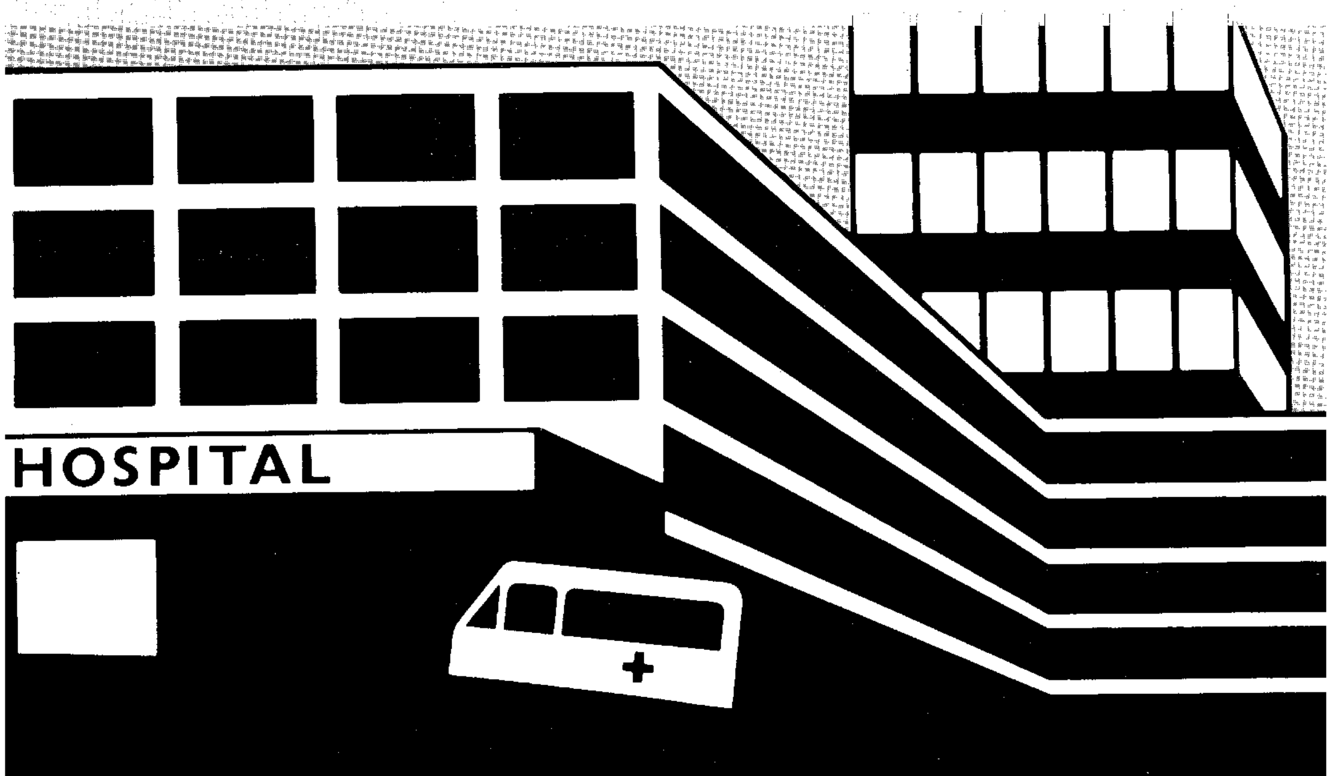
Health Service Commissioner

Annual Report for 1990-91



Health Service Commissioner

Third Report for Session 1990-91

Annual Report for 1990-91

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'These hospitals be so well appointed, and with all things necessary to health so furnished, and, moreover, so diligent attendance through the continual presence of cunning physicians is given, that though no man be sent thither against his will, yet notwithstanding there is no sick person in all the city that had not rather lie there than at home in his own house.'

Sir Thomas More, Utopia, book two

Introduction — Chapter 1

1. The year covered by this Annual Report has seen a number of changes in the National Health Service. They make it relevant to emphasise the contribution made by my Office to the quality of service which the NHS provides. Those who use the NHS need to know that there is someone who can be asked to take a thorough and independent look when things appear to have gone wrong in administering care. In a debate which took place in the House of Commons on 1 May 1991, just after the year in review, the existence of the 'Ombudsman', as I am sometimes known, was referred to as an essential part of the citizen's democratic armoury in contending with state institutions, whether government departments or bodies such as those which provide health care. I did not mind being called the grumbling appendix of the NHS, but I do not side either with the NHS or with those who are aggrieved; yet I am able - at no cost to those who bring a complaint to me - to offer both an investigation in depth and, where appropriate, the prospect of an explanation, an apology or a remedy for a justified grievance.

2. Only a very few of those who use the NHS turn to me for help. Perhaps too few patients know that my Office exists. Perhaps breakdowns in the NHS, which is committed to providing support, care or treatment to alleviate distress, are exceptional. My task is to look into those exceptions when they are brought to my attention and, by recommending remedies when I find that something has gone wrong, I am able to reduce the chances of the same problem being encountered by future patients. I am not a court or tribunal, however, and I cannot generally offer a financial remedy - an issue which I explain further in paragraph 56. How, then, can my Office be more widely publicised? That is a question which has concerned the Select Committee on the Parliamentary Commissioner for Administration, which oversees my work as Health Service Commissioner. I cannot invite complaints, as that would be seen as less than impartial, but I regard it as part of my role to tell the public what Parliament has given me the power to do. To that end I welcome opportunities for interviews and articles in the radio, the press and professional journals, and I and my senior staff will always try to respond positively to invitations to take part in conferences, seminars or teaching sessions - whether for consumers or staff. My Deputy and I have given talks during the year in England, Scotland and Wales. Last year I looked forward to contact with more professional organisations, and I am glad to say that I have had productive discussions with a number of regulatory, professional and other bodies in the health field and with consumer organisations. Such opportunities for mutual understanding produce a better chance of securing the improvements which all of us seek in quality of service. An aggrieved person wants a thorough investigation culminating in a report, the language and layout of which are easy to understand, so I try always to avoid or explain jargon. Medical terms often mean nothing to the patient or relative.

3. There are two organisations which I specifically mention. The first of these is the Medical Protection Society, which raised with the Select Committee concerns about time taken on investigations - a matter to which I return in paragraph 7 - and about the standard of proof. I am always conscious that a critical report from me can be a source of great anxiety to a member of staff, but my concern is to establish whether there has been a failure in service or administration and, if there has, invite the health authority involved to put things right. Any subsequent disciplinary proceedings are a matter in the first instance for the health authority and may subsequently involve a body regulating the profession to which the individual complained of belongs. The Society argued that I should employ the test used in criminal proceedings of 'beyond all reasonable doubt',

rather than follow the practice established by my predecessors in making findings on the balance of probabilities. In some cases the evidence is so clear that there is no practical difference. Where I find fault I recommend, but do not have the power to impose, a remedy, although my recommendation is almost invariably accepted by the health authority. Because of the potential impact of my findings, and the fact that there is no appeal against them, I take great care in arriving at them and apply a test of what would be seen as fair and reasonable: I believe that Parliament and the public would expect nothing else of me. Generally about half of the grievances put to me are upheld (see Chapter 5 on Statistics) and, where the evidence is conflicting or unclear, I reach no findings. The Select Committee's conclusion was that it would be undesirable to move to a stronger test than balance of probability because the patient was already at a disadvantage when complaining about the NHS.

4. The other organisation is the Mental Health Act Commission which, in their most recent biennial report to the Secretary of State for Health, were looking for closer co-operation with my Office in dealing with complaints from patients detained under the Mental Health Act. While I cannot share with them evidence or documents which I have obtained - because of the statutes governing my method of work - I thought it right to clarify with their Chairman our respective roles in dealing with such complaints, in the interests of patients and their relatives.

5. The year covered by my last Annual Report saw many staff changes in my Office, affecting workload and continuity. I am glad to report that, in 1990/91, the position was much better and the prospects for the future are encouraging. My staff now work to a number of targets for performance, and I am indebted to them for the enthusiasm and commitment which they have displayed in doing so.

6. In order to create a more systematic and businesslike approach, I have prepared the first three year management plan for the Office. It covers my objectives, targets for performance and the scale and use of resources. I am pursuing the possibility of increasing significantly the use of information technology, which should help considerably with text processing and the planning and monitoring of work. That should benefit staff and, more particularly, those who bring complaints to me. I can now also refer the reader to the Volume on Cabinet Office, Privy Council Office and Parliament of the Government's Expenditure Plans 1991-92 to 1993-94, which sets out the resources made available to my Office. (I note in passing that in New Zealand the Ombudsmen, who like me are Officers of Parliament, are now funded by a vote which is the responsibility of the Speaker and administered by the Chief Ombudsman. This is to signal the independence of the Ombudsman from the Executive.)

7. I gave an undertaking last year that there would be a marked improvement in the time taken on investigations. 122 full investigations were completed during the year, the annual average for the last ten years being 113. One of my major concerns has been to reduce the number of cases which have been in the Office for longer than 12 months, and that figure has reduced by 75% from 45 to 11 since March 1990. Part of the delay is attributable to the need to refer a complaint back because, for example, it has not first been put to the health authority concerned; that happened in 62 of the cases reported upon in 1990/91, with an average delay for each of those cases of 9.9 weeks. I now compute time taken from the date on which a complaint became investigable, and that figure for the year under review was an average of 58 weeks. I am committed to doing substantially better than that. The average of 49 weeks for the 17 cases completed in March, and the fact that a period shorter than 36 weeks is now nothing unusual, encourage me to believe that an investigation taking longer than a year should be very exceptional. The average length of my investigation reports has been reduced from 33 pages to just over 19 pages.

8. Time taken and throughput depend very much on the volume of complaints received. I referred in paragraph 2 to promoting awareness of my Office, and the Government's booklet on the NHS Reforms, which contained my address, was a major factor in the receipt by me of 990 complaints - the highest ever. 118 of these were accepted for investigation - again much higher than in the previous two years - and several more were in the pipeline. In January 1991 I issued a new leaflet about my work in a format intended to be more readable and helpful. Already some 150,000 copies have been distributed, and I wrote personally to the Chairman of every health authority indicating that local complaints procedures should advise patients that, where they are dissatisfied with the local investigation, they have the right to put a complaint to me. Copies were sent also to community health councils, citizens advice bureaux and public libraries.

Complaints can be put to me, as Health Service Commissioner, direct by members of the public, but Members of Parliament are often approached by constituents for advice about what they should do when things go wrong. 15 of the 122 cases on which I completed my investigations in 1990/91 came to me in that way, which is why I thought it important to send a leaflet personally to every Member. In one or two of the cases where I have rejected the request for an investigation, the complainant has questioned why I told the health authority concerned: the answer is that I am required by statute to do so. I have therefore advised certain complainants - where, for example, a NHS employee raises what seems to be a personnel issue - informally of this requirement rather than sending them a formal response. That gives them the opportunity of rephrasing their complaints. I occasionally, too, ask one of my staff to make a preliminary visit to a complainant before I decide on the scope of an investigation or whether to investigate at all. This can help me to obtain clarification of what the grievances are, and the person aggrieved to understand fully what are my powers.

9. The volumes of anonymised reports of selected investigations produced twice a year contain case histories. They are selected to enable the lessons learned to be extended beyond the health authorities directly involved. From my discussions with professional bodies I know that these volumes are seen as practical teaching aids, but I am not yet convinced that managers and trainers use them to the extent that they might, since categories of neglect recur in my reports. Professional journals are studied closely by doctors, nurses and others so that they can improve their own practice, and I believe that my published cases should act as a quality audit of the NHS, prompting periodic review of local procedures and the transfer of improvements in systems from other areas.

10. This Annual Report draws on the published volumes to illustrate in Chapter 2 some of the main topics emerging from my investigations, and in Chapter 3 cases which raise an issue of special interest or concern. There are six main themes this year, the first of which relates to the provision of long-term care. The number of private nursing homes has increased in recent years, and these can provide an alternative to extended hospital stay or relief for carers who can no longer cope. I refer to three cases each of which, though arising from different circumstances, involves the question of whether the NHS had a duty to provide a service. The second theme relates to the ambulance service. Cases involving that service have been more prevalent than usual in 1990/91, and in all three to which I refer families have had the anguish of waiting for ambulance transport to collect a critically ill relative. The supervision of patients who are disturbed returns as a theme this year. While I cannot generally question the allocation of resources or staff, I found in one case that the staffing levels in a ward were well short of what was needed to provide the necessary degree of care: that put the professionalism of staff severely to the test, but the underlying issues were more for managers to address. Complaints about records and communications continue to arise: failure to record problems in nursing care plans, loss of records, not passing on information and failure to explain the presence of medical students - these are matters which cause me considerable concern. I am precluded from investigating matters which in my opinion arise from the exercise of clinical judgment, but the administration of the clinical complaints procedure is open to investigation by me and three cases have been chosen to illuminate that process. The final theme in Chapter 2 includes two examples of poor handling of complaints by family health services authorities (as family practitioner committees are now known); although I cannot look into the handling of complaints under the formal procedure (see paragraph 39), actions - or inaction - by them in dealing with such matters by informal means are open to scrutiny by me. In Chapter 3 I cite some important cases which are diverse in nature and include such topics as resuscitation policies and the release of confidential information for research purposes. In Chapter 4 I list the remedies which I have secured for complainants during the year, and in Chapter 5 there is an analysis of workload and performance.

11. Now I comment on jurisdictional matters. NHS trusts fall within my jurisdiction, and the Secretary of State for Health has confirmed that a complaint about a service provided under contract between a NHS purchaser and provider is open to scrutiny by me. Parliament has given me considerable discretionary powers, and I exercise them to the full in deciding whether or not to investigate a complaint - and I emphasise here that whether a matter is concerned solely with the exercise of clinical judgment is a matter for me to decide and not for the practitioner concerned. I receive some complaints where there seems to have been serious injustice but they are not open to investigation by me. Then I try always to suggest what other route might be open to pursue the grievance. Some cases of apparent maladministration brought to me lie outside my jurisdiction, but I am able sometimes to take steps informally to see that the matter is attended to. There

was one such case recently where the Scottish Office Home and Health Department, on learning of a problem with superannuation rights, acted promptly to put things right. The Select Committee supports a generous interpretation of my jurisdiction - indeed, the Members have asked whether I should look into what seem to be shortcomings on the part of community and local health councils, but the actions of those bodies are not open to scrutiny by me.

12. Even if I do not uphold a complaint, the information given in my report can be a source of reassurance for some who bring a grievance to me. In two of the cases concluded in 1990/91 the complainant died before I was ready to issue my report. I invited the nearest relative in each case to take over sponsorship of the complaint so that I could give account to the family for my investigation. I expect my staff to be painstaking and searching in their enquiries, but that is sometimes misconstrued by the arrogant as being irrelevant or time-wasting. Though I decline to accept for investigation grievances for which there is very little prospect of arriving at conclusions - and this partly explains the reduction from 3.9 to 3.5 in the average number of grievances per investigated complaint - I make no apologies for taking the time necessary (but no more than that) to obtain all the evidence I need to arrive at a sustainable conclusion. In pursuing the various objectives and targets to which I have referred I shall not sacrifice thoroughness in investigation. I owe much to the openness and courtesy afforded to me and my officers by health authorities and NHS staff, and I wish to record appreciation for the work of community health councils and voluntary organisations in guiding complainants through various steps in pursuing a complaint locally and directing them to my Office.

(i) Provision of long-term care

13. In Chapter 1 I referred to complaints about long-term care for the chronically ill. Guidance from the Department of Health (DOH) appears to have been interpreted in different ways by different readers. Questions have arisen about whether the district health authority (DHA) concerned have an absolute duty to provide care and whether a relative can veto the discharge of a patient to a private nursing home. It may be that lack of precision has led some community health councils (CHCs) to interpret the guidance as supporting their client's case for care in hospital; but finite resources and other priorities can limit the help that is provided. I have selected three cases which demonstrate how the expectations of relatives and carers of what the NHS should provide for the chronically ill were not realised.

14. In the first case a man suffering from dementia was admitted to a private nursing home on the advice of a consultant psychogeriatrician, who could not offer him a NHS bed. The man's daughter tried to secure her father's admission to hospital, or financial assistance with the nursing home charges. The DHA told her that her father would certainly be admitted if a bed became available, but said that they were not empowered to help her with the nursing home costs, and that there were others waiting for a NHS bed whose need was greater. I discovered that, at around the time when the consultant first heard that there was a difficulty about the fees, the father's condition had improved in the nursing home to the extent that he was thought potentially suitable for transfer to local authority (Part III) residential accommodation. On assessment he was found not to be suitable for such a placement. From then on the consultant and others concerned were in no doubt that he needed nursing, rather than residential, care - and the daughter's health was being affected by worry. Although the consultant thought it most unlikely that the man could be offered a NHS bed unless his condition deteriorated, the daughter was led to believe otherwise. The full position was not explained to her. It seemed to me that a multi-disciplinary discussion would have helped all concerned to focus on her predicament and perhaps give some constructive help.

(a) W.194/89-90 on pages 27-39 of HC 482

15. A letter to a national charity from a Minister at the Department of Health and Social Security, as it then was, carried the implication that the NHS had an absolute duty to provide care in circumstances such as those arising in this case. I took that point up with the chief executive of the NHS Management Executive, who told me that provision of care was qualified by the resources available, and that payments intended to 'top-up' social security payments were not possible. I accepted that, where demand exceeded available resources, there might be some individuals whose clinical priority was such that their needs could not be met under the NHS. After some 16 weeks of discussion and correspondence about redress, the DHA agreed to make a suitable *ex gratia* payment to the daughter in recognition of the distress she had been caused.

16. Providing long-term care for someone who has suffered head injuries in a road accident is a vexed issue for many DHAs. A woman spent 18 months in a NHS neurosurgical unit, before being discharged to a private nursing home. The woman's son complained that the DHA had not met their responsibility to provide for his mother's needs, and that undue pressure had been put on the family to move their mother to a nursing home. I found that, although she no longer required the specialist facilities of the unit, the woman was likely to need sustained nursing care for the rest of her life. In the light of the Secretary of State's duties to provide services under the provisions of the National Health Service Act 1977, and the view of the chief executive of the NHS Management Executive - expressed to me during the investigation to which I refer in paragraph 15 - that NHS care should be provided without charge if in a doctor's professional judgment it was required, I concluded that the DHA had a duty to continue providing the care the woman required and I upheld the complaint. The DHA agreed to meet, for as long as it was needed, the nursing home costs in respect of the woman's care or treatment which it was the function of the NHS to provide. DOH guidance calls on DHAs to ensure that discharge arrangements are discussed with the family, who should

(b) W.478/89-90 on pages 80-90 of HC 482

be asked to indicate in writing their acceptance of what is proposed. Although there had been discussion in this case, written agreement had not been obtained. The DHA agreed to review their discharge procedures in this respect.

(c) W.599/89-90 on pages 90-96 of HC 482

17. Society owes a debt to those who provide care at home for helpless relatives. However devoted a carer may be to a relative who is getting more frail and dependent, the time comes when a carer can no longer cope alone. In the final case in this group a woman's husband was suffering from a chronic debilitating condition. Through his general practitioner (the GP) she sought his admission to a NHS hospital. When told that no beds were then available, she arranged his admission to a private nursing home. She continued to press for hospital admission and, nine months after her original request, a long-stay place was offered. The DHA should, she felt, have provided during that period the long-term care her husband required.

18. My investigation revealed that the request for admission through the GP was not conveyed to the consultant geriatrician responsible until five months after it was made; and then, as earlier when he had assessed the husband for another purpose, the consultant found that, though constant nursing care was required, the man was not a priority for hospital admission. As I regarded that assessment as having been made in the exercise of clinical judgment, I could not question it. Another consultant later became responsible for the husband's care and was asked by the DHA to review the position. His decision then to offer a long-stay bed was, similarly, a matter of clinical judgment. While I believed that the DHA had a duty to provide some level of care for people in the husband's condition, I found that the allocation of resources for that purpose was a discretionary decision, proper to the DHA. Such matters are not open to question by me unless there is evidence of maladministration in the decision-making process: there was none in this case. The DHA had developed, and kept under review, policies which they believed made the best use of their resources. I did not uphold this complaint.

(ii) Ambulance services

19. I think it right to publicise the fact that, except for emergencies, the ambulance service is not available on minimum notice and has to be booked well in advance. Most of the complaints that I investigate are about the circumstances surrounding a patient's care in hospital or at home. Last year several complaints (quite unconnected with the ambulance service dispute) involved transport of patients from home to hospital or from one hospital to another or, on discharge, from hospital back to the home. A delay of minutes in the arrival of an ambulance to collect a very sick patient can seem like a lifetime. I report three cases where arrangements broke down. There were long delays, hardship for the patients and agonising distress for the relatives.

(d) W.187/89-90 on pages 84-91 of HC 133

20. A woman who was terminally ill at home with cancer needed an ambulance to take her to a hospice, and a home care sister requested the ambulance for 11.00 am the next day. Despite six telephone calls by the husband to the ambulance service (the AS), and calls by the woman's GP and the hospice, an ambulance did not arrive until soon after 5.00 pm. The booking was, I found, accepted as a 'late booking', not having been received 48 hours in advance, and the journey was arranged for whenever a vehicle became available in the late morning. A heavy demand on vehicles meant that the request could not be met, so towards midday it was passed on to the central control. They dealt mainly with accident and emergency calls and accepted the booking on the basis that the transport would not be provided until the late afternoon.

21. Patients accepted for a hospice bed are surely in urgent need of support and comfort. To my surprise not all the AS staff were aware of the significance of a transfer to hospice care. The record of the original booking did not show the nature of the woman's illness or any special instructions, and the staff looked on the journey as a routine admission with a priority no higher than that for other non-urgent journeys. Then, when the request was transferred, it was reduced from an intention to provide an ambulance late in the morning, to the allocation of an ambulance as available. The AS were aware from about midday that an ambulance was unlikely to be available for some time, yet no one had taken the trouble to explain that to the patient's husband. I found that unacceptable and upheld the complaint. The regional health authority (RHA) responsible, in addition to apologising to the husband, agreed to ensure that AS staff understood the need to get more information when accepting bookings for transfer to a hospice, and to identify any special needs. They also agreed to produce revised guidance, in consultation with hospices.

22. In another case where I upheld the complaint, a GP asked at 10.18 am for a woman, who had become unwell, to be transferred to a specialist hospital (outside the area where she lived) where she was receiving treatment for cancer. He stipulated 'the sooner the better' but agreed an admission time of up to 3.00 pm. When no ambulance had arrived by 4.05 pm, another GP in the same practice told the AS that the woman was by then too ill to travel out of the area and should be taken to a local hospital. The ambulance arrived at 4.30 pm and took her there but the woman died shortly after admission.

(e) W.652/89-90 on pages 96-103 of HC 482

23. The initial request had been recorded as urgent but was treated as 'non-urgent'. Delays occurred because control room staff, who had insufficient training or experience to cope with the demands on the ambulance service that day, planned that the vehicle allocated for the journey should first transfer two babies. My enquiries revealed that the babies' journey was non-urgent and that the planned arrangements for admission to the specialist hospital by 3.00 pm could not have been fulfilled - partly because the crew were delayed for one and a half hours when collecting the babies. Although the woman's husband had, during the day, spoken to a more senior ambulance officer about his wife's deteriorating condition, the officer in the control room did not know about that or about the delay in transferring the babies. During my investigation the AS took some steps to prevent a recurrence of the faults, but I considered that they should also remind GPs what information was needed for classifying calls. I called on them in addition to review training arrangements to ensure that control room staff were equipped to respond to the demands and pressures that faced them.

24. The final case involved a woman taken to hospital by emergency ambulance after falling at home. Two days later she was transferred to a neuro-surgical unit, where she died. The woman's daughter complained that the emergency ambulance crew had used a carrying chair rather than a stretcher to take her mother to the ambulance, and that the transfer to the neuro-surgical unit had been delayed because the wrong type of ambulance was sent.

(f) W.668/89-90 and W.39/90-91 on pages 104-112 of HC 482

25. Although I criticised the ambulancemen for not examining the woman fully on arriving at her home, as they had been trained to do, the decision to use a carrying chair rather than a stretcher in that particular house was a matter for their professional judgment. I considered it an unsatisfactory ambiguity, however, that whereas their training manual required that stretchers should always be used for unconscious patients - as I understood the woman was - the chief ambulance officer's view was that crews did not have to adhere rigidly to that. The RHA responsible agreed to remind ambulance staff of the need to examine patients thoroughly, and to ensure that the guidance issued accurately reflected what was expected of the staff. As to the inter-hospital transfer, I criticised failures in the ambulance request procedure between the hospital and the ambulance service, and the fact that the family were not fully informed about the arrangements made and probable delays. The husband had to wait six hours from the time he was told to go to the hospital to escort his wife until a suitable ambulance arrived to collect her. The DHA concerned agreed to issue clear instructions about the recording of ambulance requests, and both they and the RHA agreed to take steps to ensure that patients and relatives were better informed about ambulance arrangements.

(iii) Supervision and observation of patients

26. The first case in this section concerns the serious failures of ward staff to observe and care for the needs of a terminally ill man. The second and third cases are about patients with mental ill-health. When a mentally ill patient receiving care leaves the hospital and is involved in an accident or takes his own life, it is not surprising that relatives question the extent of the surveillance provided. The extent and nature of the surveillance is largely a matter for the professional judgment of the medical and nursing staff, in which case I cannot question it. What I can look into is whether the question of observation was properly addressed and if decisions about it were correctly carried out.

27. A man underwent major surgery for cancer in one hospital before being transferred to an infectious diseases ward at another hospital for tests. The man's wife was told eleven days later that her husband was terminally ill, and she arranged for him to be taken home. He died there two days later. According to the woman, at the second hospital she regularly found her husband lying naked and uncared for, with his stoma bag leaking, so she had to ask nurses for clean bed linen, pyjamas and a stoma bag. On one occasion she found him on his bed in a semi-conscious state, naked and bleeding. I found that at times the staffing levels on the infectious diseases ward were inadequate to give the terminally ill man, who in his confused state tended to remove his clothing and

(g) W.375/88-89 on pages 11-27 of HC 482

bedclothes, the degree of care and attention that he needed. What was more, the ward was often left in charge of second level nurses. I criticised the nursing management for allowing cover to drop well below establishment figures at times, let alone their own ideal levels. The woman's account was borne out by evidence from staff and I did not find it surprising that, despite their best efforts, nurses on duty were unable to match this patient's needs. The ward was divided by glass partitions into cubicles, which made privacy for the patients hard to achieve. I was greatly concerned that, at an advanced stage of the man's illness, he should have found himself in such an unsuitable environment. I upheld the complaint. The DHA agreed to review their arrangements for staffing wards to ensure that cover was adequate for the needs of the patients.

(h) W.468/88-89 on pages 25-32 of HC 133

28. In the second case a man, detained under Section 2 of the Mental Health Act 1983 for assessment and treatment, absconded from hospital after three days but was brought back eight days later. Medical and nursing staff had initially considered that 'general', rather than 'special' or 'continuous', observation was suitable for the man, but that was again the decision when he was returned to the ward. Two days later he again absconded and went to a nearby railway station where, according to reports, he threw himself under a train and suffered multiple injuries. The man's sister did not think that her brother, as a detained patient, should have been able to leave the hospital and she believed that on his return the level of observation should have been such as to prevent him doing so again. The degree of observation considered suitable for the man was a matter of clinical judgment, but I found to my disquiet that a 'general' level of observation was assumed unless there was a specific decision to apply a different level. Further, I found that no entry was made in the records unless 'special' or 'continuous' observation was decided upon. The man had been nursed in a side room where observation was not as good as elsewhere, and he had left the hospital on both occasions at about the time of staff hand-over from one shift to another. My investigation threw light on a further occasion when he was discovered in another ward - 12 hours before he first absconded - and there was no evidence that the level of observation had been reviewed then. The DHA agreed urgently to review procedures for hand-over and for deciding upon, and recording, observation levels.

(i) W.395/89-90 on pages 96-102 of HC 133

29. The third case involved a young man also admitted to hospital under Section 2 of the Mental Health Act 1983. He was involved in an accident with a vehicle outside a hospital's grounds, and his father did not feel that the staff had provided adequate supervision or care for him. One of the young man's problems on admission was agoraphobia, yet he took to walking by himself in the hospital grounds. The ward staff, having established that he followed a set route, allowed him to continue with his walks unescorted and the responsible consultant was not unduly concerned about that. What I found disturbing was that a lack of communication between the nursing and medical staff meant that the consultant did not know that the young man had left the grounds on an earlier occasion, two days before the accident. I considered that, had the consultant been made aware of the previous incident, he might have reviewed the level of observation required and the accident might thus have been avoided. I also criticised the nursing care plan in this case, as it did not refer to the unusual or unexpected behaviour of the young man or the actions decided upon as a consequence. The nurses did not, in my view, make sufficient effort to try and contact the parents about the incident on the day it occurred. I recorded concern about the deficiencies which I had found in communications, and the DHA agreed to remind their staff of the importance of recording and communicating information directly relevant to care and treatment.

(iv) Communication and records

30. If only communications among members of staff, or with patients and relatives, were better, there would be a marked reduction in the number of complaints I receive about care provided by the NHS. A sensitive explanation or an apology may be all that is needed. A stitch in time saves nine. Poor record-keeping, too, continues to crop up in cases which I investigate. Hospital records are vitally important in conveying to staff the patient's needs and progress and, retrospectively, in tracing the course of a patient's care.

(g) W.375/88-89 on pages 11-27 of HC 482

31. I have referred in paragraph 27 to inadequate provision for the needs of a terminally ill patient. The man's wife complained also about her inability to obtain an appointment with her husband's consultant to discuss the tests or treatment her husband would receive, and about lack of information as to how her husband's condition was getting on. The consultant did not know of the woman's request, and his intention was to see her when the result of a biopsy report was received - but by then she had already decided to

have her husband discharged home. The evidence persuaded me that the junior medical staff did keep her reasonably well informed on an almost daily basis, although records of those conversations were not always made. Of greater concern to me was the inadequate record keeping in relation to nursing care. The man's nursing care plan did not adequately reflect all aspects of the care the man needed - there was no note of his tendency to undress himself and the actions nurses should take to deal with that. There was delay in updating the plan to show that the man needed encouragement with his diet and fluids, and I saw that the care plan had not been reviewed over a period of 10 days. The DHA agreed to remind nurses of the importance of matching the nursing care plan to the patient's needs.

32. In their examination of cases referred to in my last Annual Report, the Select Committee voiced serious disquiet about the loss of a patient's clinical records. In a further case this year my investigation was seriously hampered by the loss of almost all of a woman's nursing records - they went missing while the DHA were themselves investigating the complaint. I found the loss at the very least careless. I remarked, too, on the paucity of entries in the clinical records. The complaints related to the experiences of a woman who had been admitted to hospital for knee replacement surgery and, the day after her operation, experienced severe pain in her leg. Her daughter made a number of complaints on her behalf, some of which were about communications. The daughter asked several times to see a doctor about post-operative complications, but the ward sister took no action. At a meeting with a consultant shortly before her mother's discharge, she was told that there had been no infection in her mother's knee; that bewildered her, as swab tests had regularly been taken and other medical staff, and nurses, had said that infection was present. The existence of differing accounts of what constituted an infection seemed to me unsatisfactory. At the same meeting, held during the consultant's outpatient clinic, four other hospital staff were present; none of them was introduced to the daughter, and their presence intimidated her. Although it was not a teaching hospital, two were medical students and I was quite clear that consent to their attendance should have been obtained. I was critical of the consultant for lack of common courtesy. All these lapses in oral and written communications led me to recommend remedial measures, and the DHA agreed to implement them.

(j) W.417/89-90 on pages 69-80 of HC 482

33. The third case under this heading was worrying and unusual in that it involved important evidence by other patients, and the way in which that aspect was mishandled by the DHA concerned. A man, whose elderly mother had been admitted to hospital after a stroke, was told by other patients that one night a nurse had sworn at her, dragged her out of bed, and grossly maltreated her after she had soiled her bed. The man particularly wanted to know why the DHA had not told him about the incident. Although two of the other patients reported the incident to a ward sister the next day, the staff agreed not to tell the man about it until a full investigation had been carried out, so as to avoid alarming him. I regarded that as misguided. After investigation I did not find that the man's mother had been handled cruelly, but I was persuaded that the nursing auxiliary concerned had been much too abrupt and had exercised less care than should have been the case. The allegation of oral abuse was well-based. I found that no doctor had been called to examine the patient and no note had been made in the nursing records. In a case where other patients were so public spirited as to voice their concerns, I would have expected those steps to have been taken and to have found better documentary evidence of discussions with those patients who could provide information. Allegations of harm to a patient were involved yet the nurses on duty on the night in question had been transferred to other wards. I was not convinced that the DHA had - without prejudice to disciplinary procedures - demonstrated that the well-being of other patients was being safeguarded. The DHA agreed to review the procedure to be followed when an allegation is received from a patient which seems to be about harm caused to another patient by a member of staff.

(k) W.463/88-89 on pages 17-25 of HC 133

(v) Handling of clinical complaints

34. Investigations into the administration of independent professional reviews (IPRs), which can be set up to deal with clinical complaints, have been referred to in every annual report since the procedure came into force some ten years ago. Most complaints are about delay, but the three cases I have chosen this year each touch upon different aspects. Parliament did not include in my remit matters which in my opinion are founded in clinical judgment. Patients with no inclination - or case - to go to court nevertheless need answers to their concerns. I regard it as right to recommend improvements where it seems to me that the aggrieved person is not getting an effective service under the clinical complaints procedure.

(l) W.411/90-91 on pages 62-69 of HC 482

35. I referred in last year's report to a case (W.44/89-90) of delay in handling a clinical complaint. This year I have to refer to a further case, in the same RHA, which was handed over to the clinical complaints adviser (CCA) appointed to assist the regional medical officer (RMO). A woman originally complained to a DHA about hospital treatment she had received in April 1988. In December 1988 the complaint was sent to the RMO for him to consider an IPR, and ten months later the CCA met the woman and agreed to an IPR. Not until three months after that was the woman told that independent assessors had been appointed and that an IPR would be held on 31 January 1990. She was notified of the outcome on 7 February, and on 3 April she expressed concern to the CCA that the IPR findings had still not been conveyed to the DHA - who were thereby prevented from keeping an eye on the promised remedial measures. The CCA put that right on 18 April.

36. I found that some of the early delays in obtaining the clinical records occurred before the CCA took over the case and were not of the RHA's making. Three factors accounted for the inordinate delay in arranging a meeting with the woman, none of which in my view exonerated the RHA from allowing matters to drift for so long. In particular, three months to arrange a preliminary meeting with the two consultants involved in the woman's care brought the complaints procedure into disrepute. I strongly criticised both the delays and the RHA's discourtesy in not keeping the complainant informed about what was happening. The RHA not only put that right for the future but told me that - as I urged in paragraph 5 of my report for 1989/90 - they now write to the DHA concerned, rather than direct to the complainant, about the results of an IPR, as laid down in the clinical complaints procedure. That should prevent breakdowns in communication such as occurred in this case.

(m) W.369/89-90 on pages 58-62 of HC 482

37. In the next case, which did not get as far as an IPR, a man was not happy with the treatment he had received and complained to the hospital through the local CHC. He was not satisfied with the hospital's reply and asked to meet the consultant, saying that he wished to be accompanied by a representative from the CHC. The consultant was prepared to meet the man to discuss his concerns either on his own or in the presence of a relative, but only if that failed to satisfy the man would he see him with someone from the CHC. The man regarded that as unreasonable, feeling that he would be at a disadvantage on his own and that he needed support from someone who had experience of such situations. So did I, especially in view of the clear guidance from the DOH. I believed it was for the man to decide who his friend should be, and I upheld the complaint. The DHA apologised for the difficulties the man encountered and the consultant acceded to the man's request.

(n) SW.64/89-90 on pages 102-106 of HC 133

38. Issues other than those relating strictly to the exercise of clinical judgment can emerge from an IPR. A woman included in her complaint to the independent consultants conducting a review aspects of nursing care and communications relating to her late mother's treatment. They told her that they would refer to these aspects in their report to the Health Board's chief administrative medical officer (the CAMO). The woman's complaint to me was that in their response to her the Board did not deal with those non-clinical matters. I found that the assessors' report had touched upon the non-clinical issues, which were then discussed informally between the CAMO and the chief administrative nursing officer. That informality led the latter to believe that the complaint was of a clinical nature, and she did not appreciate that there were nursing matters which had not been resolved. As a result no effective action was taken on these until I began my investigation. The Board's reply to the woman was also so generalised as to be meaningless - in my view they had more to lose than to gain by dissimulating. This complaint revealed that no officer had overall responsibility for ensuring that all the issues raised in an IPR report were dealt with satisfactorily, and the Board told me that they would consider how this should be dealt with in future.

(vi) Family practitioner services

39. I cannot look at the way in which in England and Wales family health services authorities (FHSAs) - which until October 1990 were known as family practitioner committees (FPCs) - and health boards in Scotland handle complaints against GPs, dentists, opticians or pharmacists under statutory regulations, referred to as the formal procedure. I am also unable to investigate the actions of the practitioners themselves. As in previous years, though, I have investigated allegations of maladministration by FHSAs in their informal handling of complaints against GPs. I give details of two such cases.

40. In the first case, a man complained to a FPC about the handling of his complaint against his late father's GP and the delay in transferring his father's records between GPs. The father had been admitted to hospital as an emergency, and the man's mother had complained to the FPC about the actions of the GP involved. The FPC had later asked the father if he wished to pursue the complaint, and he had said that he did not. Subsequently the GP had removed the father from his practice list and, about a month after registering with a new GP, the father had died. The son then decided to pursue the complaints, but the FPC administrator rejected that involving the first GP on the grounds first that it was out of time, and second that the father had not wished it to be pursued. I considered him wrong on both counts. He did not seek, as he was required to do, an explanation for the delay in submitting the complaint, and the decision to reject it as out of time was not his, but the medical service committee's, to take. Furthermore, I thought that the man was entitled at least to have his complaint properly considered for acceptance regardless of what had gone before. The FPC agreed to give the complaint further consideration.

(o) W.189/89-90 on pages 91-96 of HC 133

41. As to the transfer of the father's records, unnecessary delay was caused by the FPC's practice of recording patient information on two computer screens and failure then to check from one screen to the other. The new GP assured me that the lack of records had not affected the father's treatment, but I saw their absence as adding to the father's concern, and that of the family, and as hindering the new GP in giving explanations after the father's death. The FPC's review of procedures should, I concluded, prevent that situation from arising again.

42. In the other case a woman concerned about her young son telephoned a deputising service first thing in the morning but was told that she should contact her GP when his surgery opened in about one hour's time. Her son was later admitted to hospital and the woman complained to the FPC about the deputising service's response to her call. Although she and the local CHC made enquiries of the FPC, she did not hear from the deputy administrator (the DA) until nine months later, and another two months passed before she was sent a definitive reply. The woman complained about the delay, and that she had not been told whether information had been sought from the GP about the incident. She also complained that the FPC did not seem to have obtained from the deputising service an assurance that their receptionists would not, in future, decide what constituted an emergency.

(p) W.212/89-90 on pages 45-50 of HC 482

43. I criticised the DA for failing both to follow up the enquiries he had set in motion on receipt of the woman's complaint, and to inform the woman of his actions. Other staff did not respond positively when reminders were received, and I criticised the general manager for not intervening when the matter was brought to his attention. I was satisfied that the DA had contacted the GP about the incident and that he had told the woman, albeit belatedly, about the position. I did not therefore uphold that aspect of the complaint. I learned that the DA, not being satisfied with the response from the deputising service, had decided to pursue the matter through the joint deputising sub-committee. However, he did not inform the woman of that, nor did he follow up his approach to the sub-committee - which was satisfied that the deputising service receptionists would not decide what was an emergency but would pass calls to the GP concerned - until prompted to do so by my officer. I criticised him for that and for failing to inform the woman of the final outcome of her complaint. This was a good example of the benefit for future NHS users which can arise from a complaint, but the FPC let the woman down. They readily apologised for that failure.

44. In the wide variety of my investigations were cases which did not fall into any particular category but nonetheless merit attention because of the particular lessons that can be learned from them.

(q) W.258/89-90 on pages 50-58 of HC 482

45. A decision not to resuscitate a patient raises important clinical and ethical issues. In an unusual case of particular concern to me a man discovered that his elderly mother's clinical records stated that she was 'not for the 222s' - meaning that, in the event of her requiring cardio-pulmonary resuscitation, she would not receive it. In fact, his mother made good progress and was eventually able to go home. The son complained to the DHA about three issues - why the decision not to resuscitate had been taken; why he had not been consulted or informed; and what the DHA's policy on resuscitation was. I found the decision by a house officer, on the night of the admission, that the woman was not to be resuscitated had been made in the exercise of clinical judgment. The consultant in charge of the case said that, by not reiterating the decision at a ward round the next day, he had in effect cancelled it - but his junior staff did not realise that, and no note of such a change was made in the clinical records. That seemed to me barely credible, but the confusion did not end there. My investigation revealed a worrying divergence of policy on consulting relatives. The consultant believed their attitude should be taken into account in arriving at a decision, whereas the junior medical staff did not think that was required - or even appropriate. Responsibility lay with the consultant to ensure that a common policy - written or otherwise - was followed. In upholding the complaint, I noted with approval that the DHA had later produced a written policy. Since I considered it remarkable that such a difficult and sensitive issue had apparently not been addressed systematically, I drew my observation to the attention of the Chief Medical Officer of the Department of Health.

(r) W.422/88-89 on pages 9-17 of HC 133

46. Another case was about the management of out-patient appointments. A man who had suffered from eye problems for a number of years, and was attending a hospital as an outpatient, complained that his appointments were repeatedly postponed - allegedly with the approval of his consultant. What I discovered was that the hospital experienced difficulties because of the very high number of patients being referred. To make matters worse GPs were rarely trained in ophthalmology, and the hospital's consultants tried to respond immediately to new referrals and rarely discharged patients. Priority was given to new patients at the cost of the service to existing outpatients, who had appointments repeatedly postponed. In an effort to cope with the inexorable demand, the clerical staff who re-arranged appointments worked to intervals considerably in excess of the guidance provided by medical staff. What could be done to prevent the situation from degenerating further into chaos? The DHA accepted my recommendation that they should commission a special study to examine the organisational and clinical issues, with the aim of devising an appointments system in which postponement would be exceptional. They also agreed that, where postponement was necessary, medical staff would be more closely involved.

(s) W.25/90-91 on pages 112-117 of HC 482

47. Patients and their relatives are entitled to expect that their wishes for confidentiality are respected, but in a case which I investigated a consultant released information about a girl on a transplant waiting list. Her details had been passed from another hospital with which the transplant programme was shared, and where the girl died during surgery. The circumstances of her case were featured in the press, and her parents' local newspaper also gave her name. The parents complained that the DHA responsible for the hospital where the consultant worked had acted unethically in releasing information which enabled the press to identify their daughter.

48. My enquiries established that the consultant had intentionally released personal information to the press in order to heighten public awareness of the needs of the transplant programme. That information had led to the girl being identified in the local newspaper. The consultant did not know that the parents had specifically prohibited publicity, and his actions contravened the DHA's policy on confidentiality. The parents' distress at the loss of their daughter was thereby made even more unbearable, and I upheld the complaint. The DHA apologised and agreed to draw the attention of all staff to their responsibility to maintain confidentiality.

49. In my predecessor's Annual Report for 1988/89, and again this year in paragraph 32, the question of consent to participate in teaching has been mentioned. Consent to involvement in clinical trials or research has less prominence but raises similar and important matters of principle. A woman suffering from cancer complained to me about the time the DHA had taken to answer questions put to them about clinical trials in which she had taken part, including two into which she had been entered without her knowledge. A further grievance concerned an alleged breach of confidence resulting from storage, without her consent, of confidential information from her clinical records on separate computer systems, including one managed by the medical school associated with the hospital where she was being treated, and another by a research centre.

(t) W.79/89-90 and W.80/89-90 (Not published)

50. My investigation revealed that there was no guidance to health authorities on whether patients should be told that personal information from their records might be disclosed for research purposes, so I did not find maladministration in the DHA's actions. I accept that clinical research cannot be conducted without information about the treatment of patients involved in a trial, but I believe that patients are entitled to expect that confidential information about them is carefully safeguarded, and that their identity is protected. In the light of this case, I felt that future patients should have the assurance that the need for confidentiality was recognised and provided for in well understood procedures. The DHA agreed to produce a policy on disclosure of information for research purposes, and to consider whether information given to patients should in future include an appropriate reference to the hospital's responsibilities in relation to clinical research. It seems to me that, if there is an absence of policy guidance, that is a matter which the Health Departments might well examine.

51. Another case I investigated centred upon the loss of a biopsy report. A man, who had a recurrent stomach ulcer, collapsed and was admitted to hospital where a biopsy was carried out. He was dissatisfied with the attention he received and discharged himself before the result of the biopsy was known. He was told before leaving the ward that his ulcer appeared to be benign, but that proved not to be the case because the biopsy report revealed malignancy. The report, delivered to the ward a day or two after he left, was then lost. The man did not learn the results of the tests until over two months later, when he made enquiries after an examination at another hospital. He died shortly afterwards and his wife complained that the DHA's failure had denied her husband medical treatment which might have helped him.

(u) W.97/89-90 on pages 69-75 of HC 133

52. I was unable to establish what had happened to the biopsy report which was received in the ward, sent to the consultant concerned but then lost. The outcome was that none of the medical team responsible for the man's care saw the report, nor was his GP informed of its contents. I was critical of the DHA and would have expected the absence of a report to be noticed by those who had ordered the tests. I was able to inform the man's widow that a clinical audit concluded that the loss of the information in the report would not have affected the progress of the illness from which her husband died.

53. In the last case I have selected for this chapter, I found that a pregnant woman was inadequately informed in advance about what facilities she would have when admitted as a private patient. She had had two previous confinements in a private ward but, because it had been closed, she was admitted as a private patient to the hospital's GP maternity unit to have her third child. Wanting rest after the birth of her child, she had arranged to stay in the unit for three days but, in the event, she found that rest was denied her as her baby remained in her room rather than in a nursery, and other things occurred to disturb her. The woman complained that the service and care she received was of a much lower standard than she could reasonably have expected in the light of her two previous admissions.

(v) W.206/89-90 on pages 40-45 of HC 482

54. I found that the unit was an active delivery unit whose purposes and practices were fundamentally different from those which had prevailed in the private ward. Contrary to guidance issued by the DOH about the management of private practice in NHS hospitals, the woman had not been given the information necessary for her to be able to make an informed decision about the nature of the facilities available, yet details of the unit were given to NHS patients during their ante-natal care. The woman told me that, had she known what to expect, she would have remained in the unit only for the 24 hour stay for which it was designed. I upheld the complaint and, on my recommendation, the DHA reimbursed two of the three days' charges which the woman had paid.

55. I referred in Chapter 1 to the solace a complainant can find in the knowledge that a failure will be put right for the benefit of others - and I always check after my report on an investigation has been issued that the promised action has been implemented. Sometimes a health authority will spontaneously recognise the need to change procedures. That is all to the good. On very rare occasions I encounter resistance to a remedy and, in respect of the investigations completed in 1990-91, it took me 16 weeks in one case after drafting my report to secure a remedy which I regarded as providing acceptable redress for the complainant (paragraph 15). In every case where I uphold a complaint, I look to the health authority for apologies to be conveyed through the medium of my report to the aggrieved.

56. In only a very small number of the cases which I investigate does the possibility of a financial remedy arise. Compensation and damages are matters for the courts and not for me. Occasionally, though, I regard reimbursement for a financial loss as a proper response and invite or recommend a health authority to make an ex-gratia payment. This year saw 9 such cases, and the sums involved were usually modest. The transactions in each case were between the complainant and the health authority.

57. Those cases for which, in 1990-91, I secured a financial remedy were:

W.375/88-89 Reimbursement for cost of providing a private ambulance and for the loss of two pairs of pyjamas.

W.490/88-89 Cost of lost nightdress to be paid.

W.620/88-89 Ex-gratia payment made in respect of the cost of travelling to and from hospital for treatment.

W.194/89-90 Ex-gratia payment in recognition of distress caused to a woman by the handling of her request for assistance with nursing home fees for her father.

W.206/89-90 Private patient charges for two days reimbursed.

W.243/89-90 Patient compensated for the full value of lost jewellery.

W.260/89-90 Patient reimbursed for lost laundry and handkerchiefs.

W.478/89-90 Nursing home costs reimbursed in respect of care DHA should have provided.

W.208/90-91 Ex-gratia payment made to cover the cost of refrigerator contents spoiled after a home assessment visit.

58. The volumes of selected and anonymised cases which I publish twice a year - some of which I refer to in Chapters 2 and 3 - provide a detailed picture of how things can go wrong. I now outline, in four broad categories, all the procedural remedies which I have obtained in 1990/91:

(i) Administrative practices or procedures associated with medical activity

W.303/88-89 Clinical role of medical students to be defined.

W.343/88-89 Staff instructed to give reports to GPs in writing and to confirm any reports given orally.

W.418/88-89 Improvements made to arrangements for communicating to a GP details of a patient's death.

W.468/88-89 (a) Process reviewed for making decisions on observation levels for patients detained under Mental Health Act;

(b) Staff to record agreed level of observation.

W.500/88-89 Review of guidance given to medical staff about consent in respect of treatment of minors.

W.568/88-89 Arrangements to be reviewed for junior doctors' response to urgent calls for assistance.

W.620/88-89 Review of guidance to consultants clarifying their role in relation to DOH circular HC(88)20 (help to NHS patients with the cost of travelling to and from hospital).

W.97/89-90 DHA to look again at instructions about the transmission of pathology results.

W.417/89-90 Consultants to seek patient's agreement to presence of medical students, and to introduce them to the patient.

W.527/89-90 (a) Consultants reminded of need for clear instructions to clerical staff about entries to the waiting list;

(b) Consultants to give patients or parents realistic assessment of when admission can be expected.

W.536/89-90 Staff to ensure that prescriptions are altered promptly when drug administration times are changed and that the timing of, and authority for, changed prescriptions are properly recorded.

WW.24/89-90 Admission procedures for the dependent elderly - particularly with regard to consent of carers and to communication with social workers - to be reviewed.

(ii) Administrative practices or procedures associated with action on the ward

W.371/88-89 (a) Further guidance to nurses on drawing up plans for nursing care to be considered;

(b) Guidance to nurses, about informing a patient's relatives about an incident resulting in injury, to be reviewed;

(c) Instructions to staff, about forewarning relatives what to expect where a Coroner's post mortem is required, to be reviewed;

(d) DHA to re-examine information leaflet given to bereaved relatives.

W.375/88-89 Arrangements for staffing wards to be reviewed to ensure that cover is adequate for patients' needs.

W.468/88-89 Ward handover procedures to be re-examined.

W.490/88-89 DHA to give attention to availability of glasses and water at patient's bedside.

W.625/88-89 Improvements made to accident report form.

W.11/89-90 Guidance issued re-emphasising the need for more regular entries in nursing notes.

W.60/89-90 DHA to consider adequacy of night staffing and to review policy on 'last offices for the dead'.

W.147/89-90 (a) Leaflet to be produced to explain isolation procedures to relatives;

(b) Guidance to be issued to nurses about making entries in the nursing records;

(c) Basis of issue of meal passes to visitors to be clarified.

W.217/89-90 Ward handover and observation procedures reviewed.

W.305/89-90 Steps taken to ensure that patients for transfer from a general hospital to a rehabilitation unit receive advance written information as to its function and practices.

W.395/89-90 Guidance to staff, about contacting relatives after any incident warranting an accident report, to be reviewed.

W.417/89-90 (a) Nurses to record and act upon requests by relatives to see a doctor;

(b) Practice in making regular entries in records to be kept under review;

(c) Nurses and doctors to resolve differences about the presence and significance of infection.

W.478/89-90 (a) Discharge procedures to be reviewed;

(b) Staff to ensure that notes for action are attributable, unambiguous and dated.

W.536/89-90 (a) DHA to ensure that ward nurses know how to get extra help when pressure of work threatens to jeopardise standard of nursing care;

(b) Staff to consider means of ensuring that patients are not inadvertently denied information they are seeking.

W.668/89-90 DHA to review, with RHA, procedures to ensure that patients and relatives are better informed about arrangements for non-urgent transfer by ambulance to another hospital.

W.23/90-91 Guidance to nurses on supervision of patients to be re-examined.

W.39/90-91 (a) DHA to review the recording of ambulance requests and issue instructions;

(b) patients and relatives to be fully informed about non-urgent transfer arrangements.

W.125/90-91 (a) Guidance given to nurses on importance of maintaining adequate records, particularly in relation to pressure sores;

(b) Review of guidance at (a) to include greater precision in describing pressure sores, both in the records and in explanations to relatives.

WW.35/88-89 Guidance to be provided for nurses regarding the shaving of patients.

iii) Administrative practices or procedures associated with action in other hospital departments

W.335/88-89 DHA to consider issuing guidance to patients working on Industrial Therapy Unit about principles governing the unit's operation.

W.422/88-89 (a) Outpatient clinic appointments system reviewed;

(b) Clinical staff to be more closely involved where need for postponement of appointment arises.

W.546/88-89 DHA to review procedures for recording movement of x-rays and to consider issuing further guidance on handling of x-rays from abroad.

W.594/88-89 Arrangements for patients' dressing/undressing to be reviewed.

W.2/89-90 Review of guidance on action to be taken to trace next-of-kin when patient dies.

W.243/89-90 Guidance provided to staff on documentation to be completed when a patient's valuables are given to a relative.

W.574/89-90 X-ray request form to be re-designed.

W.616/89-90 (a) Guidance to clinic staff on procedures when consultant cannot fulfil undertaking personally to see a patient;

(b) Procedures for recording transfer to the list of another GP to be reviewed.

W.2/90-91 Guidance to occupational therapists, about whether to leave electrical supply on after a home assessment visit, to be reviewed.

SW.66/89-90 Health Board to remind staff of need for privacy when patients are asked questions in clinic.

WW.35/88-89 (a) Arrangements for outpatient clinic appointments to be reviewed to reduce waiting time;

(b) Maintenance of records in the medical records department to be reviewed.

(iv) Other administrative practices or procedures associated with record-keeping, correspondence or complaints

W.353/88-89 (a) DHA to clarify procedure to be followed when a meeting is arranged with a complainant who has involved the CHC;

(b) DHA's record of the meeting to be sent to the complainant.

W.404/88-89 (a) Complainants to be kept informed of progress in dealing with their complaints under the clinical complaints procedure;

(b) RHA's letter to independent assessors amended to ensure that they know what is expected of them;

(c) Staff to ensure that new IPR cases are always acknowledged.

W.430/88-89 Policy on monitoring of complaints and issue of interim replies to be reviewed.

W.463/88-89 DHA to give guidance on procedure to be followed when allegations of harm to a patient are made by other patients.

W.490/88-89
W.593/89-90
W.647/89-90 Three cases in which DHA staff were to be told not to sign letters with the name of another officer

W.539/88-89 (a) Improvements made to internal communications about IPR arrangements;

(b) RMO to provide fuller response;

(c) RMO to reply to outstanding correspondence.

W.575/88-89 Staff reminded of action to be taken in the event of disruption of postal service.

W.211/89-90 Informal procedure for handling complaints to be reviewed.

W.236/89-90 (a) Use of computer-based predictions of admission date to be looked at;

(b) Complaints procedure reviewed.

W.271/89-90 RMO to reconsider IPR request.

W.318/89-90 Complainants to be informed about what ground an IPR will cover.

W.369/89-90 Consultant agreed to meet complainant in the presence of CHC representative.

W.417/89-90 DHA to look again at their method of investigating complaints.

W.478/89-90 Complaints procedure reviewed and designated officer's responsibility defined.

W.536/89-90 DHA to comply with provisions of Circular HC(88)37 in handling complaints about the care of patients.

W.570/89-90
W.647/89-90
W.684/89-90 DHA to ensure adequate systems for monitoring the handling of complaints.

W.581/89-90 DHA to satisfy themselves that systems for dealing effectively with complaints remain adequate.

59. For a health authority simply to devise a procedure is not enough. Staff need to have it explained to them and to be trained in its use, and there is an onus on management to see that it is implemented. That does not always happen, and in those circumstances I expect the health authority to rectify the lapse. Examples of this in 1990/91 were:

W.303/88-89 Nurses and doctors reminded to explain treatment regimes to relatives.

W.371/88-89 Nurses reminded of importance of administering medication as prescribed, and of the need for accuracy in record keeping.

W.375/88-89 Importance of matching the nursing care plan to patient's needs drawn to attention of nurses.

W.490/88-89 (a) Nurses to follow the regime set out in the nursing care plan;

(b) Nurses reminded of need to warn visiting relatives about significant deterioration in patient's condition.

W.513/88-89 Staff reminded to adhere to procedures and take full account of ward layout.

W.568/88-89 Need to maintain adequate documentation about aspects of patients' care reiterated.

W.594/88-89 Staff reminded of complaints procedure.

W.622/88-89 Staff reminded of procedure to be followed when decision taken not to administer medication which has been prescribed.

W.625/88-89 Role of medical and other staff in the complaints procedure underlined to them.

W.2/89-90 Staff told of the need for accurate and detailed records, which should be signed and dated.

W.146/89-90 Staff reminded about care of relatives in accident and emergency department.

W.180/89-90 (a) Re-emphasis of need for entries in nursing records to be sufficiently detailed;

(b) Staff reminded of need for care to be taken with nursing and other records.

W.187/89-90 Ambulance service staff called upon to get more information when accepting bookings for transport to a hospice.

W.210/89-90 Staff reminded of importance of contemporaneously dating and signing, or initialling, records and amendments thereto.

W.234/89-90 DHA to ensure that normal clinic procedures are operated when clinic conducted by locum and substitute staff.

W.260/89-90 Staff reminded about patients' personal laundry procedures.

W.305/89-90 Nurses reminded to maintain full records.

W.338/89-90 (a) Medical staff reminded of their responsibilities when answering complaints;

(b) Need to keep complainants informed of progress reiterated.

W.395/89-90 Staff told again about importance of recording and communicating information relevant to care and treatment of patients detained under the Mental Health Act.

W.668/89-90 Ambulance staff responding to emergency calls reminded of need to examine patients before carrying them to vehicle.

W.25/90-91 DHA staff reminded of need to be aware of responsibilities with regard to confidentiality.

W.84/90-91 Medical staff reminded what they should do when arranging admission to hospitals in other DHAs.

WW.24/89-90 (a) Nurses reminded to record the use of cot sides;

(b) Staff to check the presentation of a body before it is viewed by relatives.

60. Some of the remedies in investigations completed in 1990-91 did not fall into any obvious category:

W.321/88-89 Responsibility for provision of respite care clarified.

W.79/89-90 (a) DHA to consider whether information to patients should include reference to DHA's responsibilities in relation to clinical research, including a statement in relation to (b);

(b) DHA to carry forward a review of data protection and confidentiality to embrace also a policy on the disclosure of information for the purposes of clinical research.

W.187/89-90 RHA to produce guidance, in consultation with local hospices, on how to ensure that ambulance transport needs of hospice patients are clearly identified.

W.121/89-90 DHA to ensure that the counting of votes at DHA meetings is verified by a non-participating officer and agreed by the chairman during the meeting.

W.189/89-90 FPC (now FHSA) to reconsider a complaint previously rejected.

W.580/89-90 Consultation procedures to be reviewed, to include steps to be followed where a voluntary organisation is involved in providing services on DHA's behalf.

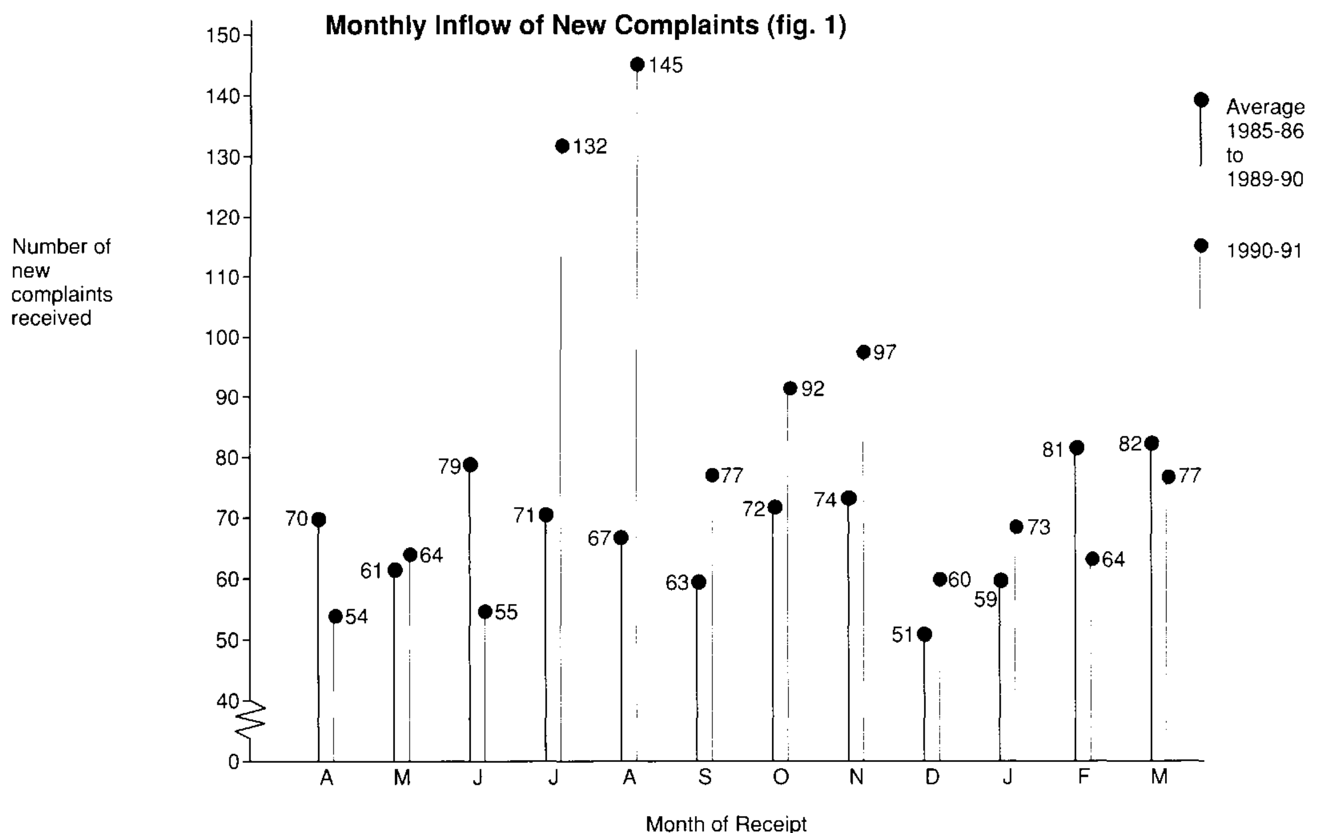
W.652/89-90 (a) DHA to issue guidance to GPs about categorising ambulance calls, to ensure appropriate handling by the ambulance service;

(b) Staff training to be reviewed to ensure that ambulance service staff are equipped to respond to control room pressures.

W.668/89-90 Guidance to ambulance staff to be reviewed to ensure that it reflects what is actually expected of them.

Workload

61. The 990 complaints received by me during 1990/91 represented the highest total for any year since the Office opened in 1973 and a 24.7% increase over 1989/90. Many of the approaches made to me were a direct result of the distribution by Health Departments to every household in the summer of 1990 of a booklet entitled 'The NHS Reforms and You'. Even though I had to disappoint many of those who wrote to me about matters not within my jurisdiction, I was pleased that the publication mentioned my role in relation to complaints about the NHS and informed the public that if, having made a complaint to a health authority and received a written reply, they remained dissatisfied, they could send their complaints to me. Its impact upon my Office first became evident in late June. July and August saw an unprecedented volume of complaints and, as figure 1 shows, not until the turn of the year did the inflow of work stabilise to more usual levels. Even so, that number of complaints is remarkably low by comparison with the number of patients treated and the level of complaints dealt with locally by health authorities and boards.



62. The breakdown of complaints between England, Scotland and Wales (together with the percentage increases over the figures for 1989/90) is shown in figure 2. Appendix G gives an analysis of the intake on a regional basis, and of the population per complaint received. In only two regions - Northern and South East Thames - were fewer complaints produced than in 1989/90. Overall the share from the four Thames regions (334) stayed

constant at some 40% of all of the complaints received for England. Of the total workload of 1254 cases action was completed on 1006 (80.2%) during the year compared with 848 (76.3%) in 1989/90. Figure 2 and Appendix A show their disposal.

Workload and Disposal (fig. 2)

Workload

Workload	
Cases brought forward from 1989/90	264
Cases received for: England — 844 (+23.2%) Scotland — 95 (+25.0%) Wales — 51 (+54.5%)	990
Total	1254

Disposal

Disposal	
Reports issued	139
Cases rejected	420
Cases discontinued	16
Cases referred back and subsequently closed	431
Cases carried forward to 1991-92	248
Total	1254

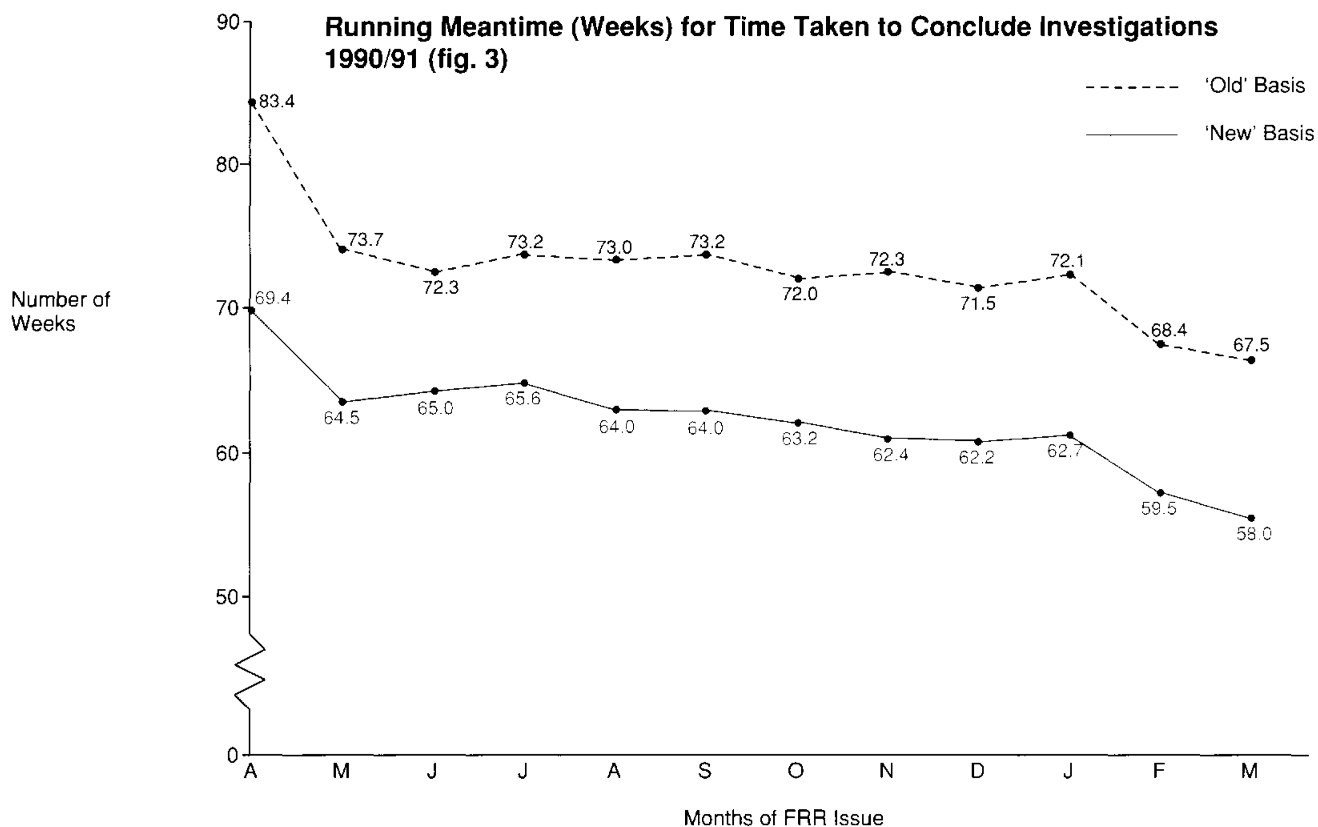
63. In addition to the complaints received, the year under review saw 184 written enquiries and requests for information and advice (142 in 1989/90) - and numerous telephone calls. The marked increase in this work was due, in part, to the DOH booklet, and in part to those who write to me for information about my work. There were also 697 supplementary letters either about complaints which had not been accepted for investigation, or in response to requests for further information or action - in relation, for example, to a complaint which I have referred back (see paragraph 77).

64. I have seen it as one of my main tasks to improve the quality of the service provided by my Office and, in particular, the speed with which complainants learn whether or not I can help them. As a general objective, I expect a definitive reply to be sent to complainants within three weeks of the date of receipt of their letter. Even though the year under review was an exceptionally busy one, that target was achieved for some three-quarters of those complaints which I rejected or referred back.

Reports issued on completed investigations

65. Of the 122 investigations concluded during the year 17 involved two health authorities. Two represented investigations undertaken in my capacity both as Health Service Commissioner and as Parliamentary Commissioner for Administration.

66. As I have said in Chapter 1 as speedy a response as possible is very important for the complainant - and for me. I referred last year to my decision to compute time taken from the date of the receipt of a complaint acceptable for investigation rather than from the date of first receipt of correspondence, but at the request of the Select Committee I am still keeping records of time taken using both the old and new methods. Under the old system of counting the average time taken to complete an investigation during 1990/91 was 67.5 weeks, compared with 68.9 weeks in 1989/90. Under the new system (paragraph 7) the 1990/91 figure was 58 weeks. In 62 cases the complaints had to be referred back before I could proceed to investigation and that process accounted for an average of nearly ten weeks per case. It is interesting to note that in several instances complainants responded to my enquiries within days, but at the other extreme some 45 weeks elapsed before the complainant produced a complaint which I could, finally, consider for investigation. I show at figure 3 how the moving average of time taken - under both the old and new systems - has decreased during 1990/91.



67. The following table (figure 4) shows the proportion of investigations concluded within various time bands and, for comparison, I have provided equivalent information from the results achieved in 1988/89 and 1989/90.

Time Bands for Investigations (fig. 4)

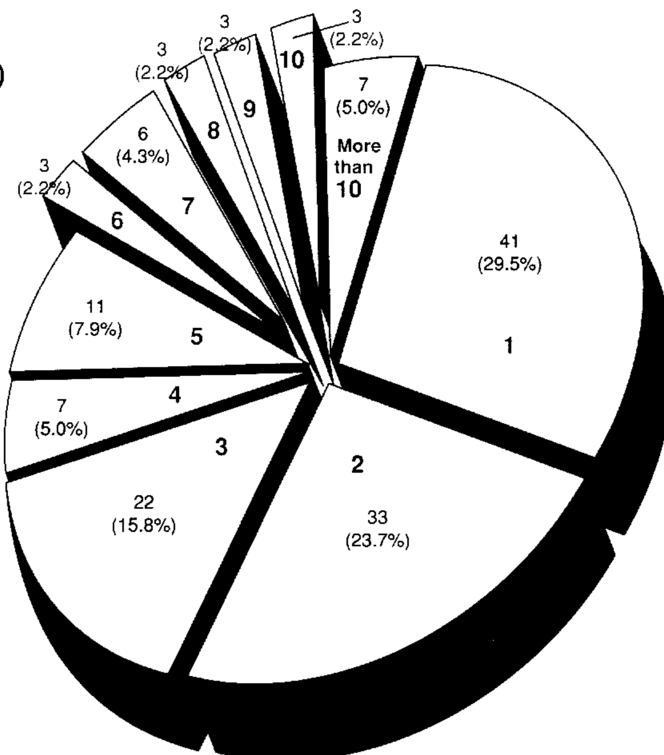
Time band	Proportion of investigations concluded			
	1988/89	1989/90	1990/91 Old basis	1990/91 New basis
Under: 40 weeks	6.5% (8)	3.7% (3)	6.6% (8)	15.6% (19)
50 weeks	16.3% (20)	20.7% (17)	23.8% (29)	37.7% (46)
60 weeks	35.8% (44)	50% (41)	40.0% (49)	55.7% (68)
70 weeks	59.3% (73)	63.4% (52)	54.9% (67)	77.0% (94)
80 weeks	65.0% (89)	75.6% (62)	75.4% (92)	85.2% (104)
100 weeks	92.7% (114)	87.8% (72)	92.6% (113)	100% (122)
130 weeks	98.4% (121)	97.6% (80)	100% (122)	
175 weeks	100% (123)	100% (82)		

Note: Figures in brackets represent actual investigations concluded.

68. I investigated 487 separately identified grievances during 1990/91. That represents an average of 3.50 for each report (3.88 in 1989/90). The slight fall in the average number of grievances per report in part reflects my wish to give investigations a sharper focus and to discount grievances of minimal substance.

69. Figure 5 shows the distribution of grievances amongst the 139 reports issued. Although in nearly 60% of cases complainants raised five or fewer individual grievances, 11 cases had ten or more aspects and, at the extreme, one investigation covered 18 grievances.

Analysis of Grievances – Number per Report Issued (fig. 5)



Figures in Black: No. of Reports

Figures in Red: No. of Grievances per Report

Total No. of Reports: 139

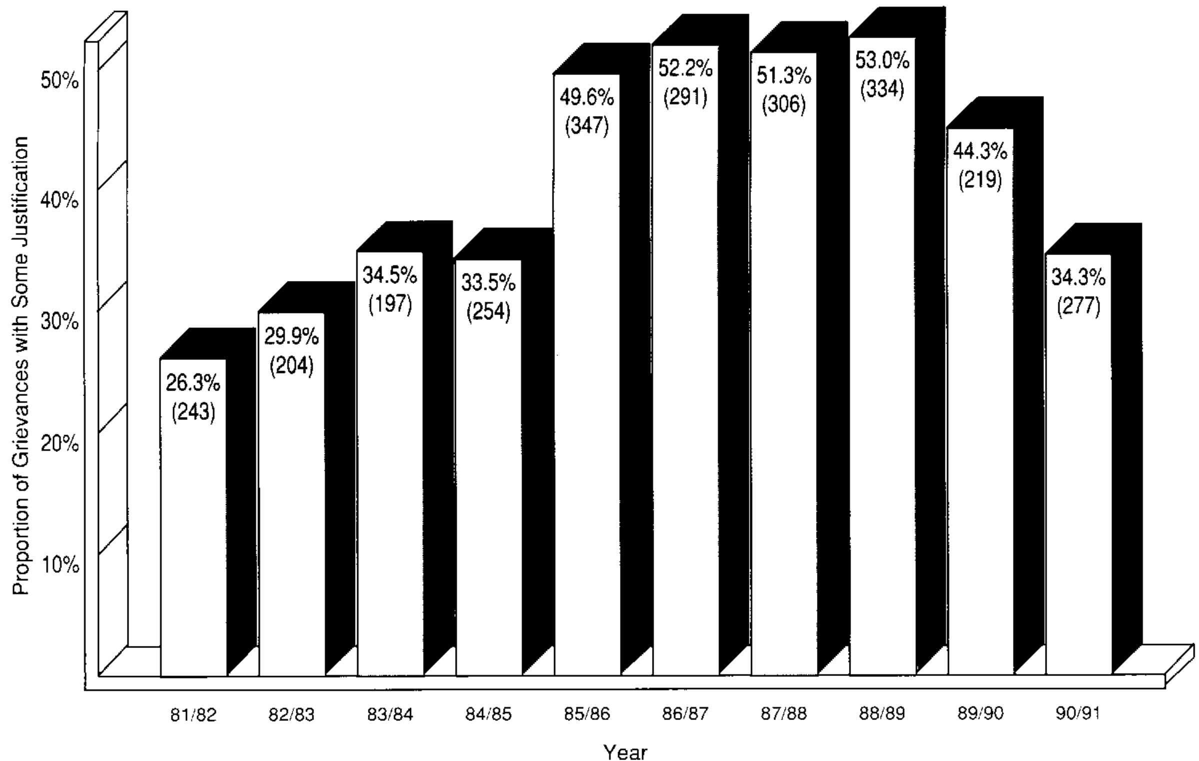
70. There is in many cases a correlation between the number of grievances per complaint and the time needed to investigate it. The slower that process, the less satisfactory it is for the complainant and the authority subject to investigation. I do not believe that it helps if, as a matter of course, I take up investigable grievances which are clearly peripheral to the substance of a complaint - particularly where, for example, an authority has acknowledged a fault, apologised for it and applied a suitable remedy. To investigate in those circumstances diverts attention away from the complainant's major concerns. While attentive to a complainant's feelings and prepared to receive his or her views, I am not generally disposed to encumber an investigation with otiose grievances if in my judgment that would end up with an outcome of little real value to the complainant - or others. Parliament has given me general discretion to decide whether or not to investigate any particular complaint and I exercise it, giving reasons.

71. I found some justification in 48.5% of the grievances I investigated during 1990/91, compared with 51.3% in 1989/90. Investigated grievances are analysed in outline in figure 6 below, and in more detail in Appendix B.

Grievances Received Compared with Grievances Upheld (fig. 6)

72. Investigated complaints against nurses and doctors increased by some 26% as compared with 1989/90 and were at the centre of 277 (56.9%) of the grievances upon which I reported (63.5% in 1989/90), but a reduced proportion (34.3%) was upheld. This compares with 44.3% the previous year - that year having seen a fall of nearly 9% on 1988/89 (53%). It is, I suppose, inescapable that nurses and doctors, who have most of the contact with the public, will attract the greatest proportion of all complaints made to me about hospitals - whether justified or not. However, the number of these complaints investigated over the past ten years and their outcome reveals an interesting pattern (figure 7).

Medical and Nursing Grievances and Proportion with Some Justification – 1981/82 to 1990/91 (fig. 7)



I can offer no confident explanation for the return to a lower proportion of justified grievances. Perhaps increased awareness of my work, the recommendations made by my predecessors and myself and the concerns of the Select Committee about attitudes and communications are leading to improvements.

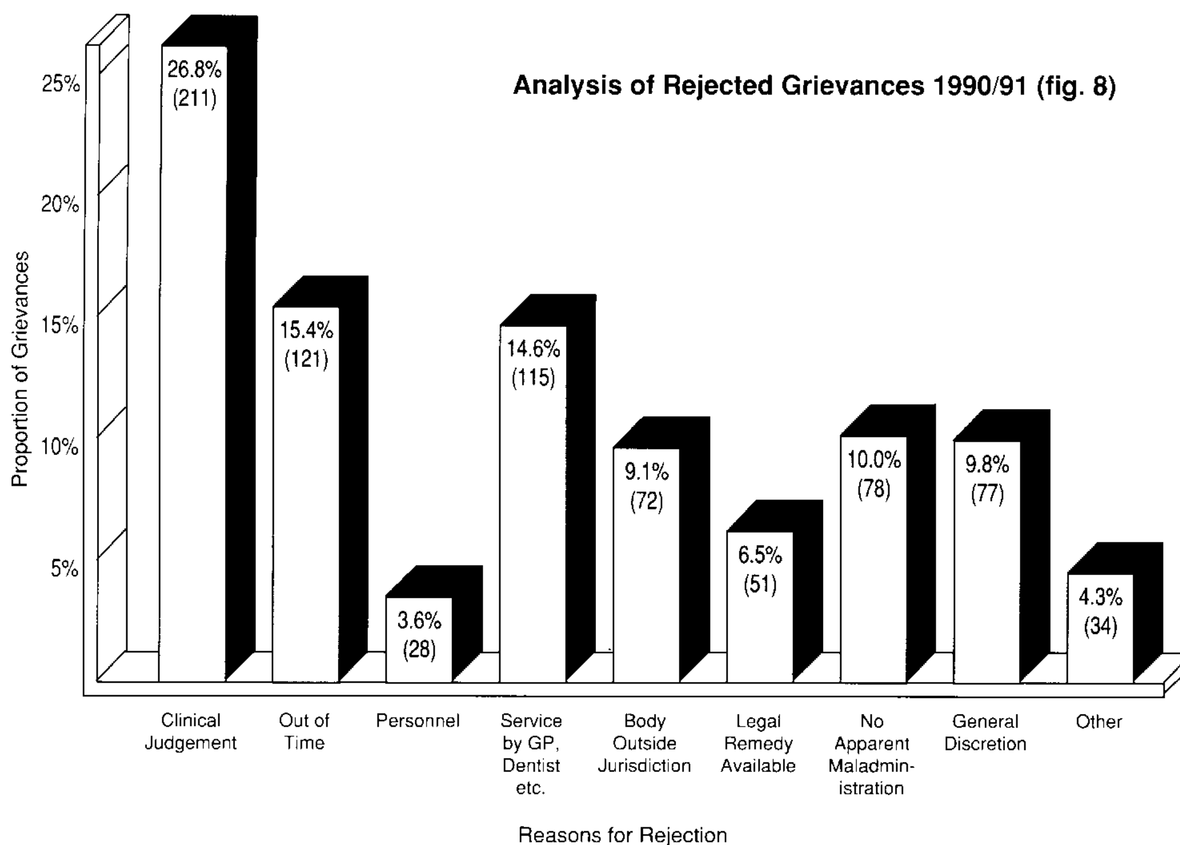
73. Grievances about administrative matters accounted for 16.0% of the total investigated, and 61.5% of these were found to have some justification; this was very similar to the equivalent proportions for 1989/90. Failures in service gave rise to the smallest proportion of grievances investigated (4.5%), of which less than half had some justification. Grievances about the handling of complaints increased to 22.6% of the total investigated, and 76.4% were found to have some justification (16.5% and 64.9% respectively in 1989/90). This last point is worrying, in view of the official guidance given to health authorities in 1988 on the Hospital Complaints Procedure Act 1985.

74. During the year I accepted 118 cases for investigation compared with 99 in 1989/90 and 101 the preceding year. The increase in the number of complaints reaching me during the year obviously had its effect, and a further increase in the number of cases taken on for investigation may emerge from the higher volume of cases referred back (see paragraph 77).

Cases rejected or discontinued

75. The 420 rejected, and 16 discontinued, cases (figure 2) represent 43.3% of all cases concluded during the year. This compared with 57.3% in 1989/90. While I attach no great significance to this year on year variation I believe the movement in the percentage is attributable, in part, to the increase in the total of complaints received and the fact that a higher than average proportion of them was referred back.

76. During the past year I rejected 787 individual grievances, an average of 1.87 per rejected case (this compares with 959 and 2.03 respectively in 1989/90). The main reasons for rejection are shown at figure 8 - a full analysis is provided at Appendix E.



Cases referred back

77. Experience has shown that just under half of all complaints to my Office have to be referred back to the complainants - usually because further information, or action, by them is needed before I can decide whether to conduct an investigation. Very often it is because a complaint has not first been put to the health authority - or other relevant body - concerned. During the last year the proportion of cases referred back increased to nearly 58.0%. That arose because many complainants wrote to me as a result of reading the booklet on the NHS Reforms. They did not appreciate that they should approach me only if, after receiving a written response from the relevant body, they remained dissatisfied. In many instances complainants sought my help before first taking up their concerns locally. In addition, a significant number of complaints related to matters which, due either to the passage of time or to their substance, appeared to be not for me to investigate, but insufficient information was provided to allow me to decide. The result was that many complaints were referred back and, as Appendix F shows, an unprecedented 43% (431) of cases were 'concluded' because after three months I had heard nothing further from the complainants. I can assume only that, on the basis of the guidance given by my Office, most of the complainants decided not to pursue their grievances with me - or were satisfied by the replies they received from the hospitals or other bodies to whom they then put their complaints.

Cases carried forward

78. The 248 cases carried forward (compared with 264 brought forward from 1989/90) were made up as follows: 84 under investigation; 129 referred back within the final three months of the year and on which no further action was taken before 31 March; 27 being actively considered for investigation, rejection or reference back and 8 awaiting attention.

W K REID
Health Service Commissioner

June 1991

England 90/91	England 89/90	Scotland 90/91	Scotland 89/90	Wales 90/91	Wales 89/90	Totals 90/91	Totals 89/90	
235	281	21	24	8	13	264	318	Brought forward from previous year
844	685	95	76	51	33	990	794	**Add** received in current year
1079	966	116	100	59	46	1254	1112	Total considered
221	235	15	21	12	8	248	264	**Deduct** carried forward to next year
858	731	101	79	47	38	1006	848	Concluded
363	421	52	41	21	24	436*	486	Complaints rejected or discontinued
367	230	41	32	23	11	431	273	Complaints 'referred back'
128	80	8	6	3	3	139	89	Results reports issued
858	731	101	79	47	38	1006	848	Totals
164	128	16	11	4	3	184	142	Written enquiries/advice sought

*This figure includes 16 discontinued cases of which 12 were discontinued at the request of the complainant before a decision was taken on whether or not to investigate.

Analysis of categories of investigated grievances, 1989/90 and 1990/91

Upheld-wholly or in part	Not upheld	Sub Total	Total 1990/91	1989/90	
					Nursing
30	85	115			failure in care
8	14	22			lack of or incorrect information
9	19	28			attitudes
1	3	4			maltreatment
48	121		169	153	**Total**
					Medical
17	24	41			lack of or incorrect information
10	18	28			attitudes
20	19	39			failure in non-clinical procedures
47	61		108	66	**Total**
					Administration
11	9	20			policy decisions (manner in which reached)
14	7	21			day-to-day (hospital in-patient)
12	8	20			day-to-day (hospital out-patient)
—	—	—			day-to-day (hospital casualty)
11	3	14			day-to-day (family practitioner services)
—	2	2			day-to-day (community health)
—	1	1			day-to-day (other)
48	30		78	54	**Total**
					Failure in service
5	6	11			ambulance
—	2	2			community
1	1	2			laboratory/technical/house-keeping
3	4	7			paramedical
9	13		22	15	**Totals**
84	26		110	57	**Handling by authority**
236	251		487	345	**Totals**

Numbers of grievances investigated and upheld, 1981/82 to 1990/91

Appendix C

Year	Number investigated: Total	Number investigated: No. of grievances per report issued	Number upheld: No	Number upheld: % of (ii)
(i)	(ii)	(iii)	(iv)	(v)
1981/82	407	4.03	152	37.35
1982/83	368	3.20	160	43.47
1983/84	350	2.94	167	47.71
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
Totals	4490	3.66	2336	52.03

Analysis of main categories of grievances investigated 1981/82 to 1990/91

Appendix D

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
1981/82	407	107	26%	136	33%	73	18%	26	6%	65	16%
1982/83	368	103	28%	101	27%	59	16%	36	10%	69	19%
1983/84	350	136	39%	61	17%	101	29%	15	4%	37	11%
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%
Totals	4490	1645	36%	1027	23%	847	19%	249	6%	722	16%

England 90/91	England 89/90	Scotland 90/91	Scotland 89/90	Wales 90/91	Wales 89/90	Totals 90/91	Totals 89/90	
61	88	8	9	3	2	72	99	Body complained of outside jurisdiction
90	83	19	6	6	8	115	97	Complaint against GP, dentist, pharmacist, optician
17	17	1	4	1	2	19	23	Service Committees and Tribunal Regulations
178	182	25	14	8	8	211	204	Clinical judgment
46	63	4	6	1	1	51	70	Legal remedy available
21	27	7	7	—	2	28	36	Personnel matter
106	145	8	14	7	5	121	164	Out of time
—	3	—	3	—	1	—	7	Right of appeal to tribunal
—	—	2	1	—	—	2	1	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
72	98	3	9	3	6	78	113	No prima facie failure/maladministration
8	7	—	—	1	1	9	8	Contractual/commercial transaction
66	119	9	4	2	1	77	124	General discretion
3	9	—	—	—	1	3	10	Complainant not aggrieved or acceptable as complainant
1	2	—	1	—	—	1	3	Complainant from local authority, other public body or nationalised industry
669	843	86	78	32	38	787	959	Totals

Category		Year: 1973-74 from 1.10.73	1974/75	1975/76	1976/77	1977/78	1978/79	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89	1989/90	1990/91	Totals
Complaints received	E	287	402	418	483	494	590	484	556	586	658	770	711	807	752	668	641	685	844	10,836
	S	53	40	43	56	49	70	47	49	62	107	76	67	85	87	87	75	76	95	1,224
	W	21	51	43	43	41	52	31	42	38	33	49	37	34	44	39	37	33	51	719
	Total	361	493	504	582	584	712	562	647	686	798	895	815	926	883	794	753	794	990	12,779
Cases concluded	E	187	405	422	457	421	594	482	579	603	657	761	686	761	715	719	580	731	858	10,618
	S	44	42	48	47	43	66	54	56	54	94	90	67	80	76	95	73	79	101	1,209
	W	11	59	35	43	35	52	34	41	42	35	38	45	32	40	44	35	38	47	706
	Total	242	506	505	547	499	712	570	676	699	786	889	798	873	831	858	688	848	1006	12,533
DISPOSAL: Rejected (inc. discontinued)	E	155	239	248	285	267	426	334	398	419	460	520	387	407	338	421	299	421	363	6,387
	S	39	23	34	27	23	47	33	35	38	76	50	38	43	40	60	38	41	52	737
	W	7	31	26	29	29	35	24	29	27	23	22	21	15	24	24	20	24	21	431
	Total	201	293	308	341	319	508	391	462	484	559	592	446	465	402	505	357	486	436	7,555
DISPOSAL: Referred back	E	14	64	60	69	59	67	58	83	95	96	145	195	238	262	187	158	230	367	2,447
	S	2	9	6	12	10	12	10	11	10	10	20	17	24	25	20	23	32	41	294
	W	2	12	3	4	1	9	5	7	9	6	13	15	11	11	13	11	11	23	166
	Total	18	85	69	85	70	88	73	101	114	112	178	227	273	298	220	192	273	431	2,907
DISPOSAL: Results Reports issued	E	18	102	114	103	95	101	90	98	89	101	96	104	116	115	111	123	80	128	1,784
	S	3	10	8	8	10	7	11	10	6	8	20	12	13	11	15	12	6	8	178
	W	2	16	6	10	5	8	5	5	6	6	3	9	6	5	7	4	3	3	109
	Total	23	128	128	121	110	116	106	113	101	115	119	125	135	131	133	139	89	139	2,071
Average % "Disposal" of cases concluded	Rej	83	58	61	62	64	71	68	68	69	71	67	56	53	48	59	52	57	43	60
	R/B	7	17	14	16	14	13	13	15	16	14	20	28	31	36	26	28	32	43	23
	Inv	10	25	25	22	22	16	19	17	15	15	13	16	15	16	16	20	11	14	17

Geographical distribution of complaints received for 1990/91

Appendix G

Region of origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s)† per complaint	
Northern	34	3.4	3,077	91	(75)
Yorkshire	57	5.8	3,605	63	(66)
Trent	47	4.7	4,646	99	(108)
East Anglia	36	3.6	2,014	56	(84)
London and Home Counties:					
North West Thames	82	8.3	3,488	43	(51)
North East Thames	104	10.6	3,772	36	(50)
South East Thames	75	7.5	3,636	48	(43)
South West Thames	73	7.4	2,960	41	(49)
Wessex	63	6.4	2,906	46	(94)
Oxford	34	3.4	2,502	74	(125)
South Western	50	5.1	3,206	64	(89)
West Midlands	64	6.5	5,198	81	(100)
Mersey	41	4.1	2,409	59	(63)
North Western	84	8.5	3,991	48	(71)
Total for England	884	85.3	47,410	56	(69)
Scotland	95	9.6	5,094	54	(67)
Wales	51	5.1	2,836	56	(86)
Overall Total	990	100.0	55,340	56	(70)

† The comparable figures for 1989/90 are shown in parenthesis

Geographical distribution of investigations completed in 1990/91

Appendix H

English Regions	Investigations Completed
Northern	5
Yorkshire	4
Trent	8
East Anglia	5
London and Home Counties:	
North West Thames	5
North East Thames	17
South East Thames	22
South West Thames	8
Wessex	6
Oxford	2
South Western	4
West Midlands	9
Mersey	5*
North Western	13*
Total England	112*
Add: Scotland	7
Add: Wales	3
Overall Total	122

Notes:

1. *One investigation involved two health authorities situated in different regions.
2. 22 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (12) and Cardiff (10).
3. 90 investigations were conducted by the London based Investigation Units: 52 (58%) related to the four Thames Regions, of which 26 (50%) involved health authorities within the Greater London area.

AS	Ambulance service
CAMO	Chief administrative medical officer
CCA	Clinical complaints adviser
CHC	Community health council
DA	Deputy administrator
DHA	District health authority
DOH	Department of Health
FHSA	Family health services authority
FPC	Family practitioner committee
GP	General practitioner (family doctor)
IPR	Independent professional review
NHS	National Health Service
RHA	Regional health authority
RMO	Regional medical officer

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