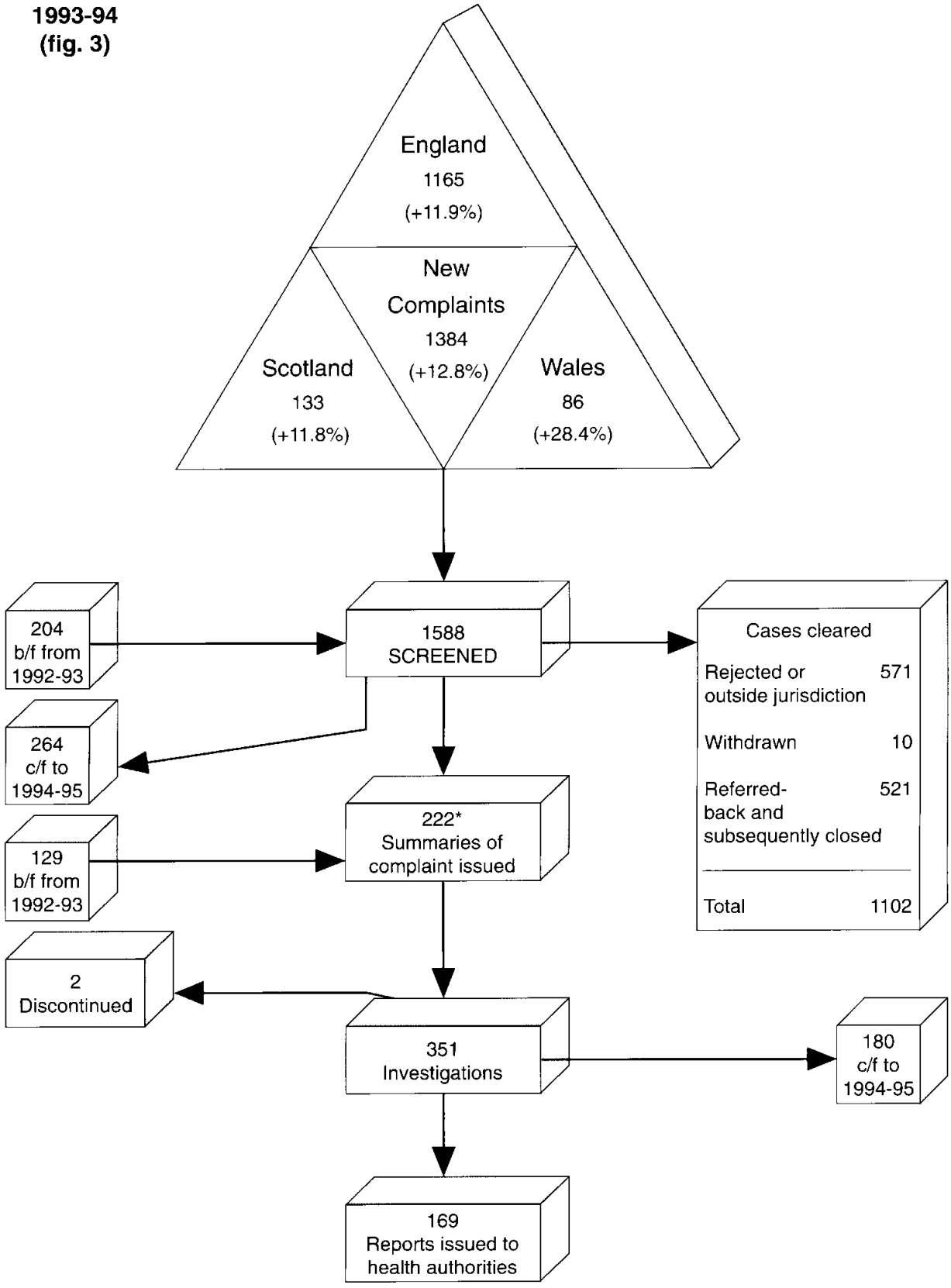
5.3 Appendix J gives an analysis of the new complaints received on a regional basis. All but four regions (South East Thames, Wessex, Oxford and North Western) saw some growth, with increases ranging from 4 (4.2%) in South West Thames to 27 (23.1%) in North West Thames. The largest percentage increase (39.6%) was in the North Western region, the number of complaints rising from 55 in 1992-93 to 79 in 1993-94. The share for the four Thames regions fell within the usual range, accounting for 42.7% of all complaints received for England.



5.4 Action was completed on 1273 (74.1%) of the total of 1717 cases which made up the workload for the year. This compares with 1176 (77.9%) of the 1509 cases dealt with in 1992-93. I made particular reference in my report for 1992-93 to the growth seen in that year in the number of supplementary letters received from complainants following an initial reply which either rejected their complaints or asked for further information. I received 914 such letters in 1992-93 (an increase of 13.3% over 1991-92) but in 1993-94 the total fell to 778 (a reduction of 14.9%). I have not changed my working practices in any way which would account for that but I have noticed that other Ombudsman offices have observed a similar trend. The number of written requests for information and advice increased to 193 (compared with 135 for 1992-93).

5.5 Although I had expected that the number of complaints reaching me would continue to grow, and had strengthened my office's screening unit accordingly, I had to devote some of those resources to a temporary need: testing the computerised case management system and the development of the office's management information strategy. This, coupled with an increased workload, meant that I was not able to send complainants full replies as promptly as I would have liked. My target for the year was to send replies to letters within 18 days of receipt in 75% of all cases. The target time was realised in 50% of cases handled during the year, with an average response time of 19 days for all cases (70% and 16 days respectively in 1992-93). I have arranged to recruit an additional screener to improve performance.

WORKFLOW
1993-94
(fig. 3)



* This figure is higher than that quoted in paragraph 1.12 (summaries of complaint issued -203) because some cases related to more than one health authority

Workload and Disposal (fig. 4)

Workload

Cases brought forward from 1992-93	333
Cases received in 1993-94	1384
Total	1717

Disposal

Reports issued (see paragraph 5.7)	169
Cases rejected or outside jurisdiction	571
Cases discontinued (or withdrawn)	12
Cases referred back and subsequently closed	521
Cases carried forward to 1994–95	444
Total	1717

5.6 In addition to dealing with written complaints and enquiries my screening unit staff answer numerous telephone enquiries about how to pursue complaints and the limits of my jurisdiction. The volume of such calls varies greatly from day to day but such activity generally increases after press, radio or television coverage of my work. That was particularly evident after the issue of the special report to which I refer in Chapter 1. Some callers can be very time consuming. Many believe that I can intervene there and then to help and are disappointed (a few are abusive) when told that the law requires them to take up their concerns first with the relevant NHS authority or Trust. My staff are careful to explain that I have to work within the limits of the powers given me by Parliament and there can be no guarantee – even were I to investigate and uphold a complaint – that I could provide the remedy which the caller is seeking.

Reports issued on Completed Investigations

5.7 148 investigations were concluded during the year, which was the highest number in any year since the office came into being in 1973. They resulted in the issue of 169 reports because 21 cases each involved two NHS bodies.

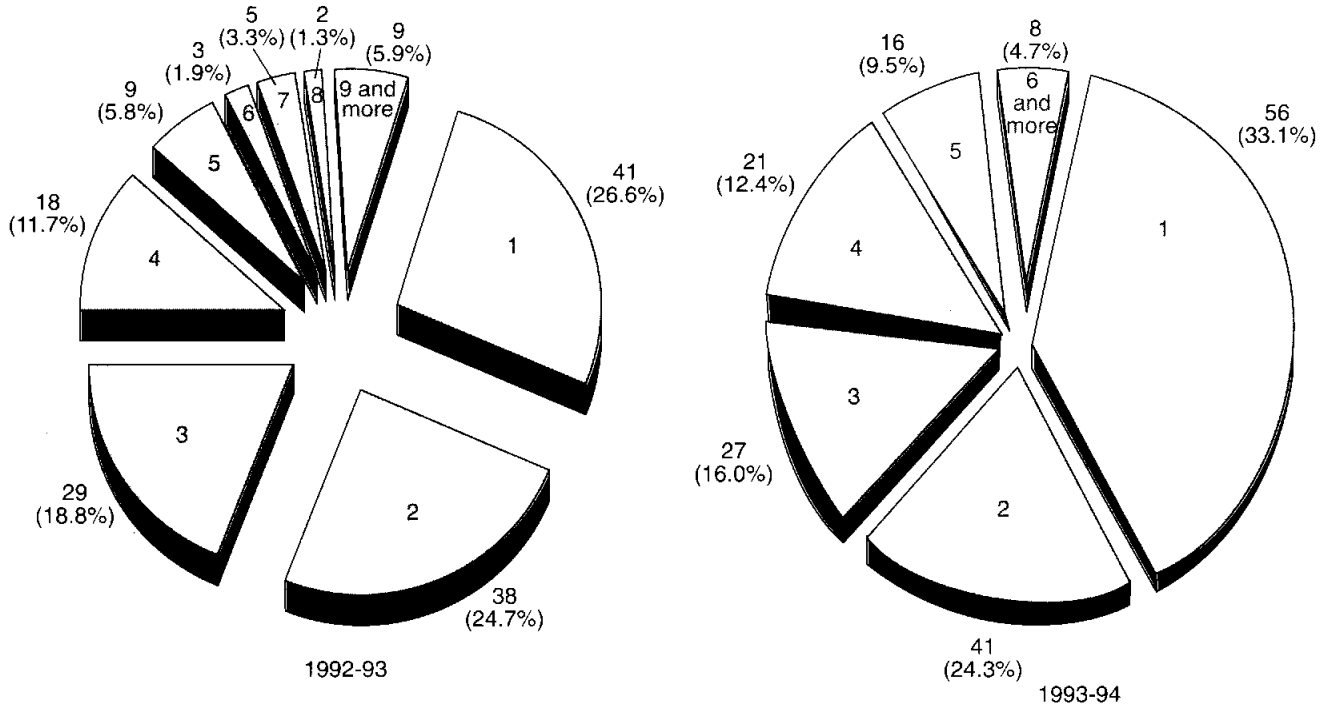
5.8 I referred in Chapter 1 to the further increase in the amount of investigative work and the fact that, despite the demands arising from that, the average time taken to complete an investigation was contained at 48.6 weeks (45.3 weeks in 1992-93). An increase in the average investigation time means that more cases took longer to complete than was the case in 1992-93, and the table at figure 5 shows the full picture. The most time consuming case took nearly 87 weeks, while the report for the speediest investigation was issued within 22 weeks of my receiving the complaint.

5.9 During 1993-94 I investigated 436 separately identified grievances, an average of 2.58 for each report issued (476 and 3.09 respectively in 1992-93). I have explained in previous reports the importance I attach to the need to keep investigations focused sharply on the complainant's principal concerns, and to exclude matters which are incidental or peripheral to those issues. This policy gives greater impact to my work and ensures that my findings are reported in the shortest possible time. I view the further decrease in the

Time Bands for Investigations (fig. 5)

Time band	Proportion of investigations concluded		
	1991-92	1992-93	1993-94
Under: 40 weeks	35.5% (44)	29.1% (41)	28.4% (42)
50 weeks	68.5% (85)	61.0% (86)	48.0% (71)
60 weeks	88.7% (110)	92.9% (131)	83.8% (124)
70 weeks	96.8% (120)	100% (141)	96.6% (143)
80 weeks	99.2% (123)		99.3% (147)
90 weeks	99.2% (123)		100% (148)
100 weeks	100% (124)		

Analysis of Grievances – Number per Report Issued (fig. 6)



Figures in Black: No. of Reports

Figures in Red: No. of Grievances per Report

Total No. of Reports: 169 (154 in 1992/93)

average number of grievances per report issued as useful because it reduces the time needed to deflect NHS staff from delivering care to answering complaints. I do not turn away grievances unless there are good and valid reasons for doing so. While 73% of the reports I issued dealt with three or fewer grievances, eight investigations examined six or more. Figure 6 shows the distribution of grievances among the 169 reports issued (paragraph 5.7).

5.10 Of the grievances investigated in 1993-94 I found some justification in 275 (63%), which compares with 287 (60%) in 1992-93. Further comparative information is provided in Appendix C.

5.11 The tables at Appendices D and E provide detailed analysis of the grievances I investigated in terms of the subject matter, the NHS service areas complained about and the health service staff involved. This system of classification is much more flexible than that used previously (which I discarded finally at the end of 1992-93) but, because the subjects of the complaints investigated vary from year to year, it is not feasible to give comprehensive data from 1992-93 alongside data for 1993-94. I have therefore restricted previous year's figures to those totals which can sensibly be compared.

5.12 I investigated 226 grievances about hospital acute services, which accounted for 51.8% of all grievances (267 and 56.1% respectively in 1992-93). I upheld 127 (56.2%) as compared with 137 (51.3%) last year. Services for the elderly and mentally ill attracted 32 grievances (7.3% of the total), down from 40 (8.4%) in 1992-93, and only 5 grievances (1.1%) related to maternity care. Ambulance, community health and family health services were involved in 46 grievances (10.5%) and I upheld 32 (69.6%) of them. There were 115 grievances about health authority administrative services, being 26.4% of the total (127 and 26.6% respectively in 1992-93); I upheld 82.6%, which was a marked increase over 1992-93 (72.4%). Most of those 115 grievances (92) related to the handling of complaints, including the administration of independent professional reviews under the clinical complaints procedure; I upheld 78 (84.8%) – a disappointing increase on the comparable figures for 1992-93 (67 and 67.7% respectively).

5.13 Not surprisingly, grievances about doctors (109) and nurses (139) – who have most contact with patients – accounted for 56.9% of all those I investigated (108, 167 and 57.8% respectively in 1992-93). 121 (48.8%) of these were upheld – a fall from the 138 (50.2%) seen in 1992-93. The proportion of complaints about administrative staff (37.8%) was very similar to that in 1992-93 (38.0%), although the actual number of grievances fell to 165 as compared with 181 for the previous year. I found that there was some justification for 84.2% of those grievances, which is a further worsening of the position reported for 1992-93 (73.5%). The handling of complaints was the most common topic of complaint. Although poor communications (16.7%) again featured strongly, grievances about admission and discharge arrangements (6.6%) and poor attitudes (5.3%) were fewer than during last year. The proportion of investigated complaints about aspects of care and treatment (116) was, at 26.6%, similar to that experienced in 1992-93.

5.14 The grievances have been classified according to the complaints I was asked to investigate. The analyses do not reflect all the faults I might have found. For example, a grievance about poor nursing care ('care and treatment') may have been compounded by poor communication or inadequate record keeping. These are issues which would come out in my

report and not in the analyses of the grievances as put to me. This type of detail is available from the published volumes of selected anonymised investigation reports.

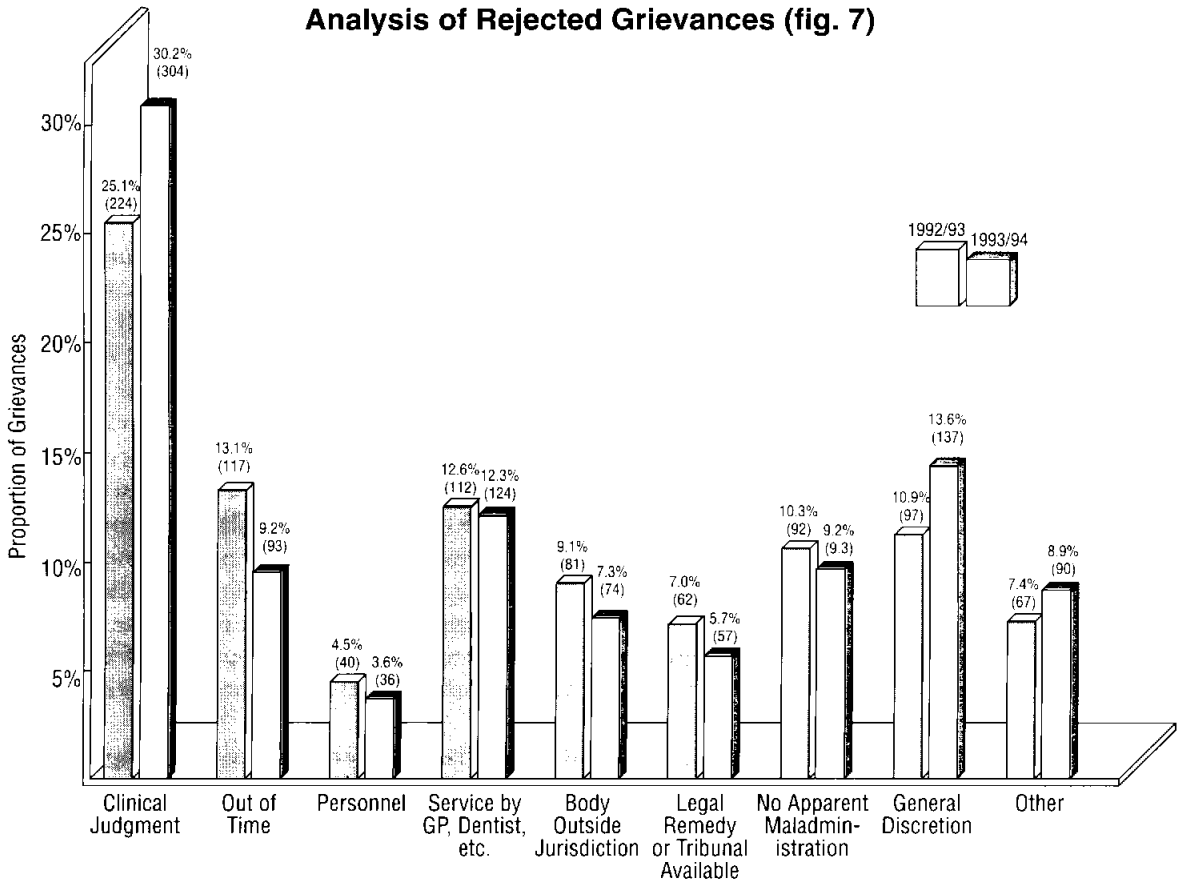
Cases rejected, outside jurisdiction or discontinued

5.15 In all 571 complaints were 'rejected' either because they were either outside my jurisdiction or because I exercised my discretion not to investigate them. A further 12 complaints were discontinued or withdrawn (figure 4). The combined total (583) accounted for 45.8% of all case cleared during the year. The comparable figures for 1992-93 were 528 and 44.9% respectively but the increase is well within the normal yearly fluctuations.

5.16 The relatively static proportion of rejected cases perhaps indicates that a substantial number of complaints, when first put to me, are not in such a form that I can decide whether I can help. That is generally either because complainants approach me before they have given the authority which is subject to complaint the opportunity to investigate the matter, or because they have not sent me the relevant background papers and information (see paragraph 5.19).

5.17 This year I extended to rejected complaints the system of classification used for investigated grievances (paragraph 5.11). Therefore, in addition to the analyses of the reasons for which complaints were rejected (figure 7 and Appendix G) I have provided at Appendices H and I some information about the subjects of rejected complaints according to the NHS services areas complained about, and the health service staff alleged to have been at fault.

Analysis of Rejected Grievances (fig. 7)



5.18 I rejected 1008 grievances – an average of 1.77 per rejected case. This compares with 892 and 1.78 respectively for 1992-93. The highest proportion of complaints (36%) was about aspects of care and treatment, and I had to turn away 304 grievances because in my opinion they related to the exercise of clinical judgment – a matter which I am not permitted to investigate. 110 of the grievances focused on the handling of complaints, but that does not necessarily indicate that the handling was faulty. Complainants sometimes do not accept information given to them by the NHS authority even if it is factually correct. Disagreement does not of itself amount to evidence of maladministration and in its absence I cannot investigate. Even where there is some evidence of faulty handling it may occur where the substance of the underlying complaint is beyond my jurisdiction – for example, about a clinical matter. Experience has shown that an investigation into the handling of a complaint where the substance is outside my jurisdiction is usually going to be of little real value to the complainant. If so I may exercise my discretion not to investigate. I turned away a total of 137 grievances on discretionary grounds in 1993-94, a substantial proportion relating to the handling of complaints. In one case the complainant was disposed not to accept my independence unless I found in his favour. I would have wasted everyone's time if I had investigated.

Cases referred back

5.19 Where the relevant health authority (or other body) has not been given a reasonable opportunity to investigate and answer a complainant's concerns, I have no option but to refer back such a complaint to the sender. I give guidance on what must be done before I can consider an investigation. Refer back action was taken for 729 of the new complaints received for 1993-94. That represents 52.7% and compares with 54.8% in 1992-93.

5.20 The number of cases in which the complainants returned to me after I referred the case back fell in 1993-94 to 485 (516 in 1992-93). The high level of such responses in 1992-93 contributed to the increase in the number of complaints accepted in that year for investigation (164), 105 (64.0%) of which had required preliminary reference back. In 1993-94 the number of cases accepted for investigation reached a record 203, of which 97 (47.8%) had required reference back before I could decide whether to investigate.

5.21 If I refer back to a complainant and hear nothing further within three months, I close the file. That action was taken on 521 complaints during 1993-94, representing 41% of all concluded cases (494 and 42% respectively in 1992-93). I hope that in many of those cases redress will have been provided locally.

Cases carried forward

5.22 Of the 444 cases carried forward (333 in 1992-93) 180 were under investigation, 176 had been referred back within the final three months of the year on which no concluding action had been taken by 31 March, 11 were being considered and 72 waiting for attention.

Output and performance targets

The workload forecasts are based on estimates made early in 1994–95, and the projected increase in staff numbers is dependent on funding approval. No account is taken of any changes in jurisdiction which arise from the Select Committee's review and the review of NHS complaints procedures undertaken by Professor Wilson (see paragraph 1.2)

	Actual 1992–93	*Forecast 1993–94*	*Actual 1993–94*	*1994–95*	*Forecast 1995–96*	*1996–97*
1 Complaints received	1227	1400	1384	1550	1650	1750
2 Percentage accepted for investigation	13.4	16	147	15	15	15
3 New Investigations begun	164	230	203	230	247	262
4 Average time taken (weeks) to complete investigations	45.3	45	48.6	45	42	39
5 Percentage of new complaints screened in 18 days	70	75	50	75	85	90
6 Investigations completed	141	156	148	196	230	250
7 Length of reports (pages)	16	16	14.2	15	16	16
8 Staff in post:						
(i) All investigative staff	26.1	27	27.5	36	39	42
(ii) Investigating officers	15.9	17	16.5	23	26	28
(iii) Screening staff	3.6	4	4	4.5	5	5
9 Investigations/total investigative staff	5.4	5.8	5.6	5.4	5.9	6.0
10 Investigations/investigating officers	8.9	9.2	9.0	8.5	8.8	8.9
11 Cases screened/staff in post	341	350	346	344	330	350

Summary of workload

England		Scotland		Wales		Totals		
1993/94	1992/93	1993/94	1992/93	1993/94	1992/93	1993/94	1992/93	
287	239	26	19	20	24	333	282	Brought forward from previous year
1165	1041	133	119	86	67	1384	1227	**Add** received in current year
1452	1280	159	138	106	91	1717	1509	Total considered
384	287	31	26	29	20	444	333	**Deduct** carried forward to next year
1068	993	128	112	77	71	1273	1176	Concluded
482	442	61	57	40	29	583*	528	Complaints rejected or discontinued
438	415	55	45	28	34	521	494	Complaints 'referred back'
148	136	12	10	9	8	169	154	Results reports issued
1068	993	128	112	77	71	1273	1176	Totals
169	121	19	10	5	4	193	135	Written enquiries/advice sought

*This figure includes 12 discontinued cases of which 10 were discontinued at the request of the complaint before a decision was taken on whether or not to investiage.

Number of grievances investigated and upheld, 1984/85 to 1993/94

Number investigated			Number upheld	
Year	Total	No. of grievances per report issued	No.	% of (ii)
(i)	(ii)	(iii)	(iv)	(v)
1984/85	443	3.54	209	47.18
1985/86	526	3.84	302	57.41
1986/87	483	3.69	290	60.04
1987/88	525	3.94	321	61.14
1988/89	556	4.00	322	57.91
1989/90	345	3.88	177	51.30
1990/91	487	3.50	236	48.46
1991/92	442	3.37	243	55.00
1992/93	476	3.09	287	60.29
1993/94	436	2.58	275	63.07
TOTALS	4719	3.51	2662	56.41

Analysis of investigated greivances 1993/94—by service areas and subjects

	Subjects of complaint															Totals	
Services Areas	Admission, Discharge and Transfer arrangements (incl. transport)	Aids and Equipment	Appointments Waiting lists and Delay	Attitude	Care and Treatment	Comminication Consent and Counselling	Mortuary and Post Mortem arrangements	FHSAs informal procedures and admin.	Failure to follow procedures	IPR Administr-ation	Policy dicisions and ECRs	Patients property and Expenses	Patients status Discrimin-ation	Records Medical Certificates	Hospital complaints handling	1993/94 Upheld wholly or in part **Not upheld**	1992/93 Upheld wholly or in part **Not upheld**
Hospital acute — In patient	10	—	3	3	31	27	2	—	—	—	—	3	1	4	16	100	115
	5	**1**	**—**	**4**	**36**	**13**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**2**	**2**	**63**	**104**
— Out patient	—	—	9	1	3	3	—	—	—	—	—	1	—	2	—	19	21
	1	**2**	**2**	**5**	**8**	**5**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**23**	**14**
A & E	2	—	—	—	3	1	—	—	—	1	—	1	—	—	—	8	1
	3	**1**	**1**	**3**	**3**	**1**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**1**	**—**	**13**	**12**
Geriatric	—	—	—	—	4	3	—	—	—	—	—	—	—	—	—	7	6
	—	**—**	**—**	**3**	**6**	**2**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**11**	**4**
Mental Health	—	—	—	—	7	3	—	—	—	—	—	—	—	—	3	13	20
	1	—	1	—	4	4	—	—	—	—	—	—	1	—	2	13	10
Maternity	—	—	—	—	—	1	—	—		—	—	—	—	—	—	1	2
	—	**—**	**—**	**2**	**1**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**1**	**—**	**4**	**7**
Ambulance	—	—	3	—	2	1	—	—	1	—	—	—	—	—	10	17	18
	—	**—**	**1**	**—**	**3**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**1**	**—**	**5**	**1**
Other Community Health	—	1	—	—	2	1	—	—	—	—	—	—	—	—	1	5	2
	1	**—**	**—**	**—**	**3**	**1**	**—**	**—**	**—**	**—**	**2**	**—**	**—**	**—**	**—**	**7**	**1**
Administrative (excl. FHSAs)	4	—	1	—	—	7	—	—	1	12	3	—	—	1	66	95	92
	2	**—**	**—**	**2**	**—**	**—**	**—**	**—**	1	**4**	**—**	**—**	**—**	1	**10**	**20**	**35**
Family Health Services	—	—	—	—	—	—	—	9	—	—	—	—	—	1	—	10	10
	—	—	—	—	—	—	—	**2**	—	—	—	—	—	—	—	**2**	1
Totals Upheld	16	1	16	4	52	47	2	9	2	13	3	5	1	8	96	275	287
Not upheld	**13**	**4**	**5**	**19**	**64**	**26**	**—**	**2**	**1**	**4**	**2**	**—**	1	**6**	**14**	**161**	**189**

Analysis of investigated greivances 1993/94—by professions and subjects

Professions involved in Complaints	Subjects of complaint: Admission, Discharge and Transfer arrangements (incl. transport)	Aids and Equipment	Appointments Waiting lists and Delay	Attitude	Care and Treatment	Comminication Consent and Counselling	Mortuary and Post Mortem arrangements	FHSAs informal procedures and admin.	Failure to follow procedures	IPR Administr-ation	Policy dicisions and ECRs	Patients property and Expenses	Patients status Discrimin-ation	Records Medical Certificates	Hospital Complaints handling	Totals: 1993/94 Upheld wholly or in part / **Not upheld**	Totals: 1992/93 Upheld wholly or in part / **Not upheld**
Medical and Dental	5	—	7	3	14	17	2	—	—	2	—	—	1	—	7	58	65
	4	**—**	**2**	**9**	**15**	**16**	**—**	**—**	**—**	**1**	**—**	**—**	**—**	**1**	**3**	**51**	**43**
Professions allied to medicine	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	2	1
	1	**—**	**1**	**1**	**3**	**1**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**—**	**7**	**1**
Nursing midwifery and health visiting	5	1	—	1	34	21	—	—	—	—	—	4	—	4	—	70	73
	6	**3**	**—**	**6**	**42**	**8**	**—**	**—**	**—**	**—**	**—**	**—**	**1**	**3**	**—**	**69**	**94**
Scientific, technical and professional	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	2
Ambulance crews	—	—	2	—	2	—	—	—	—	—	—	—	—	—	—	4	10
	—	—	**1**	—	**3**	**4**	—	—	—	—	—	—	—	**1**	—	**5**	**1**
Maintenance and auxiliary staff	—	—	—	—	1	1	—	—	—	—	—	—	—	—	—	2	4
	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—
Health authority administrative staff	5	—	7	—	—	8	—	9	2	11	3	1	—	4	89	139	133
	2	**—**	**—**	**3**	**1**	**1**	**—**	**2**	**1**	**3**	**2**	**—**	**—**	**1**	**10**	**26**	**48**
FHSA lay conciliator MHAC Commissioner	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
	—	—	—	—	—	—	—	—	—	—	—	—	—	—	**1**	**1**	—
Totals Upheld	16	1	16	4	52	47	2	9	2	13	3	5	1	8	96	275	287
Not Upheld	**13**	**4**	**5**	**19**	**64**	**26**	**—**	**2**	**1**	**4**	**2**	**—**	**1**	**6**	**14**	**161**	**189**

Analysis of main categories of grievances investigated 1984–85 to 1993–94

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
1984/85	443	153	34%	101	23%	87	20%	32	7%	70	16%
1985/86	526	236	45%	111	21%	76	14%	36	7%	67	13%
1986/87	483	179	37%	112	23%	108	22%	19	4%	65	13%
1987/88	525	205	39%	101	19%	102	19%	27	5%	90	17%
1988/89	556	204	37%	130	23%	109	19%	21	4%	92	17%
1989/90	345	153	44%	66	19%	54	16%	15	4%	57	17%
1990/91	487	169	35%	108	22%	78	16%	22	5%	110	22%
1991/92	442	198	45%	89	20%	38	8%	34	8%	83	19%
1992/93	476	167	35%	78	16%	79	17%	25	5%	127	27%
1993/94	436	139	32%	109	25%	41	9%	22	5%	125	29%
Totals	4719	1803	38%	1005	21%	772	16%	253	6%	886	19%

Analysis of rejected grievances 1993/94 — by reference to powers and jurisdiction

England		Scotland		Wales		Totals		
1993/94	1992/93	1993/94	1992/93	1993/94	1992/93	**1993/94**	1992/93	
66	68	4	10	4	3	**74**	81	Body complained of outside jurisdiction
99	89	17	16	8	7	**124**	112	Complaint against GP, dentist, pharmacist, optician
39	31	2	1	3	1	**44**	33	Service Committees and Tribunal Regulations
258	189	30	23	16	12	**304**	224	Clinical judgment
42	56	6	4	5	2	**53**	62	Legal remedy available
33	37	1	2	2	1	**36**	40	Personnel matter
83	99	3	15	7	3	**93**	117	Out of time
2	2	—	—	2	—	**4**	2	Right to appeal to tribunal
—	—	10	1	—	—	**10**	1	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
76	75	11	8	6	9	**93**	92	No prima facie failure/maladministration
10	9	1	1	2	—	**13**	10	Contractual/commercial transaction
121	89	9	6	7	2	**137**	97	General discretion
20	18	—	—	1	2	**21**	20	Complainant not aggrieved or acceptable as complainant
1	1	—	—	1	—	**2**	1	Complaints from local authority, other public body or nationalised industry
850	763	94	87	64	42	**1008**	892	Totals

Analysis of rejected grievances 1993/94 — by service areas and subjects

Services 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	Comminication Consent and Counselling	FHSAs complaints and admin.	IPR Administr-ation	NHS Contractors and DPB	Non-NHS and Non-relevant body	Patients property & Expenses	Personnel and Terms of service matters	Policy decisions ECRs and Commercial	Records, Breach of confidence Test results	Hospital complaints handling	Others	
Hospital acute — In patient	5	3	12	5	186	30	—	—	—	—	—	—	1	4	—	5	251
— Out patient	1	2	—	7	74	9	—	—	—	—	2	1	1	6	1	—	104
A & E	1	—	—	1	14	4	—	—	—	—	—	—	—	—	—	—	20
Geriatric	—	—	—	—	7	—	—	—	—	—	1	—	—	—	—	—	8
Mental Health	3	—	—	1	54	6	—	—	—	—	—	—	5	2	4	1	76
Maternity	—	2	—	1	11	—	—	—	—	—	1	—	2	—	—	—	17
Ambulance	2	2	—	1	—	—	—	—	—	—	—	4	—	—	1	—	10
Other Community Health	—	2	—	—	8	2	—	—	—	—	—	—	—	—	—	1	13
Administrative (excl. FHSAs)	3	1	5	1	2	7	—	11	1	—	7	32	11	30	104	3	218
Family Health Services	—	—	—	—	—	—	66	—	124	—	—	4	3	7	—	—	204
Not specified	1	—	2	—	6	—	—	1	—	—	1	1	1	—	—	—	13
None	—	—	—	—	—	—	—	—	—	74	—	—	—	—	—	—	74
Totals	16	12	19	17	362	58	66	12	125	74	12	42	24	49	110	10	1008

Analysis of rejected grievances 1993/94 — by professions and subjects

NHS Professions involved in complaints	Subjects of complaint																Totals
	Admission, Discharge and Transfer arrangements (incl. transport)	Aids, Equipment Premises and Equipment	Appointments Waiting lists and Delay	Attitude	All Aspects of Care and Treatment	Comminication Consent and Counselling	FHSAs complaints and admin.	IPR Administr-ation	NHS Contractors and DPB	Non-NHS duties Non-relevant body	Patients property & Expenses	Personnel and Terms of service matters	Policy decisions ECRs and Commercial	Records, Breach of confidence Test results	Hospital complaints handling	Others	
Medical and Dental	5	—	3	9	300	37	—	5	—	5	—	1	2	7	2	4	380
Professions allied to medicine	3	—	1	1	13	—	—	—	—	—	—	—	4	2	—	—	24
Nursing, midwifery and health visiting	—	8	—	6	40	14	—	—	—	—	2	—	—	—	—	2	72
Scientific, technical and professional	—	1	—	—	1	—	—	—	—	—	—	—	—	1	—	—	3
Ambulance crews	1	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Maintenance and auxiliary staff	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	2
Health authority administrative staff/members	6	1	14	1	2	7	30	6	1	—	9	40	17	38	108	4	284
FHSA Service Committees	—	—	—	—	—	—	35	—	—	—	—	—	—	1	—	—	36
FHSA lay conciliators	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1
NHS contractors	—	—	—	—	—	—	—	—	124	—	—	—	—	—	—	—	124
Not specified	1	—	1	—	4	—	—	1	—	—	1	1	1	—	—	—	10
None	—	—	—	—	—	—	—	—	—	69	—	—	—	—	—	—	69
Totals	16	12	19	17	362	58	66	12	125	74	12	42	24	49	110	10	1008

Geographical distribution of complaints received for 1993/94

Region of Origin	Number of complaints received		Proportion of total (%)		Nominal population (000s)	Population (000s) per complaint	
Northern	49	(37)	3.5	(3.0)	3,075	63	(83)
Yorkshire	89	(72)	6.4	(5.9)	3,656	41	(51)
Trent	81	(58)	5.9	(4.7)	4,705	58	(81)
East Anglia	39	(28)	2.8	(2.3)	2,059	53	(73)
London and Home Counties:							
North West Thames	144	(117)	10.4	(9.5)	3,499	24	(30)
North East Thames	130	(115)	9.4	(9.4)	3,803	29	(33)
South East Thames	123	(125)	8.9	(10.2)	3,658	30	(29)
South West Thames	100	(96)	7.3	(7.8)	2,979	30	(31)
Wessex	53	(69)	3.8	(5.6)	2,940	55	(43)
Oxford	46	(49)	3.3	(4.0)	2,564	56	(52)
South Western	79	(55)	5.7	(4.5)	3,262	41	(59)
West Midlands	97	(85)	7.0	(6.9)	5,219	54	(61)
Mersey	62	(50)	4.5	(4.1)	2,403	39	(48)
North Western	73	(85)	5.3	(6.9)	4,016	55	(47)
Totals for England	1165	(1041)	84.2	(84.8)	47,838	41	(46)
Scotland	133	(119)	9.6	(9.7)	5,120	38	(43)
Wales	86	(67)	6.2	(5.5)	2,881	34	(43)
Overall Totals	1384	(1227)	100.0	(100.0)	55,839	40	(45)

†The comparable figures for 1992/93 are shown in parenthesis

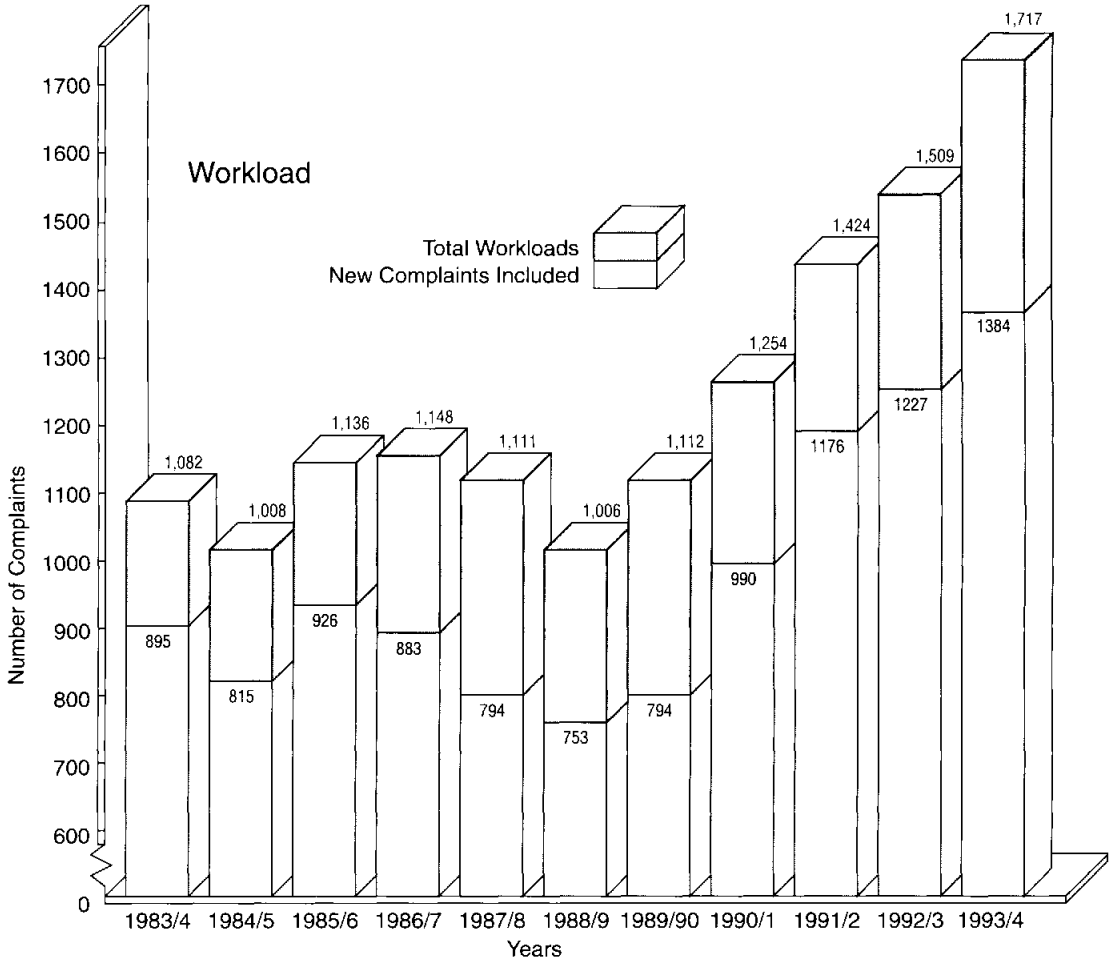
Appendix K

Geographical distribution of investigations completed in 1993/94

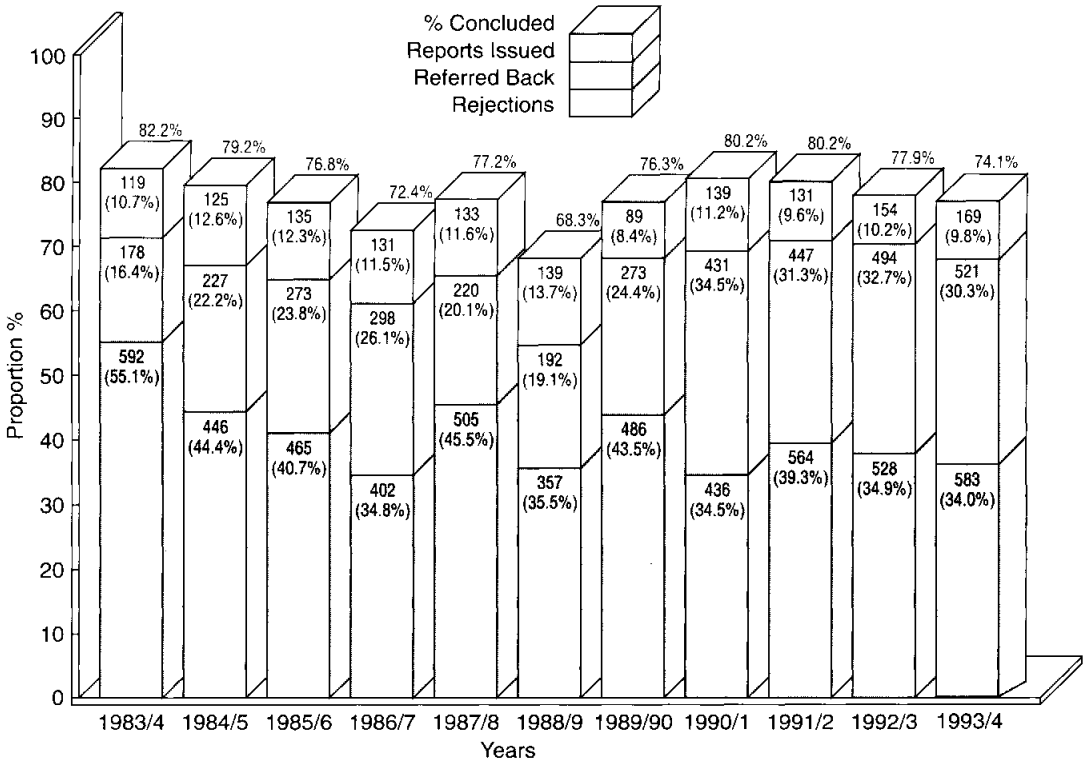
English Regions	Investigations Completed
Northern	3
Yorkshire*	13
Trent	9
East Anglia*	1
London and Home Counties:	
North West Thames*	11
North East Thames*	17
South East Thames	25
South West Thames*	15
Wessex	8
Oxford	6
South Western	6
West Midlands	8
Mersey	4
North Western*	7
Total England	133*
Add: Scotland	11
Add: Wales	8
Overall Total	152

Notes:
1. *Four investigations involved two health authorities situation in different regions.
2. 19 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (12) and Cardiff (7)
3. 109 investigations were conducted by the London based investigation Units 65 (60%) related to the four Thames Regions, of which 45 (69%) involved health authorities within the Greater London area.

Analysis of Workloads and Disposal 1984-85 to 1993-94



Disposal of Workload concluded within each year



Glossary of acronyms used in this report

A and E	Accident and emergency
DH	Department of Health
FHSA	Family health services authority
GP	General practitioner
HA	Health authority
HB	Health board
IPR	Independent professional review
IVF	In vitro fertilisation
SHA	Special health authority
UKCC	United Kingdom Central Council for nursing, midwifery and health visiting

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