HEALTH SERVICE COMMISSIONER

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ANNUAL REPORT FOR 1991–92

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1 INTRODUCTION

A commitment to quality

1. Health authorities are required as a consequence of the Hospital Complaints Procedure Act 1985 to tell complainants that they have the right to come to me if the local investigation leaves them dissatisfied. That requirement can have a direct bearing on the number of complaints which I then receive. My postbag is a reflection either of a poor local service or of a mature and open approach to complaints. All complaints, whether or not they prove in the end to be justified, should prompt a review of procedures, communications or attitudes. What the service feels like to the consumer of care is a dimension of audit which all managers should acknowledge.

2. Initiatives on quality rely for their results on action not words. Improvements in service result from what staff do rather than from slogans or procedures, however well they have been drafted. Clinical audit is a process by which staff, within one discipline or with colleagues from other disciplines, review their own practice and performance, identify areas for improvement, make necessary changes and then monitor their effectiveness. Clinical judgment is not something which I can investigate, but translating it into effective care calls for well understood protocols and procedures, training, monitoring and clear communications. All these matters or the absence of them I find cause to criticise in my investigations. Incomplete or inaccurate records continue to be a source of concern to the Select Committee on the Parliamentary Commissioner for Administration, which also oversees my work as Health Service Commissioner. The volumes of selected, anonymised cases which I publish every six months, to many of which I refer in Chapters 2 (main topics) and 3 (special interest cases), show just how far my investigations reveal maladministration affecting patient care. That is why my senior staff and I have contributed to conferences and seminars in the past year covering topics such as records, audit, discharge policies and handling of complaints. Failures by health authorities to heed a lesson which has been promulgated in one of my published volumes—and very helpfully circulated by Health Departments in summary form to health authorities and boards—can justifiably be criticised.

Workload, targets and resources

3. It is very hard to forecast how many letters of complaint sent to me will lead to investigations in detail. Many letters are about matters which I have not been empowered to investigate. I have no control over the volume of demand, so estimating the resources my Office requires has to be a mixture of measurement and guesswork. Last year saw the highest number of complaints since the Office came into being in 1973. In my last report I referred to the first three year Management Plan for the Office. As an innovation this year Appendix A of my report gives actual and forecast figures for a five year period. I had expected that the Government's leaflet on the NHS Reforms (July 1990) might have led to a reduced number of complaints to me, but instead the year under review produced a total of 1176, a further increase of nearly 19%. The similar experience of other ombudsmen suggests that the increase owes much to growing public awareness of how to complain and to whom.

4. The National Health Service and other public services are expected to improve the quality standards of what they provide. I have set performance targets for my staff with the aim of giving complainants a more effective

service. Appendix A incorporates the targets for 1991-92 as forecast in mid-1991. Instead of the higher intake of new cases jeopardising the achievement of those targets, the reverse has happened. Thanks to the enthusiasm and commitment of my staff, the average time taken from receipt of an investigable complaint to issue of the final report has dropped from an average of 58 weeks per case in 1990-91 to an average of 45.1 weeks in 1991-92. I hope we shall improve on that. I record here my appreciation to health authorities and boards for their co-operation in providing responses to me in good time, as that makes possible an earlier report to the person who has complained. The initial screening of new cases has also speeded up, three-quarters now receiving replies within 18 days rather than the 21 days of last year. While the thoroughness of my investigations is not compromised, a long report can be indigestible and difficult for a complainant to follow. I can now claim that the average length of a report has fallen in the last year from 19 to 16.6 pages (in 1990 it was 33 pages), and what I send to the complainant is now enclosed in a simple cover to preserve the pages from handling and re-reading.

5. During the year under review 124 investigations were completed—again an increase over 1990-91—while I accepted 150 new cases for investigation, a figure which is significantly above the annual average. The Office recruited an additional investigating officer and I expect to take on an additional investigating officer and screening officer during 1992-93. The average direct salary cost for each investigation completed in 1991-92 (that is, the total of reports issued and cases which I discontinued—see figure 3 in chapter 5) was £5,102.29 (£4,320.72 in 1990-91). The equivalent cost for screening new complaints was £76.55 (£81.76 the previous year). Though free to the complainant, a thoroughly researched investigation cannot be done on the cheap.

Themes and Issues from complaints

6. While some topics—such as record-keeping, complaints handling and observation of patients—feature regularly in these annual reports, others are less predictable. 1991-92 was no exception, and the first group of cases in Chapter 2 is a selection of the complaints I have received about maternity care. Expectant mothers are increasingly sensitive to their part in the baby's method of being born—and their own part in the delivery itself—as well as to the contribution made by midwives, doctors and other professional staff. The next group of cases provides examples of insensitivity to patients' needs, and I have chosen four cases to illustrate this failure of service. One was a particularly deplorable case in which—as in two of the other cases—the records were deficient on key aspects of care. In another investigated case which I have not published, a nurse made an entry in the records which was not truthful for fear that what had actually occurred would be discovered. It was however discovered. Even where actual care has been effective, poor communications and attitudes by staff can mar the patient's experience and leave behind a sense of dissatisfaction: examples were lack of awareness of a mother's need for information about the aftercare of her teenage son, inadequate preparation for a meeting with bereaved relatives, and over-optimistic advice from a nurse. Each example in different ways added to the complainant's anxieties.

7. Though I cannot look at matters which in my opinion are concerned solely with the exercise of clinical judgment, I take my jurisdiction as far as I legitimately can to establish whether there are related factors—such as

procedures or communications—which might have vitiated the quality of clinical treatment. Inadequate planning and preparation for a surgical procedure, lack of advice about what to do when a catheter becomes blocked and insufficient rigour in assessing bowel preparation for surgery are examples of this cited in Chapter 2. In Chapter 3 (special interest cases) I refer to the distressing consequences of a failure to follow procedures for dealing with cases of suspected child sexual abuse—a case which, in anonymised form, I drew to the attention of the Minister for Health who was sufficiently concerned to ask the NHS Management Executive to take up the issues revealed by my investigation. Lapses in ambulance services were a subject of concern to the Select Committee last year, and I allude to three further cases in this report.

8. Delay in replying to a complaint is not only discourteous, but can have a direct bearing on the chances that the eventual reply will satisfy the complainant. The five handling cases in Chapter 2 illustrate not only that but also other shortcomings such as lax monitoring of progress and delegation of responsibility to inexperienced officers. The Patient's Charter for England gives the right to a reply from the chief executive of the NHS Management Executive—a proper recognition of public accountability for the services provided. Sometimes, when it seems to me that the final reply from local management has been sent from someone apparently with insufficient seniority, I will invite the complainant to go back to the general manager or chief executive before deciding whether I need to investigate myself. Occasionally, after I have started my investigation, the authority will see the error of its ways and spontaneously offer restitution—such as reimbursement for missing property—to the complainant. That happened in three of the handling cases. When such action is taken, because there may be underlying maladministration, I do not necessarily discontinue my investigation. I have again this year included, in Chapter 2, a case involving the clinical complaints procedure. As the Chief Medical Officer for England is currently reviewing that procedure, I provided him with a synopsis of issues arising from problems with the procedure that I have encountered in the last three years. I was interested to observe that, in Wales, the Medical Officer for Complaints adopted a variant on the procedure by asking two general practitioners to carry out an independent professional review of a complaint about a clinical assistant. I am asked from time to time if I can produce a good practice guide. My answer is that that is a task for the Health Departments and the NHS, not for me, though I am ready to provide illustrations of where pitfalls and failures can occur.

Jurisdiction

9. In the miscellany of special interest cases in Chapter 3 I refer to an example of poor handling of a complaint by a family health services authority. The degree of impartiality of family practitioner complaints procedures—I do not have the power to investigate where the formal, service committee procedure is invoked and this puzzles and annoys complainants—has been a matter of debate by the Select Committee and the Council on Tribunals in the past year. I take my jurisdiction as far as I can in looking into the operation of informal procedures including lay conciliation, but I have seen *prima facie* examples of maladministration in operating the formal procedures which I cannot investigate because of the limitation to my powers.

10. My predecessors and I have over the years received, and in some cases investigated, complaints from family practitioners themselves about the family health services authorities (formerly family practitioner committees) in England and Wales—or, in Scotland, health boards—with which they are in contract. A Court of Appeal judgment in *Roy v. Kensington and Chelsea and Westminster Family Practitioner Committee* (1990) 1 Med LR328 held that the relationship between the two parties was a contractual one. Because I am unable to look into 'contractual or other commercial transactions' I interpreted that judgment as taking all such cases outside my jurisdiction. The judgment was taken by the authority concerned to the House of Lords, which seemed to throw doubt upon, but did not overrule, the Court of Appeal decision. As matters now stand I shall generally regard as being outside my jurisdiction complaints from family practitioners about their contractual relationship with the family health services authority concerned. In common equity, as Health Service Commissioner for Scotland, I shall follow the same line in relation to Scottish complaints of that nature.

11. Because I was concerned that separation of accountability for purchasing and providing health care under the NHS should not blur accountability for complaints, I took the matter up with the Health Departments. There seemed to be the possibility also that, where a service was provided by a non-NHS institution, the patient might be denied access to proper complaints procedures. I have been assured that, though some of the details are still to be worked out, wherever users obtain their NHS care they will continue ultimately to have access to me if they are dissatisfied. It is vital that members of the public, faced with an array of new authorities and organisational arrangements, should know to whom they should address any complaint. I should add that a member of staff can bring a complaint to me if there is no-one else—such as a relative—more appropriate to represent an incapacitated patient's interests. I investigated one such case in 1991-92, and that led me to ask the DHA concerned to ensure that local procedures protected a member of staff, concerned about treatment of a patient, against isolation or victimisation.

To conclude

12. I hope that the cases included anonymously in my six-monthly volumes, those to which I have referred in Chapters 2 and 3 and the comprehensive list of remedies in Chapter 4 will illustrate the variety of cases I can investigate, though there are limits to my remit. Paragraph 77 in Chapter 5 (Statistics) also describes the various categories of staff, and types of complaint, which have featured in cases completed during the year. The Patient's Charters for England, Scotland and Wales all remind the public of my existence, and that I welcome. It sometimes happens that a published anonymised case results in media attention. That is all to the good in general terms, for it serves to remind the public and the NHS of what I can do to help improve standards. Just occasionally, though, there are headlines such as 'Ombudsman says NHS staff are rude' and 'Senior consultants are not caring'. Let me make my position quite clear. I shall not hesitate to criticise where I find fault, but I do not uphold every complaint and I have no doubt that poor attitudes, inadequate care or sloppy administration are very much the exception rather than the rule. Finally, I take this opportunity of expressing my personal thanks to the Select Committee, and particularly to those who are no longer Members of the House of Commons. Sir Antony Buck was chairman of the Committee from 1977 until his retirement from

the House of Commons in 1992. He has been a source of much support and encouragement to me and my predecessors. With the Members' backing and the help of my staff—and that of health authorities and boards and of community health councils and other agencies—it has been a busy but productive year.

W K REID
Health Service Commissioner June 1992

(i) Maternity services

13. The birth of a baby in hospital is normally a matter of routine for the staff. Their efforts should be directed towards a safe delivery and making the birth a happy experience for the parents. Things do not always go to plan, and that is when professional skills and procedures should come into play so as to give confidence and ease distress. Each of the following three investigations illustrates what can happen if established safeguards are not observed. This recital is intended to encourage professional staff to do better than their colleagues whose actions are described here.

(a) W.545/89-90 on pages 11—20 of HC 74

14. The first describes how midwifery staff did not monitor the progress during labour of a woman who had previously had a baby by caesarean section and was admitted, late one evening, for a trial of labour. The woman complained to me that the progress of her labour had not been checked until she demanded to be examined in the early hours of the following morning, by which time she was in established labour; and that the midwifery sister had not responded to an earlier message she had sent through a student midwife asking to be examined. As clinical judgment was involved, I could not question the admitting doctor's assessment that the woman should be induced on the ante-natal ward rather than in the central delivery suite during the day, which would have been the usual practice. I considered that the doctor's decision and the midwives' acceptance of it placed on them a special responsibility to ensure that the woman's progress in labour was closely monitored. In fact, the woman's clinical status was not discovered by the midwives for some five hours, and I was told by the consultant obstetrician that the sister should have responded immediately on being told by the student that the woman was in pain. The senior midwifery manager agreed.

15. I found that, when the sister did respond, that was as a result of the woman's later plea rather than the student's message. The sister had been busy that night and had had no intention of appearing unhelpful, but I did not think that she had been sensitive enough to the woman's plight. Documentary evidence of attention given to the woman's needs was scant, and I called on the district health authority (DHA) concerned to remind their midwives of the importance of maintaining regular records of a patient's progress, particularly when an element of risk was involved.

(b) W.104/91-92 and W.147/91-92 on pages 90-96 of HC 32

16. In the second case I upheld a complaint of unexplained delay by a community midwife who went to the patient's home and then advised her to go to the hospital, where she would meet her. The midwife made a detour in her journey and arrived 30 minutes after her patient. She must have known that there would be some delay before she could rejoin her, yet she failed not only to explain that but also to advise the hospital of the patient's impending arrival—and that she too would be delayed. The baby died soon after birth. The woman complained that medical assistance had not been summoned when signs of fetal distress appeared during labour. My investigation revealed that the midwife, who was employed by a different DHA from the one which administered the hospital, was unaware of hospital guidelines. Those included an instruction that a doctor should be

informed if a patient exhibited particular symptoms such as signs of fetal distress. Though the midwife's assessment of the signs and symptoms displayed during her patient's labour was a matter for her clinical judgment, I considered—and the midwife herself acknowledged—that, had she known the hospital's guidelines, she would have summoned medical assistance irrespective of her own assessment. The DHA responsible for the hospital agreed to consider action to ensure that midwives coming from neighbouring DHAs were aware of what was expected of them.

(c) SW.70/90-91 on pages 102-108 of HC 74

17. The third case demonstrated the danger of not having adequate contingency plans to deal with an abnormally high workload. A woman had to wait for six hours after the birth of her baby before being taken to the operating theatre for the removal of a retained placenta. That was because the anaesthetist and the obstetric registrar, who were to attend to her, were required to deal with emergency cases with a higher clinical priority. For much of the time the woman was left all alone unsupervised. That would have been worrying enough, but she was also out of reach of the alarm buzzer, and that seemed to me potentially dangerous for a woman in her condition. The staff themselves accepted that a combination of the number of staff on duty and the more urgent needs of other patients had resulted in the woman not receiving the degree of care and attention her condition warranted. The health board (HB) concerned agreed to review as a matter of urgency their contingency arrangements for dealing with such situations.

(ii) Observation and care

18. A recurring theme is the failure to keep a proper check on a patient's progress. It is always difficult to assess how much attention doctors and nurses can be expected to give to any one patient—and some patients, I accept, can be very demanding. Staff have to contend with competing claims on their time, calling for difficult clinical decisions, but even so there have been cases this year where the attention given fell short by any reasonable standards of what it should have been. The patients suffered lack of care as a consequence.

(d) W.21/90-91 on pages 31—38 of HC 74

19. A man complained that his wife had been left unattended in an accident and emergency (A and E) department for the two hours preceding her death. The woman was seen first by a casualty officer, who referred her to a senior house officer (SHO). The SHO, who had been busy with other patients, went to examine the woman not far short of two hours after the referral by the casualty officer and found that she had died, he thought, some twenty minutes earlier. I was unable to establish exactly what had happened during the intervening period, but I concluded that nurses had thought, mistakenly, that the man and his son were with the woman for most of the time and had expected them to draw their attention to any change in her condition. The relatives, on the other hand, had understood that they were to wait outside the woman's cubicle and had been to see her only infrequently. I did not find that the woman had gone completely without attention while waiting to be seen by the SHO, but she had been dead for some twenty minutes before any member of staff realised that. I also found it unsatisfactory that the woman's family had not been told at the outset that they could stay with her. The DHA agreed to ensure that the

relatives of A and E patients were in future told that they could remain with the patient if they so wished.

(e) W.232/90-91 on pages 41-57 of HC 32

20. In the next very distressing case the problems arose partly from the way in which a hospital was managed. Financial limits were applied in such a way that a surgical ward was closed at weekends, originally as a temporary measure but then for more than two years until the hospital closed. I found that management had not considered how the continuing care of long-stay or terminally ill patients would be affected. Staff tried to make their concerns felt, but their representations on behalf of patients passed unheeded.

21. A woman with cancer was in the ward for ten weeks and underwent three abdominal operations. She was moved each Friday to another ward, returning on the Monday. That was a manifest and deplorable lack of regard by management for the welfare of an inpatient. As if that was not enough, the woman suffered from claustrophobia but nurses who knew about it made no record of it nor did they pass on the information. She was often in a small side room at weekends, and a special mattress which was necessary to help prevent pressure sores was not always immediately available. I criticised the absence in care plans of reference to meeting the woman's personal hygiene needs—though the oral evidence persuaded me that she had been given help with washing. Aspects of her illness had made her susceptible to pressure sores and, while she might not have required as much regular re-positioning or as many drainage bag changes as her husband thought, I was not convinced that her condition had been as closely monitored as it should have been. The distress of the woman and her husband could have been eased by earlier transfer to a hospice—she died only three days after being moved to one—than occurred. A co-ordinated effort could have been made much earlier to discuss that possibility with them. The delay was in part due to the nurses' false assumption that the hospice admitted patients only within two or three weeks of death. I criticised the fact that, even when a hospice bed became available, the ward sister was reluctant to make immediate arrangements for the woman's transfer.

(f) W.377/91-92 on pages 117-123 of HC 32

22. In another case a young man—who, I discovered during my investigation, had at the time been detained under Section 2 of the Mental Health Act 1983—suffered burns on his back from an unprotected hot pipe in a lavatory cubicle in a psychiatric ward. There was central guidance on heated surfaces in health care buildings and it drew attention to the fact that the risk of injury from heated surfaces was greater in psychiatric wards and with pipes at a low level; but the staff of the ward did not consider the pipe in question to be a risk. It is not in my view acceptable to wait until an incident occurs before giving attention to likely hazards. Although there had been no known similar incidents either before or after the event, it concerned me that any patient should come to harm in such a way. Was corrective action taken then? No—the incident was not apparently considered serious enough to merit attention by works or safety staff or senior management. The level of supervision required by the patient at the time of the incident was decided by the nurse involved solely in the exercise of her clinical assessment of his condition, but I criticised the fact that changes in the levels of observation ordered for the young man were not recorded in his nursing notes. The DHA agreed to reassess the risk of such

an accident and consider what steps needed to be taken to avoid it, and to give priority to the protection of hot pipes in the psychiatric unit.

(g) SW.87/90-91 on pages 126-130 of HC 32

23. Pressure sores are very distressing not only to the patient but to any informal carers—such as a relative—who have to help tend them. A man was discharged from hospital with pressure sores which then required many months of treatment. His wife complained both that the sores had developed in hospital because of lack of preventive care and that she had not been told about them. A feature of this case which disturbed me was that from his condition and past medical history the man was clearly at risk of sores, but there was nothing relevant in his nursing records before they developed. I found it very worrying that for a patient so evidently at risk there was no evidence of a systematic approach in that respect, the nurses simply relying on word of mouth. They maintained in evidence that the man would have received routine pressure area care. I would have been more prepared to accept that, had it not been for their poor recollection of him, his condition when discharged and the lack of any positive evidence, written or oral, of what care was actually given. It did not seem to have occurred to anyone to take the initiative in speaking to the man's wife about the sores either when they first developed or at the time of his discharge. The HB agreed to review instructions to nurses about giving information to carers before discharging a patient from hospital, and have taken steps to improve nursing records with the introduction of patient care plans.

(iii) Communications and attitudes

24. Failures in communication amongst staff, or between staff and patients or relatives, very often feature in complaints which I investigate. It can be difficult to find out exactly what was said, sometimes long after the events in question. Staff too often assume that what is clear to them is equally clear to their patients or to relatives, but that is not always the case.

(h) W.231/90-91 on pages 38—48 of HC 74

25. An eleven year old boy was discharged from hospital three days after having his appendix removed. His mother was a single parent. Nurses had not asked her how she was taking her son home or given her an adequate explanation of what post-operative care she should give him. The boy should have had an outpatient appointment six weeks later but did not receive one. The nurses said that they usually left it to the patient or relatives to raise with them the matter of getting transport home. As the woman had asked for help with travel costs, that at least should have alerted them to her problems. I noted that a more systematic approach to discharge arrangements was set out in procedures issued just over a year after the boy's discharge and I criticised their previous absence. It seemed to me that the nurses should have been aware of the need to brief relatives fully about aftercare arrangements. I regarded the DHA's proposal to publish a leaflet to make matters clearer for parents as a positive measure, and I recommended its publication without delay. The DHA accepted that the arrangements for the child's follow-up care had been badly handled, and I looked to them to monitor the performance of a new computerised system which should minimise the risk of confusion, such as the woman had experienced, in allocating outpatient appointments.

(i) W.459/90-91 on pages 66—73 of HC 74

26. It is understandable that parents who have lost a child shortly after birth should want to know why, in case the same thing might happen to a

subsequent baby. Six weeks after her discharge from hospital a mother bereaved in such circumstances had an appointment to meet the consultant obstetrician concerned, but because of her anxiety the appointment was brought forward one week. When she and her husband got there, they learned that the consultant did not have with him the reports he needed. He told them that he had not received a copy of the coroner's post mortem report; that he knew only that their baby had died from asphyxia; and that he would see them again when he had the report.

27. The purpose of the meeting and the emotions involved should have been clear beforehand. The post mortem report was crucial to the discussion, and the fact that it was not there added considerably to the parents' distress. Neither the consultant nor any other member of the hospital staff had thought to check that the report had been received. Because the baby had been transferred to another hospital, procedures called for the consultant to request the post mortem report, in writing, from the coroner. He had not done so and, on his own admission, only when he opened the medical records at the time of the appointment did he discover that the report was not there. I was appalled at the apparent lack of preparation for such a sensitive and important meeting.

(j) WW.47/90-91 on pages 142-149 of HC 32

28. Poor communications are bad. The third case illustrates the danger of making up information and the problems which can arise if a nurse, with the best of intentions, gives information beyond her knowledge or competence. Relatives anxious for encouraging news can place undue reliance on or misunderstand what they are told. A man's son complained that the family had been given incorrect advice by a nurse about how long his father's operation was likely to last. The family telephoned the hospital repeatedly over a period of a few hours on the day of the operation and kept being told that he was still in the operating theatre—yet the nurse had said that the operation would take about an hour. The consultant told me that he would have given a very qualified reply and that the nurse should have referred the family to a doctor. The nurse acknowledged that she had been remiss to express such an optimistic opinion. The DHA agreed to remind nurses that such enquiries should be referred to a doctor to deal with.

29. The son also complained that the same nurse had been insensitive in making a remark to the effect that his father's condition was deteriorating because he had given up the will to live. The nurse, who had spoken to the family in Welsh, was adamant that she would not have done so but agreed that she might have used an expression which signified that the father was feeling daunted. The enquiries I made suggested that either of the expressions, in Welsh, could be taken to convey a sense that the father was unable to cope with the situation. I had no doubt that the nurse meant no unkindness and was doing what she could to identify with the family's concerns. In view of the linguistic niceties of expression and the absence of any evidence that the nurse was lacking in sympathy, I did not find this further complaint made out.

(iv) Operation of clinical procedures

30. I cannot investigate cases of clinical judgment, but some complaints reaching me suggest that staff may not have followed proper procedures.

What might at first sight seem to be unimportant deviations can have serious consequences for patients.

(k) W.653/90-91 on pages 67-75 of HC 32

31. A severely disabled young man was admitted to a hospital for the removal of a surgical plate from his left ankle and a special nail from his left hip. Although the man's consultant knew that removal of the nail would need special equipment which was not held by the hospital, he did not ensure that theatre staff were told beforehand. The registrar carrying out the operation had doubts before going ahead about whether the equipment needed was available but did not follow them up. As a result the operation had to be confined to removal of the plate.

32. The man's mother complained that, in going ahead with the operation in those circumstances, the consent she had given on her son's behalf had not been complied with. Guidance issued by the Department of Health (DH) in 1990 stated that the power of a parent to give a valid consent did not extend to a young person who, as in this case, had reached the age of 18, regardless of the young person's mental capacity; but that it was nonetheless good practice to consult relatives and others concerned. By not following up his doubts, the registrar lost the opportunity of discussing with the man's mother how he should proceed. I could not establish whether the registrar had spoken to the mother after the operation, but I found that a SHO had told her, just as she was about to leave the hospital, that the special equipment needed for the removal of the nail had not been available. I concluded that the woman had not been given the full explanation to which she was entitled. The DHA agreed to lay down procedures whereby theatre staff would in future be alerted to the need to obtain any special equipment; and to remind medical staff that they should keep anxious relatives informed in cases such as this and record any such discussion in the clinical records.

(l) W.790/90-91 on pages 75-80 of HC 32

33. A man had a urological operation in hospital. A couple of weeks after returning home his catheter became blocked and he was referred by his general practitioner (GP) to the A and E department at an associated hospital. He waited there for some 65 minutes, and a doctor then told him that he would have to be transferred to a ward so that the catheter could be removed by the urology staff. Unbeknown to the GP, the hospital's policy in such cases was for blocked catheters to be dealt with by the urologists, and it was open to the GP to contact them direct. When the man had originally been discharged home after the operation, he apparently received no advice about what he should do if the catheter became blocked. The evidence did not suggest any delay in transferring the man to the ward or in removing his catheter once he got there, but he suffered considerable discomfort. Had the GP been made aware of the hospital's policy, the patient's needs might have been attended to sooner. As a result of the steps taken by the DHA in the light of this case, GPs and their patients should in future know what they should do and how to deal with problems of this kind.

(j) WW.47/90-91 on pages 142-149 of HC 32

34. The case to which I referred in paragraph 28 threw up other lessons. I found entirely justified the son's complaint that on admission there had been a delay of eight hours before his father was allocated a suitable bed. The patient had been admitted with cancer of the rectum and was understandably anxious. I regarded it as quite wrong for him to have had to

spend so long in a bed within the day patient area of the ward which was normally used for those needing minimal nursing attention. That said, I did not find that the nurses had neglected the man's needs while he was waiting for a bed in the main ward. The DHA have now withdrawn the bed from use by inpatients. I was concerned, too, about inadequate assessment of the results of bowel preparations administered to the patient on each of the two days before his operation. Bowel preparation was particularly important for the operation he was to undergo, so for the consultant to proceed on the strength of a remark made by the patient to a nurse the day before the operation—to the effect that the laxative had produced good results—seemed to me less than satisfactory. The complaint led to a review by the DHA of guidance to nurses on monitoring and recording a patient's response to bowel preparation.

(v) Ambulance services

35. My predecessors and I have not often found it necessary to highlight ambulance service (AS) cases, but I mentioned three last year. There have been other serious cases this year. I do not suggest that this reflects any general decline in standards, but it is worrying—particularly because all the cases to which I refer below involved the same regional health authority (RHA), which administer the AS concerned, and related to emergency rather than booked journeys.

(m) W.637/89-90, W.359/90-91 & W.360/90-91 on pages 13-26 of HC 32

36. The first case related to the provision of a service during an industrial dispute to a pregnant woman who was haemorrhaging, and whose baby was later found to have died. The service was being provided by an outside crew. The woman, booked to have her baby in one hospital, complained that the crew had taken her to the nearest A and E department in another hospital which had no maternity facilities. The crew also seemed ill-equipped and unsure as to what to do.

37. I found that there had been significant differences between the working arrangements during the dispute, and normal ones. When the woman's partner rang, a midwife—unaware of the extent of those differences—followed the usual practice in advising him to request an emergency ambulance. I could think of no good reason why the AS should have not circulated to user health authorities details of the arrangements operating during the dispute. The decision to take the woman to the A and E department was at odds with the AS's procedures and resulted initially from an error of judgment by an AS controller, though I had no doubt that the abnormal situation during the dispute had increased the risk of such a mistake. One of the crew attending the woman's home questioned the destination, but that opportunity of correcting the error was missed. The woman's discomfort in having to spend the journey sitting in a folding carrying-chair can readily be imagined. That departure from established AS procedures might have been avoided had the crew been better briefed. The AS agreed to review their contingency plans and procedures for providing emergency services during disputes.

(n) W.508/90-91 on pages 73-82 of HC 32

38. Another case was about a delay by an ambulance crew in removing a man suffering from diabetes from his home to hospital. The ambulance attendant gave the man glucose tablets but did not want to take him to hospital immediately. The man's partner told me that, even though he

complained of chest pain, the crew still declined to take him to hospital. The man then stopped breathing and the driver went to collect a carrying-chair from the ambulance. Attempts at resuscitation both in the ambulance and at a local hospital were unsuccessful. The partner complained about the crew's refusal to take the man to hospital; that finger prick tests to determine the blood sugar level had not been undertaken; and that transfer to the ambulance had been delayed as the crew had not brought carrying equipment into the house with them.

39. My enquiries established that the crew spent 29 minutes in the house, as their intention was to stabilise the man's condition before conveying him to hospital. According to senior officers they should have spent no more than 15 minutes at the house. Although I did not doubt that the crew were well-intentioned, I therefore upheld the complaint. The crew said that they had undertaken a finger prick test, but without success. I did not find the crew's evidence sufficiently convincing to put that beyond question. I learned that it was protocol not to take carrying equipment into a ground floor, where access was not restricted, until the patient's condition had been assessed and the most appropriate form of conveyance decided upon. I concluded that the crew should have taken in carrying equipment earlier; and that they had apparently used equipment which was inappropriate. The RHA agreed to remind staff about guidance on the use of carrying equipment, and about procedures to be followed with regard to finger prick tests.

(o) W.590/90-91 on pages 82—89 of HC 74

40. Delays in getting a response to a '999' call can be acutely worrying, and a woman complained that there had been unacceptable delay by ambulance control in responding to two such calls after her mother collapsed at home. She abandoned her first call, held in a queue on a computer, in order to help her mother who was in distress. She then placed a second call which was also held on the queuing system. By now getting desperate, she asked a passing motorist to take her mother to hospital. She considered the computerised system deficient because it was unable to differentiate between 'life and death' calls and those which were less urgent; nor was there any way of indicating how long a caller would have to wait for a reply. It was the woman's belief that there were discrepancies in the AS's records, which showed that an ambulance had arrived at her home quite soon after her second call.

41. I discovered that it had taken ambulance control eight minutes to answer the woman's call. The RHA acknowledged that to be unacceptable—I was told that their target for '999' response times was 30 seconds. Technical difficulties stood in the way of devising an automated system which could distinguish between one emergency call and another, and which could predict how long the caller would have to wait. Though the delay was intolerable, I did not regard the system itself, and the way it was operated, as being the cause. As a result of my officer's investigations, I did not uphold the complaint about the alleged discrepancies in the records.

(vi) Handling of complaints

42. The way in which an authority handles a complaint is of vital importance. Poor handling is at the very least irritating. At worst it can destroy the credibility of a reply with the result that the complainant is not

prepared to accept anything that is said. When handling of a complaint by an authority appears on preliminary scrutiny to have been particularly bad, I sometimes agree to investigate cases involving that aspect alone. In view of the detailed guidance that should be available to all staff handling complaints, it is highly unsatisfactory to have to report on a number of cases where things went badly wrong. I very much hope that the emphasis given in The Patient's Charter to this important matter will produce improvements much needed in certain authorities.

(p) W.677/89-90 on pages 20—31 of HC 74

43. Rarely have I encountered such a catalogue of ineptitude and lack of personal accountability in dealing with a complaint as in this case. A man complained to a DHA about the treatment and care given to his late father at an A and E department, and about the attitude of a doctor. The DHA acknowledged the complaint on receipt and set the necessary enquiries in train at the hospital. Not until the local community health council chased things up some two months later did the administrative officer concerned tell the complainant that he should get a definitive response within a month. The officer also told the DHA that the hospital would deal with the complaint and provide the final response. It took them a further two months to do so and then, unforgivably, they addressed their letter to the father who had died. Much of what went wrong could have been avoided with proper monitoring and with less ready acceptance that others would attend to the complaint. There was confusion over where responsibility lay for ensuring progress, and some of the staff involved had no experience in complaints work. The hospital is now run by a National Health Service (NHS) Trust. They undertook to ensure that staff dealing with complaints fully understood what the complaints procedure required of them and that those newly assigned to this area of work were properly trained.

(h) W.231/90-91 on pages 38—48 of HC 74

44. I referred in paragraph 25 to deficiencies in the discharge arrangements for a young boy. His mother's dissatisfaction did not stop there. She had originally complained to the DHA through her Member of Parliament, but it took 17 months for the DHA to send a reply to the Member. Even then they did not, in her view, deal adequately with her complaints. I found that the necessary enquiries had been put in hand on receipt of the Member's letter and a draft reply prepared within two months. The matter then went to ground, for the draft reply from the hospital never reached the DHA. That was not spotted until the Member wrote in again some 14 months later. Prudence would suggest that the draft should have been checked and brought up to date. That did not happen, and the reply was sent virtually in the terms of the original draft—even to the extent of failing to apologise for not having replied earlier!

45. The absence of a system at the DHA's headquarters for recording and monitoring letters such as that from the Member lay behind the inordinately long delay in replying. I did observe that a timely reminder from either the Member or the woman might have produced an earlier response. The unit general manager accepted that the letter eventually sent had not dealt adequately with the woman's concerns. I agreed. I also criticised the discourtesy of sending a reply without even acknowledging the lapse of time since the original complaint. As a result of my intervention the DHA offered the complainant an opportunity to discuss her complaints afresh with a representative of the hospital.

(q) W.562/90-91 on pages 58-67 of HC 32

46. I have selected one case resulting in criticism of the handling of a complaint under the clinical complaints procedure. A man whose mother had died of a heart attack while in hospital complained to the regional medical officer (RMO) about the consultant's diagnosis and treatment of his mother and the prescribing of a particular drug to control her diabetes. The son considered that the RMO had acted unreasonably in refusing an independent professional review (IPR) without dealing with his own reasoned contention that the administration of the drug had been medically inappropriate and had led to his mother's decline. The evidence led me to conclude that the RMO had not followed correct procedures in reaching his decision about whether the case was, or was not, one of substance and appropriate therefore for an IPR. The RMO had apparently neither seen the woman's medical records nor received an oral report from the consultant. To have gone ahead without information from the consultant involved was contrary to the provisions of the second stage of the clinical complaints procedure. The RMO said that he had refrained from including clinical information in his letter to the son because the son had earlier met the consultant—who, he had hoped, would answer the son's questions about the administration of the drug. I accepted that the clinical complaints procedure did not require the RMO to explain his reasons, but the son had presented a detailed and well argued case and was, in my view, entitled to a reasoned explanation in return. The RHA agreed to my recommendation that the RMO should either explain his decision or address afresh the matter of the prescribing of the drug.

(r) W.67/91-92 on pages 80-90 of HC 32

47. My predecessor and I have had cause to criticise one particular DHA's handling of complaints in previous reports. In a further case this year, which involved dilatory handling, solicitors acting as executors for a woman's aunt enquired about a watch mislaid while the aunt was in hospital. I was unable to establish what had happened to the solicitors' initial letter. They complained through the Department of Health (DH), nearly three months later, that they had received no reply. A deputy administrative services manager was asked to investigate the loss. She did not document her investigation in any detail and replied *over five months afterwards* that, as there was no record of the loss and the staff could not recall seeing the watch, the DHA could take no further action. The solicitors immediately wrote challenging that but, despite again pressing both the hospital and then DH, they did not receive a reply. The manager was inexperienced and was sure she had discussed the case with her senior officers and that her reply had been checked before despatch. None of the senior officers recalled that. The correspondence from the solicitors was not treated as a complaint, nor was progress on it monitored. I had no hesitation in finding the senior officers as much at fault as the manager concerned. The DHA had recently created a post of complaints officer and had revised their complaints procedure. Because improvements which had been promised as a result of my predecessor's and my earlier investigations were not manifest in this case, I placed little reliance on the promise that that would suffice. I therefore felt the only thing to do was to draw to the attention of the relevant RHA my expectation that the DHA would ensure once and for all that the implementation of the revised complaints policy secured the required improvements.

48. This was one of the cases, to which I referred in paragraph 8, where the DHA offered an *ex-gratia* payment for the lost property while my

investigation was in progress. I decided not to discontinue my enquiries—a decision fully justified by the resulting action aimed at improving complaints and patients' property procedures.

(s) SW.26/91-92 on pages 137-142 of HC 32

49. That was a feature also of another case, in which a man sought reimbursement from a HB for property stolen from his mother's room at a long-stay hospital. When his claim was rejected on the ground that the property was technically in his mother's possession at the time of the theft, he asked for the decision to be reviewed and set out various points for consideration. The HB's reply simply reaffirmed the original decision without addressing the specific points he had raised. I criticised that, but I was even more disturbed to find that the HB had clearly indicated that the appeal would be considered by an officer other than the one who had dealt with the original claim—and indeed the letter rejecting the appeal appeared to come from someone else—but in fact both the claim and the appeal were dealt with by the same person. I regarded that as little short of dishonest. Only during the course of my investigation did the HB write again to the man attempting to address the issues he had raised. In addition they reviewed the circumstances of the loss and agreed to pay reimbursement. The HB agreed to review their procedures to ensure that appeals were dealt with by someone independent of the original decision.

50. I investigated another case (SW.32/91-92) against the same HB involving a claim for reimbursement of the replacement cost of lost or stolen patients' property. In that case also the HB rejected the claim but, shortly after I decided to investigate, they reversed their decision.

51. Many cases which I investigate do not readily fall into any obvious classification. That is hardly surprising given the variety of issues investigated. Every year cases arise which are of such significance that publication may help those called upon to deal with similar situations.

(t) W.99/90-91 on pages 26-40 of HC 32

52. One case concerned procedures in a case where child sexual abuse was suspected. I found that despite all the guidance given during and since the Butler-Sloss Inquiry the correct procedures had not been followed. A GP referred a young girl to an outpatient clinic where a consultant paediatrician suspected, contrary to the GP's view, that abuse might have occurred. He conveyed his suspicions to the child's mother and discussed with her how the abuse might have happened, giving the impression that he suspected the father. He and another doctor, experienced in dealing with abuse, jointly examined the girl and admitted her to hospital where she remained for 19 days. Only on the day after admission were the social work department contacted; and they later arranged a case conference, after which the parents were told that no clear decision had been made as to whether or not sexual abuse had occurred. The consultant examined the girl's little brother while she was in hospital, and the parents believed that that was to be a full medical examination. They were told eventually that their daughter had not been abused but that she had an unusual skin condition aggravated by an ointment used before her admission. According to them, that information was not circulated until much later to those who had attended the case conference. They complained that the consultant had not followed correct procedures for dealing with cases of suspected sexual abuse; about the dissemination of information to those invited to the case conference; and about the way their son had been examined.

53. The consultant's explanation for his actions was that the primary issue had been to treat the girl's condition, but I found that he should not have communicated his suspicions to the parents before admitting her to hospital. Had he followed the DHA's procedures in line with clear guidance which the Department of Health had issued, the social workers and the GP would immediately have been contacted. The consultant purported to justify his actions on the grounds that the procedures were guidelines and were not binding upon him. The initial case conference had been attended by staff from various professions. I considered it unsatisfactory that the only ward nurses present were two students who had attended without senior support and had made no record of their attendance. I found the DHA's procedures flawed in that no one had had responsibility for ensuring that those invited to the case conference were told of the eventual diagnosis. The final diagnosis had been suggested seven days after the girl's admission, and the suspicion of sexual abuse had been discounted at least three days before her discharge from hospital. I regarded it as wholly unacceptable that the parents had not received definite information until they threatened to discharge their daughter. The consultant had not informed the GP definitively until one month after the girl's discharge, and other staff had had to wait until a second case conference was called to close the case, two months after that. I found that the son's examination had not been as generalised as recommended.

(u) W.120/91-92 on pages 96-103 of HC 32

54. A case of interest in the light of current initiatives on waiting lists and times concerned an elderly woman who was referred by her GP to a hospital consultant for an ophthalmic appointment. After waiting nearly twelve months without receiving even an acknowledgement of the referral from the hospital, and as telephone calls to the hospital elicited no information, the woman's daughter was so concerned about her mother's deteriorating condition that she took her to the hospital's A and E department. My enquiries revealed that it was because the woman's referral had not been processed through the normal procedures at the hospital that she had not received an acknowledgement letter or any indication of how long she might have to wait for an appointment. That probably also explained the lack of success when the daughter telephoned about progress. The main problem seemed to have been the pressures under which the clerical staff were working at the time—a situation since improved. Even if the woman's referral had been processed correctly, the category of urgency accorded to her would anyway have meant a wait of some 16 months for an appointment. I learned that the DHA had taken steps to bring down that excessive waiting time and were continuing their efforts to make further improvements.

55. That was not the end of the woman's problems, for when her daughter took her to the hospital she had to wait some six and a half hours in the A and E department in uncomfortable surroundings before being seen by a doctor. Her anxiety was increased because she did not have some essential medication with her. I found that the department operated a triage system to allocate priority to patients, and that a sister had put the woman in the least urgent category. That inevitably meant some delay, but the length of time in this case was excessive. I could not escape the conclusion that for at least part of the time the staff forgot or overlooked how long the woman had already waited. I was pleased to note that the DHA had introduced changes aimed at alleviating such problems, particularly for elderly patients. They agreed to continue monitoring their effectiveness.

(v) W.226/91-92 on pages 112-117 of HC 32

56. I dealt with a case where budget constraints had resulted in charges being levied in breach of statutory exemptions. A chiropodist prescribed a pair of orthoses for a thirteen year old girl to correct her gait. The girl subsequently received an invoice for £28 from the private laboratory making the orthoses on payment of which, she was told, they would be sent to her. Her father complained that, as a child, his daughter should have received the orthoses free of charge under the NHS. The view of the managers in the community services unit (now a NHS Trust) was that, because of financial constraints, diagnosis could be provided without charge but manufactured orthoses could not. I learned that the biomechanics service, which had started three years previously, had developed rapidly but with no extra funding. The DHA staff were simply wrong to liken the charge to that made for spectacles, as the provisions in the NHS Act 1977 governing charges for optical services do not extend to chiropody services. (The Act makes it clear anyway that children under sixteen years old are exempt from charges for appliances that fall within the legislation and are prescribed by a hospital doctor.) In the light of my investigation not only did the DHA, in conjunction with the Trust, agree that the girl should receive any necessary orthoses free of charge under the NHS, but they undertook to review charges similarly made to 20 other patients and to take appropriate action if any had been wrongly charged.

(w) W.174/91-92 on pages 103-112 of HC 32

57. Many complainants are taken aback that, where family health services authorities (FHSAs) are concerned, I can investigate complaints only when the *informal* procedure has been used. A complaint once referred to the chairman of the appropriate service committee is beyond my jurisdiction. The NHS (Service Committees and Tribunal) Regulations—those made in 1974 were extant at the time of the complaint in this case—say that a complaint should be referred to the service committee chairman once the FHSA has a clear statement of what it is about. A woman complained about the treatment and care she had received from two GPs in the same practice, and officers of the family practitioner committee (later FHSA) contravened the Regulations when they sought the comments of the GPs on the woman's complaint, and then sought the woman's observations on those comments, before submitting the case to the service committee chairman. The effect of that was that the formal procedure was not properly invoked until some 15 months after the complaint had first been made. The FHSA officers also told the woman that a complaint could not be brought against the first of the GPs as she had been a trainee at the time of treatment; and that, as the second GP had since retired, a complaint could not be brought against him either. Both statements were wrong. I found that staff did not have a written procedure to guide them, and that training and supervision of junior staff was deficient. The FHSA agreed to review their procedures. Their muddle was so grievous that I also recommended that they should report my findings and what they proposed to do by way of remedy to the appropriate RHA.

(x) W.452/90-91 on pages 61—66 of HC 74

58. Another case highlighted a very worrying concern sometimes expressed by patients that they may be victimised if they make a complaint. A woman whose GP had referred her to a consultant for an urgent appointment found that she had been assessed as needing only a routine appointment. She put that down to the fact that she had made a complaint some five years previously. Later she found that correspondence about her earlier complaint was with her medical records and that it included material which she considered to be non-medical and offensive. The DHA refused to remove the earlier correspondence from the records. My investigation enabled me to reassure the woman that her suspicion of discrimination was groundless. The consultant had not known of her earlier complaint, or seen her medical records, when he decided from the information provided by the GP that a routine appointment was appropriate. The DHA told me that they had no policy about the filing of complaint correspondence with a patient's medical records, so there was no consistency in what consultants did with such letters. I felt that as a general rule, unless the content of a letter of complaint had clinical significance such as to warrant its inclusion in a patient's medical records—and only a doctor could decide that, there was some merit in avoiding the practice. The DHA agreed to formulate a policy and associated procedures and to review the woman's records in the light of that policy.

(y) W.839/90-91 on pages 93—96 of HC 74

59. Many motorists and their passengers are probably unaware that section 158 of the Road Traffic Act 1988 requires health authorities to collect a statutory fee for emergency treatment in hospital following a road traffic accident. Provision for a charge was originally contained in a similar Act of 1972. Misunderstanding and resentment can arise, in this as in many other areas of activity, if hospital staff act insensitively. A woman was taken to an A and E department after a road accident and, a few days later,

received from the DHA an invoice for £18.20 and an accompanying letter referring to recourse to debt collection agencies and the courts if the fee was not paid. The woman's complaint was that she had not been informed at the time of her treatment that a charge would be levied. She also found the letter offensive and lacking in adequate explanation for the charge: I agreed with her. While I accepted the argument that staff have to use their discretion as to what they say at the time to an injured patient, I found that there was an absence of guidelines and nothing in the information booklet for A and E patients. The DHA agreed to put that right and to display a more prominent notice in the waiting area. They also agreed to change the threatening tone of the letter sent with invoices.

4 REMEDIES

60. Sometimes all that distinguishes a complaint put to me from those which are not is lack of an apology freely given. I suspect that, if only a thorough and critical local investigation had been carried out, the need for me to intervene and then to call for apologies and, just as important, for remedial action would in many cases not arise. What I can provide is a thoroughly researched investigation, information which might otherwise not have come to light, and snapping at the ankles of the health authority concerned until I am satisfied that the steps I consider apt have been taken. Only on very rare occasions does an authority prevaricate on a recommended remedy, and in those circumstances I draw this to the attention of the Select Committee. Such a situation did not arise in any of the investigations completed in 1991-92.

61. On occasions it is clear from the letter to me that a complainant believes that negligence has occurred and is after compensation. I cannot generally look into such matters, which are for the courts to determine. Parliament has given me discretion to investigate if I consider that it would be unreasonable to expect the matter to be pursued through legal proceedings. In the same way as health authorities should not adopt too defensive a stance for fear of litigation—which may be the last thing in the complainant's mind—I consider it appropriate to go back to some complainants in order to check that, despite reference to such things as neglect, there is in fact no intention to pursue litigation. Reimbursement for an identifiable financial loss suffered as a consequence of maladministration I am prepared to consider recommending. In such circumstances I invite the health authority to make an *ex gratia* payment. There were only three such cases in 1991-92, but in a further four cases financial remedies resulted when the health authorities concerned reviewed their earlier decisions after I had started my investigation. The three cases producing a financial remedy were:

W.669/89-90 Reimbursement for lost clothing.

W.185/90-91 Reimbursement of private chiropody charges in respect of a patient who had subsequently died.

W.825/90-91 Ex-gratia payment made in respect of costs of transport to hospital.

62. Some of the wide variety of cases and remedies encountered last year are outlined in Chapters 2 and 3. These and other cases I include in the volumes of selected and anonymised cases published twice a year. I am often told how valuable those volumes are as teaching material for staff and students in the NHS. I also produce epitomes—or summaries—of those cases, and the Health Departments circulate them widely to health authorities and boards. I have decided against giving such a summary at the beginning of each report sent to a complainant and the body complained against when I have completed a particular investigation. I see it as important for the parties directly involved to study the evidence before reading my findings.

63. I now outline, in four broad categories, all the procedural remedies which I have obtained in 1991-92. English cases are prefixed W, Scottish cases SW and Welsh cases WW.

(i) Administrative practices or procedures associated with medical activity

W.402/89-90 DHA to ensure that consultant with continuing responsibility for a patient is promptly informed of significant developments.

W.670/89-90 Procedures for bringing patients round from anaesthetic, and for transferring patient from operating table to bed, to be examined.

W.325/90-91 Prescribing procedures to be reviewed with the aim of avoiding errors.

W.506/90-91 DHA to consider how to improve communication to relatives about the full extent of planned operations.

W.507/90-91 DHA to consider introduction of a policy about the use of anaesthetic when performing lumbar puncture on children.

W.526/90-91 Review of arrangements for referring patients between specialties.

W.564/90-91 Medical staff reminded of the importance of making a note in clinical records when called to see a patient and decide about treatment.

W.598/90-91 Weaknesses in the administration of the appointments system to be remedied.

W.653/90-91 Medical staff reminded of the importance of:
(a) involving anxious relatives in decisions about how to proceed when operations do not go according to plan; and
(b) making entries in records of any such discussions.

W.790/90-91 (a) DHA to clarify the arrangements for treating urology patients who develop problems with their catheters post-operatively; and
(b) DHA to make their policy known to Gps.

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

W.203/90-91 DHA to review discharge procedures.

W.231/90-91 Leaflet clarifying for parents details about the aftercare of their children to be published without delay.

W.232/90-91 DHA to clarify arrangements for transfer of patients to hospices.

W.368/90-91 Procedures for Last Offices to be reviewed.

W.380/90-91 DHA to consider advice to nurses about how to proceed when they consider that medical assistance is required.

W.407/90-91 Steps taken to ensure that the procedure for handing over medicines to be taken away on discharge is correctly observed.

W.423/90-91 Review of procedures to ensure that supervision of patients is maintained during ward handover.

W.432/90-91 Because of conflicting staff opinions on whether relatives should help lift patients, DHA to clarify nursing policy on that matter.

W.503/90-91 DHA to take steps to ensure that there is no confusion about where responsibility lies for informing parents about significant events in their child's treatment.

W.506/90-91 DHA to consider need for formal liaison arrangements between hospital and community care staff attending a patient in hospital.

W.507/90-91 Procedures for dealing with urgent re-admissions of children to be reviewed.

W.564/90-91 (a)Student nurses to be made aware at an early stage in their training how to respond to requests from patients' relatives; and
(b)DHA to review guidance to nurses about determining a patient's dietary needs.

W.614/90-91 DHA to clarify nurses' responsibilities to patients during ward handover.

W.649/90-91 Review of guidance to nurses about action to be taken when a patient dies.

W.702/90-91 DHA to review way in which nursing records are made about a patient's deteriorating condition.

W.705/90-91 DHA to consider what should be done to minimise risk of relatives first hearing about the condition of a seriously ill patient from another patient.

W.750/90-91 (a) Review of guidance to nurses on attending a patient after administering an enema; and
(b) staffing levels in wards with a high level of patient dependency to be examined.

W.790/90-91 DHA to review what advice should be given to patients, and in what form, about what to do if a catheter becomes blocked after a patient has left hospital.

W.51/91-92 Written guidance for nurses, about informing relatives of patient's accident, to be considered.

W.67/91-92 Action taken to implement and monitor policy on handling patients' property, and to train staff in the relevant procedure.

W.125/91-92 DHA to complete a review of drugs policy, issue guidelines as soon as possible, and remind staff of the importance of adhering to that guidance.

W.147/91-92 Measures put in hand by DHA to ensure that community midwives from neighbouring DHAs attending patients in their maternity hospital know the procedures to be followed—guidelines to be given clear date of issue.

W.377/91-92 DHA to review how their policy on observation of patients works in practice.

SW.21/90-91 Health Board (HB) to review communication among members of staff.

SW.70/90-91 HB to review provision, or contingency arrangements, for dealing with abnormally high levels of workload in a maternity hospital.

SW.87/90-91 HB to review instructions to nurses about:
(a) conveying information to relatives in preparation for a patient's discharge; and
(b) recording that information for benefit of colleagues.

SW.24/91-92 HB to ensure all nursing staff are aware of drug administration procedures.

WW.23/89-90 DHA to consider placing in wards which do not have ready access to the street those patients who have a tendency to wander.

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

W.402/89-90 DHA to ensure that staff know where available information (in this case medical records) is located.

W.669/89-90 Operation of laundry arrangements reviewed to prevent loss of personal clothing.

W.141/90-91 DHA (in consultation with NHS Trust) to arrange for pamphlet on nursing home admission procedures to include details of how priorities for entry are arrived at.

W.153/90-91 (a) Update of policy on management of private patients;
(b) issue of guidance on the retention of letters from patients; and

(c) review of procedures for issuing, and recording the issue of, appointments.

W.199/90-91 DHA to produce handout leaflet about those shoes which NHS can adapt free of charge, and what type of shoes to purchase.

W.219/90-91 Discharge procedures in A and E department to be reviewed to ensure that patients who are not returning home by ambulance are adequately clothed.

W.325/90-91 (a) DHA to review appointments system; and
(b) DHA to look again at the way in which information about the training function of a clinic is brought to the notice of patients.

W.506/90-91 Action to ensure that there is no misunderstanding about the limited role of the 'bereavement officer'.

W.611/90-91 DHA to review procedures so that:
(a) consultants in outpatient clinics are told if a patient's records are missing and that an extended wait could result;
(b) additional bookings are allocated in a manner which keeps clinic delays closer to target;
(c) patients spend as little time as possible waiting in poorly lit and ventilated area (DHA also to consider what steps can be put in hand to improve conditions at clinic); and
(d) storage and retrieval of records is so organised as to minimise the risk of records being mislaid.

W.653/90-91 Clearly understood procedure to be laid down so that theatre staff know in good time of the need to obtain any special equipment before an operation.

W.718/90-91 DHA to review, with social services department, the arrangements for notifying appointments to patients referred by consultants for social worker support.

W.750/90-91 Action to prevent notice of outpatient appointments from being sent to patients who have died.

W.839/90-91 (a) Guidance to be produced for A and E staff about notifying patients about road traffic accident charges; and
(b) public notice, information leaflet and standard letter requesting payment to be reviewed.

W.87/91-92 DHA (in consultation with NHS Trust) to ensure that all staff have guidance on discharge procedures which accords with that contained in DH circular HC(89)5.

W.120/91-92 DHA to monitor new policies and procedures being introduced in A and E department.

W.254/91-92 Action to ensure that where, because of a domestic crisis, care of a psychiatric day patient passes from hospital to community, the hospital advises the patient in writing of that fact.

W.377/91-92 (a) Consideration of steps needed to avoid patients burning themselves on hot pipes; and
(b) immediate priority to be given to providing protection from hot pipes in the psychiatric unit.

WW.21/91-92 Procedure to be introduced in the radiology department whereby patients can summon immediate assistance should that become necessary.

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

W.677/89-90 DHA (in consultation with NHS Trust) to ensure that staff dealing with complaints understand procedures and their role in relation to them.

W.37/90-91 Guidance on complaints handling to be reviewed.

W.66/90-91 DHA to review complaints procedure.

W.231/90-91 (a) Review of A and E procedures to ensure that doctors understand the need to record what they have done and that loose leaf records are appropriately filed; and
(b) monitoring of new computerised system for keeping records.

W.262/90-91 DHA to implement written complaints procedure.

W.368/90-91 DHA to take steps to ensure that officers who handle complaints are properly instructed on what to do.

W.438/90-91 RHA to consider—in conjunction with the Joint Consultants Committee of BMA—whether the advice given to independent assessors under the clinical complaints procedure should be clarified.

W.452/90-91 DHA to formulate a policy about retention of letters of complaint on patients' medical records and review the complainant's records in the light of the new policy.

W.562/90-91 Agreement by RMO either to explain to complainant his decision not to proceed to an IPR or to address afresh the substance of the clinical complaint.

W.611/90-91 DHA to make clear, when copying complaints to consultants for comment, what is expected of them.

W.627/90-91 Procedures for dealing with complaints involving more than one hospital to be reviewed.

W.652/90-91 DHA to review complaints procedure.

W.660/90-91 DHA to audit complaints procedure regularly.

W.667/90-91 DHA to revise policy for dealing with complaints from staff.

W.833/90-91 A Special Health Authority (SHA) to clarify with DH, if necessary, the RMO to whom they should refer complaints under the clinical complaints procedure, and to offer to refer the complainant's case accordingly.

W.67/91-92 DHA to review regularly the handling of complaints and other correspondence.

W.174/91-92 DHA to review and issue their complaints procedure and then to monitor compliance.

W.181/91-92 DHA (in consultation with NHS Trust) to ensure that procedures for handling complaints are clearly understood and that an effective monitoring procedure is in operation.

W.199/91-92 (a) Action to avoid recurrence of delay in complaints handling; and
(b) review of how and by whom letters to complainants should be signed.

W.254/91-92 Steps taken to ensure adequate and accurate record-keeping by community staff.

SW.47/90-91 HB to give fuller account of findings when responding to a complaint.

SW.24/91-92 HB to ensure that:
(a) their nominated recipient of complaints is correctly identified in the information booklet; and
(b) their complaints procedure is complied with.

WW.23/89-90 Review of procedure for convening meetings to discuss complaints with relatives so as to ensure proper co-ordination between the two sides.

WW.47/90-91 DHA to review guidance to nurses on monitoring and recording a patient's response to bowel preparation.

64. Sometimes I find that a procedure exists but staff have forgotten, not understood or failed to observe it. Where that happens, I may decide that action to remind the staff concerned of the procedure is the appropriate remedy. Some examples in 1991-92 were:

W.545/89-90 (a) Midwives to be reminded of the importance of maintaining regular and complete records of a patient's progress, particularly where an element of risk is involved; and

(b) staff handling complaints to be advised of the importance of taking action expeditiously.

W.669/89-90 DHA to remind:
(a) nurses of the procedures for handling complaints about the loss of patients' clothing; and
(b) doctors of the need to record discussions with relatives about withholding treatment.

W.670/89-90 Staff reminded of the need to deal with complaints in accordance with procedures.

W.677/89-90 Medical staff reminded of importance of accuracy in dating and timing entries in clinical records.

W.26/90-91 (a) Reiteration to nurses of the importance of maintaining comprehensive records on assessments and care given; and
(b) staff reminded of need for strict adherence to the complaints procedure.

W.63/90-91 DHA to remind staff of the need to keep full, accurate and legible records.

W.100/90-91 (a) SHA to complete implementation of DH circular HC(86)14—which set out requirements for food hygiene in all NHS premises as a consequence of the NHS (Amendment) Act 1986; and
(b) action to ensure that the SHA's complaints procedure is operated in compliance with HC(88)37.

W.231/90-91 DHA to remind nurses of the importance of recording information which could have a bearing on a patient's aftercare, the need to brief relatives fully before a child's discharge and the importance of making records comprehensive.

W.268/90-91 Nurses to be reminded of the importance of recording patients' refusal to tolerate material aspects of care and any proposed remedy, and of scrupulous accuracy in recording administration and withholding of drugs.

W.296/90-91 DHA to remind:
(a) nurses of the importance of accurately recording fluid intake;
(b) staff to date entries in records; and
(c) complaints staff of the guidance in HC(88)37.

W.368/90-91 Reminder to nurses that they should give relatives as much notice as possible when a patient is to be moved from one ward to another, maintain adequate records, be sensitive in describing to relatives the potentially distressing appearance of a body, and remember that it is their responsibility to escort relatives to view a body.

W.407/90-91 DHA to remind staff of the importance of adhering to patients' property procedures.

W.432/90-91 DHA to remind nurses of the need to document requests for a doctor to see a patient.

W.459/90-91 Women attending parentcraft classes to be given the maternity unit's information booklet.

W.482/90-91 DHA to remind nurses of the need for clear, concise records which include the detail of the care given.

W.515/90-91 Nurses to have regard to the patient's dignity when deciding whether personal or hospital clothing should be used.

W.526/90-91 DHA to remind nurses of the importance of recording and passing on information given by patients and their relatives.

W.605/90-91 DHA to remind staff what is expected of them under the complaints procedure.

W.614/90-91 DHA to remind staff of the need to keep relatives and patients informed about reasons for delay, of the importance of a thorough handover, and of the importance of noting in records information about the patient's condition.

W.653/90-91 DHA to remind staff of the importance of registering a complaint and informing complainant of reasons for any delay.

W.660/90-91 Doctors to be reminded of the importance of recording their actions and decisions in the clinical records.

W.702/90-91 DHA to remind nurses of guidance on contacting next-of-kin.

W.705/90-91 DHA (in consultation with NHS Trust) to remind doctors and nurses of need for a patient's reservations about general anaesthesia to be drawn to attention of the anaesthetist.

W.731/90-91 (a) Nurses reminded of the assistance they are expected to offer patients on admission; and
(b) the need for recording times accurately to be stressed.

W.750/90-91 (a) Reminder to nurses of their responsibility to trim patients' nails; and
(b) action to ensure that staff understand the complaints procedure and their own role in relation to it.

W.828/90-91 DHA to remind:
(a) medical staff of the importance of dating, timing and initialling entries in the medical records;

(b) all staff of the need to explain alterations to records; and
(c) nurses of their responsibility to ensure that patients take medication as prescribed and of the need for accuracy in recording the administration and withholding of drugs.

W.28/91-92 (a) Need for staff to keep relatives informed of deterioration in patient's condition; and
(b) reiteration of guidance on when a patient's property list should be prepared.

W.55/91-92 DHA to remind nurses of the importance of:
(a) recording changes in a patient's condition and of notifying relatives expeditiously of a deterioration which gives cause for concern;
(b) reporting defective ward equipment; and
(c) recording accurately the timing of administration of drugs and the taking of observations.

W.58/91-92 Emphasise to staff the importance of ensuring that patients understand the nature and purpose of proposed treatment.

W.151/91-92 DHA to remind staff involved in complaints work of the need to register complaints and of what is expected of them in handling a complaint.

W.191/91-92 DHA to ensure that new complaint monitoring systems are followed.

W.363/91-92 NHS Trust to remind staff of guidance on the completion of accident report forms and to stress to those investigating complaints the importance of accuracy and methodical inquiry.

W.404/91-92 DHA to remind consultants of their responsibilities under the clinical complaints procedure.

WW.23/89-90 DHA to remind medical and nursing staff of the importance of making a note in the clinical and nursing records about meetings with relatives.

WW.47/90-91 DHA to remind nurses that questions about the likely duration of an operation should be referred to a doctor.

65. Some of the remedies in investigations completed in 1991-92 did not fall into any obvious category:

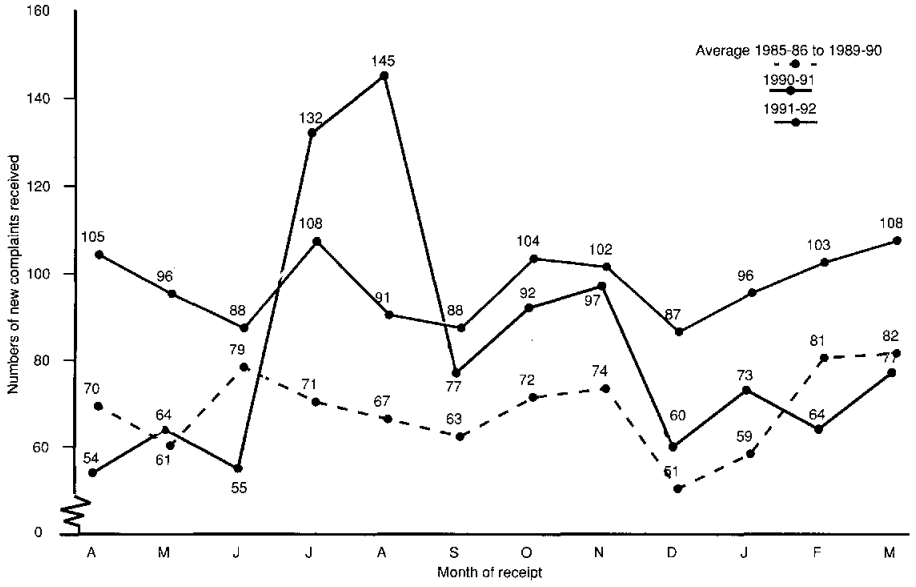
W.637/89-90 RHA to look to the ambulance service (AS) to review contingency plans and procedures for providing emergency ambulance services during industrial disputes.

W.669/89-90 DHA to promote better communications with relatives and carers.

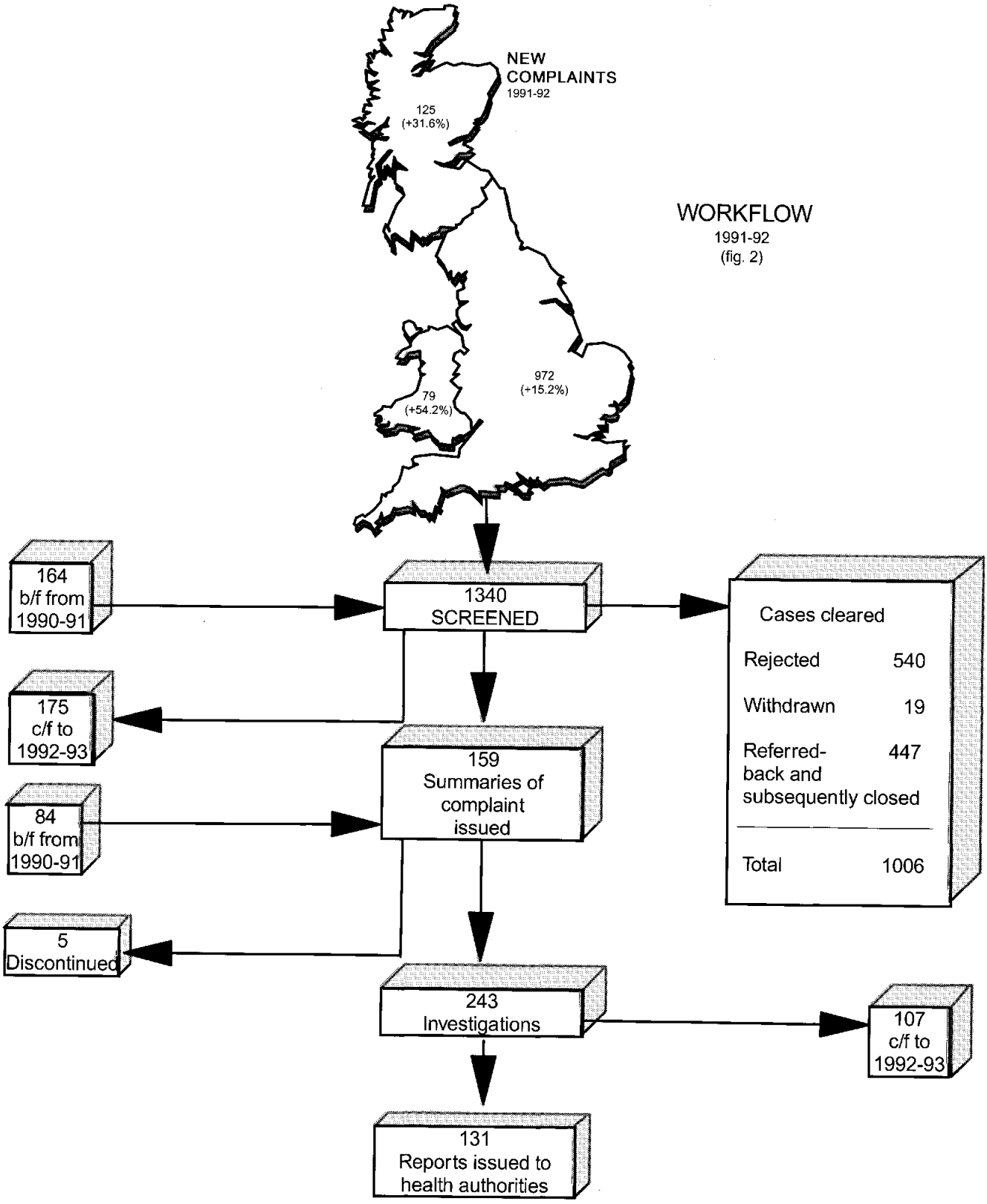
W.99/90-91	(a) DHA to review the attendance of student nurses at case conferences; and (b) action to ensure compliance with established procedures for dealing with cases of suspected child sexual abuse.
W.135/90-91	DHA to improve signposting for the benefit of visitors coming to the hospital at night.
W.286/90-91	DHA to offer a discussion on any aspect of the aggrieved's care about which she remained concerned.
W.508/90-91	AS to remind ambulance crews of guidance about 'carrying' equipment, and of procedures to follow in respect of BM stix tests.
W.174/91-92	FHSA to report to RHA my findings and what action they have taken in response to them.
W.226/91-92	(a) DHA to examine charges made for the supply of orthoses to children and, if *ultra vires*, take action to remedy; (b) assistance to be offered to complainant's family in providing, free of charge, any necessary orthoses; and (c) review of provision of chiropody services under contract with NHS Trust.
W.303/91-92	DHA in future to consider sympathetically NHS convalescence, where needed, for a disabled patient even though NHS convalescence is normally available only to those who are not disabled.
SW.26/91-92 SW.32/91-92	HB to review Loss and Compensation procedures (see also paragraphs 50 and 51).

Workload 66. I referred in paragraph 3 to the fact that 1991-92 has seen more complaints to me even than in the record-breaking year which preceded it. The NHS has attracted considerable public attention during the past twelve months which included a General Election. Some of that attention arose from the launch of the Patient's Charters for England, Scotland and Wales and their emphasis on the improvement of services generally and the setting of certain minimum standards. The diagram at figure 1 shows how the 1176 new cases came in during the year. Exceptional peaks were experienced during the summer of 1990, but a more normal pattern returned in 1991-92.

Monthly inflow of new complaints (fig. 1)



67. In figure 2 I provide more detail about the complaints received for England, Scotland and Wales during 1991-92 (together with the percentage increases over the figures for 1990-91) and show how the total workload for the year was dealt with. This information is brought together in figure 3 and at Appendix B.


NEW
COMPLAINTS
1991-92
125
(+31.6%)
972
(+15.2%)
79
(+54.2%)
WORKFLOW
1991-92
(fig. 2)
164
b/f from
1990-91
1340
SCREENED
Cases cleared
Rejected 540
Withdrawn 19
Referred-back and subsequently closed 447
Total 1006
175
c/f to
1992-93
159
Summaries of
complaint
issued
84
b/f from
1990-91
5
Discontinued
243
Investigations
107
c/f to
1992-93
131
Reports issued to
health authorities

Workload and Disposal (fig 3)

Workload

Cases brought forward from 1990-91	248
Cases received in 1991-92	1176
Total	1424

Disposal

Reports issued	131
Cases rejected	540
Cases discontinued (or withdrawn)	24
Cases referred back and subsequently closed	447
Cases carried forward to 1992-93	282
Total	1424

68. Appendix G gives an analysis of the intake of new complaints on a regional basis. The growth in work was not uniform. The number of complaints received actually fell in five regions, compared with 1990-91, while the increases in other areas ranged from 3.6% (North Western) to 68.0% (South East Thames). The share for the four Thames regions (426) increased slightly to 44% (normally about 40%) of all the complaints received for England.

69. Of the total of 1424 cases dealt with during the year, action was completed on 1142 (80.2%)—that compares with 1006 (80.2%) of the 1254 cases dealt with in 1990-91. In addition to the complaints received, there were 191 written enquiries and requests for information and advice (184 in 1990-91). There were also 807 supplementary letters either about complaints which had not been accepted for investigation, or in response to requests for further information or action (697 in 1990-91).

70. Recent experience makes me reluctant to speculate whether this higher level of activity will continue, but it has been difficult at times during the past year to ensure that complainants receive as prompt replies to their letters as I would wish. At the beginning of the year I set my staff a somewhat tougher target by asking them to help me to respond to each complaint within 18 days of the dates of receipt. Despite the increased volume of work the new target was achieved in 76% of all cases, the average response time being 14 days.

71. Over the years I, and my predecessors, have been on the receiving end of a number of campaigns, with many individuals writing about the same issue—generally matters with a particular local interest. Often those concerned do not appear to have acquainted themselves beforehand with what my functions are or the limits set by Parliament to my powers. To such

it has rarely been possible to hold out any prospect of help. During the summer of 1991 I was approached by 28 individual parish councils seeking help in their campaign to achieve the abolition of the so called 'one-mile-rule', which can limit the ability of family doctors (GPs) practising in rural areas to dispense medicines for their patients. Not only am I unable to accept complaints from public service bodies, such as parish councils, but it is not my function either to lend support to any pressure group or to seek to change legislation—that is a matter for Parliament. That said, I am always prepared to consider any matter properly put to me by a complainant who believes that he or she has suffered hardship or injustice as a result of a failure in service or maladministration by a body within my jurisdiction. In that connection, I sometimes have to write back if I am not satisfied that the complainant is the next-of-kin or nearest surviving relative of a patient who has died. For the reasons I have mentioned in paragraph 10 of Chapter 1, I expect to receive fewer complaints from GPs, dentists, opticians and pharmacists which stem from their contractual relationship with family health services authorities.

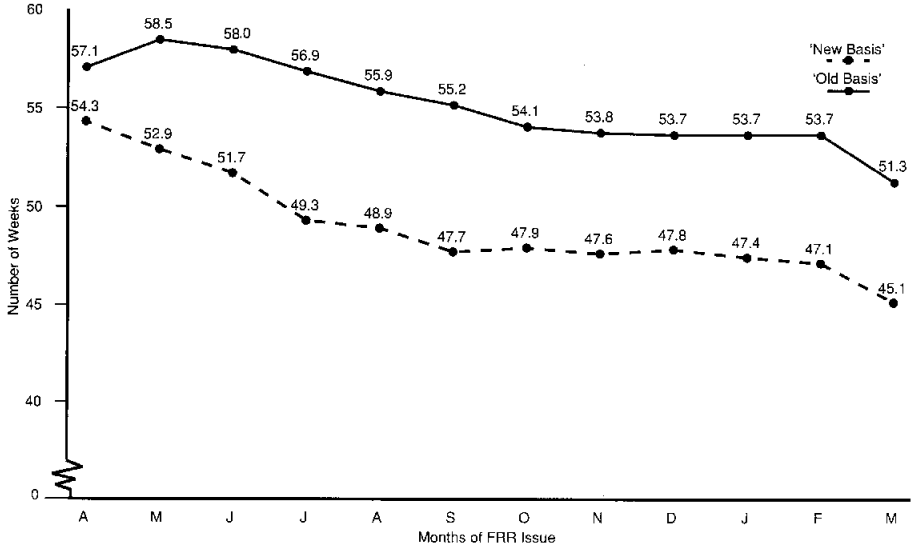
Reports issued on completed investigations

72. Of the 124 investigations concluded during the year five involved two or more health authorities resulting in the issue of 131 individual reports.

73. One of my main objectives during the year had been to reduce further the average time taken to complete investigations. As I explained in my last report I have kept records using two methods of counting time. The 'old' method computes time from the date on which a complaint is first received by me—regardless of whether or not I can at that stage, on the basis of the information provided, decide to investigate—until the date on which my final investigation report is issued. The new method counts time only from the date on which a complaint becomes investigable—that is, once I have been provided with sufficient information to enable me to decide to investigate. In 53 of the cases concluded during 1991-92 I had to ask the complainants to provide more information or take further action before I could proceed. On average the time which elapsed between my writing to the complainant and receiving the information I needed accounted for 7.3 weeks. That is time over which I have no control.

74. Under the old method of counting the average time taken to complete an investigation during 1991-92 was 51.3 weeks, compared with 67.5 weeks in 1990-91—a 24% improvement. Using the new method, the average time taken on those same cases was 45.1 weeks (58.0 weeks in 1990-91) representing an improvement of 22.2%. Of the 124 completed investigations, 67 (54.0%) were concluded in less than the average 45.1 weeks; the actual time taken for all cases ranged from 19.3 weeks to 97.6 weeks. Figure 4 shows how the moving average of time taken calculated under both old and new systems changed during the year. I propose now to discontinue the old method of calculation.

Running Meantime (Weeks) for Time Taken to Conclude Investigations 1991-92 (fig. 4)



The following table (figure 5) shows the proportion of investigations concluded within various time bands, comparing results for 1991-92 with those for 1989-90 and 1990-91.

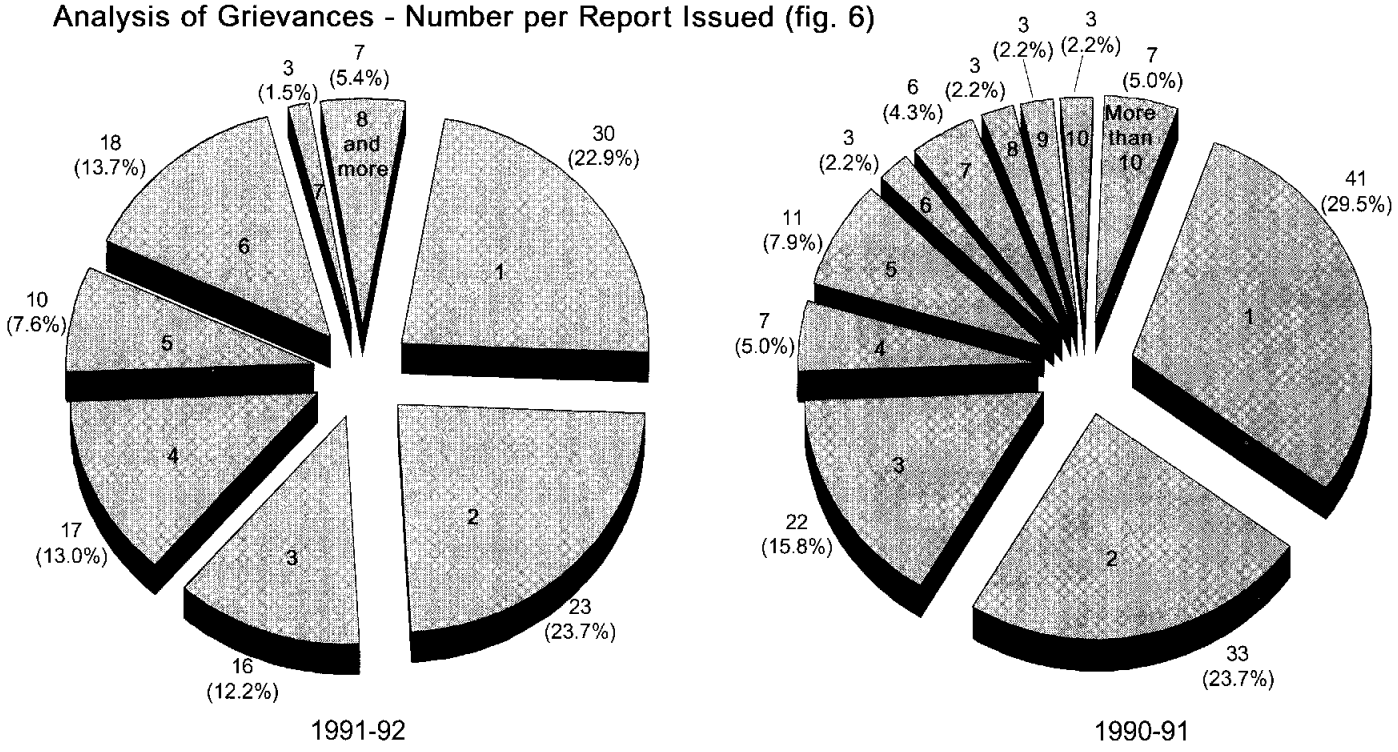
Time Bands for Investigations (fig. 5)

Time band	Proportion of investigations concluded				
	1989-90	1990-91		1991-92	
		Old basis	New basis	Old basis	New basis
Under 40 weeks	3.7% (3)	6.6% (8)	15.6% (19)	22.6% (28)	35.5% (44)
50 weeks	20.7% (17)	23.8% (29)	37.7% (46)	50.0% (62)	68.5% (85)
60 weeks	50.0% (41)	40.0% (49)	55.7% (68)	72.6% (90)	88.7% (110)
70 weeks	63.4% (52)	54.9% (67)	77.0% (94)	91.1% (113)	96.8% (120)
80 weeks	75.6% (62)	75.4% (92)	85.2% (104)	97.6% (121)	99.2% (123)
100 weeks	87.8% (72)	92.6% (113)	100% (122)	99.2% (123)	100% (124)
130 weeks	97.6% (80)	100% (122)		100% (124)	
175 weeks	100% (82)				

75. I investigated 442 separately identified grievances during 1991-92. That represents an average of 3.37 for each report issued (3.50 in 1990-91).

I see this further slight fall in the average number of grievances per report as giving investigations a sharper focus by leaving aside matters which are incidental or peripheral to the main substance of a complaint. That makes investigations more meaningful. Figure 6 shows the distribution of the grievances among the 131 reports issued. In some 73% of cases I investigated five or fewer individual grievances (compared with 60% in 1990-91). In only two cases were 10 or more grievances involved.

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



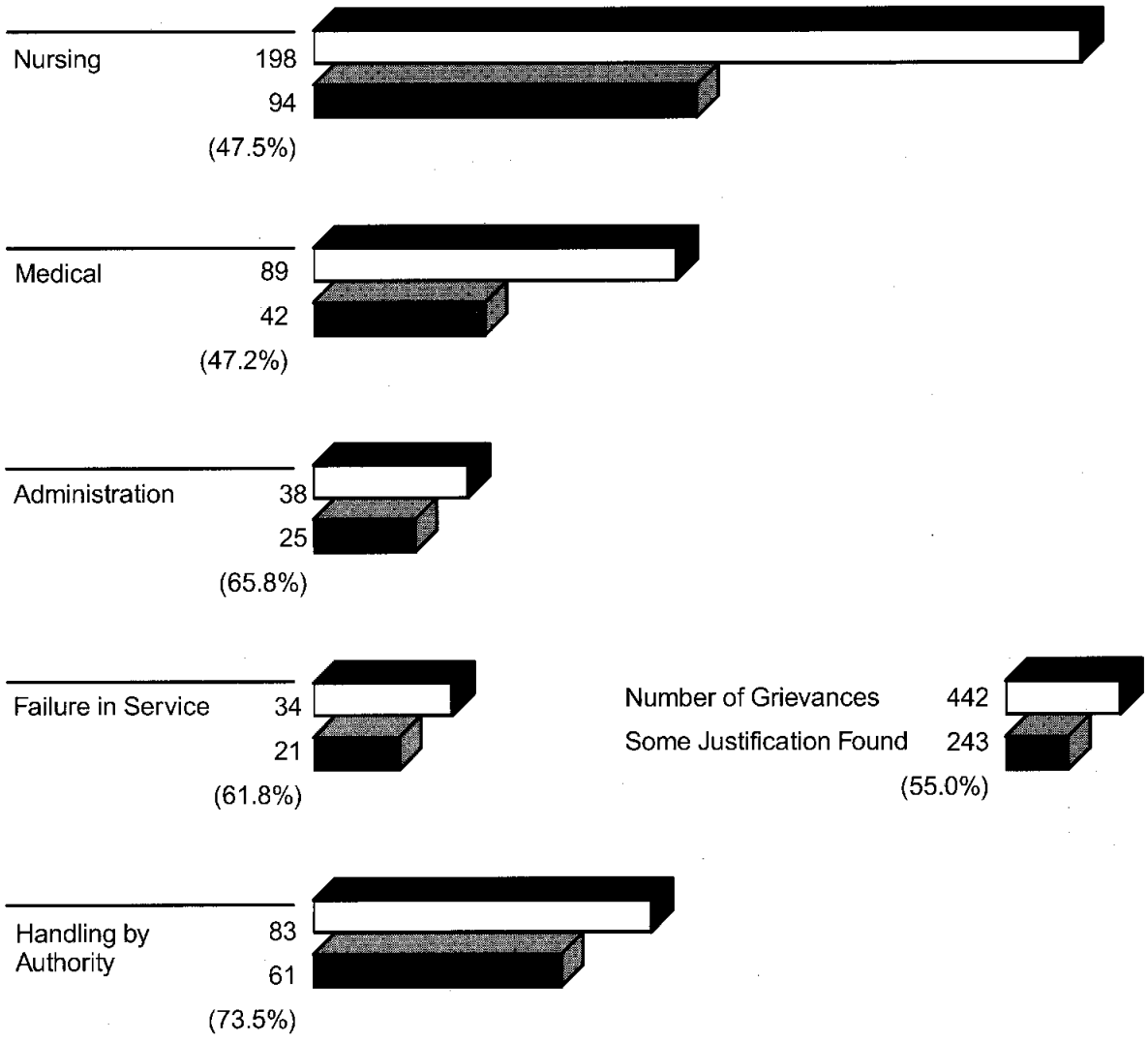
Figures in Black: No. of Reports

Figures in Red: No. of Grievances per Report

Total No. of Reports: 131 (139: 1990-91)

76. Of the grievances I investigated during 1991-92 I found some justification in nearly 55%, compared with 48.5% in 1990-91. Investigated grievances are analysed in outline in figure 7 below, and in more detail in Appendix C.

Grievances Received Compared with Grievances Upheld (fig. 7)



77. I investigated 287 complaints about nurses and doctors, which represent nearly 65% of all investigated grievances (277 and 57% in 1990-91). I upheld 139 (47.4%)—an increased proportion and reversing the trend of recent years to which I drew attention in my last report. The number of grievances about administrative matters (38) reduced considerably and accounted for only 8% of the total investigated. I found some justification in 65.8% of these cases—a proportion which is in line with previous years' figures. A similar number of grievances (34) arose in relation to failures in service, of which 61.8% had some justification (an increase from 40.9% in 1990-91). The proportion of investigated grievances about the handling of complaints fell back to 19% (22% in 1990-91), but 73.5% were found to have some justification (76.4% last year). While I welcome the lower

number of such complaints, the high proportion found justified is still worrying and is an area of service which health authorities might improve.

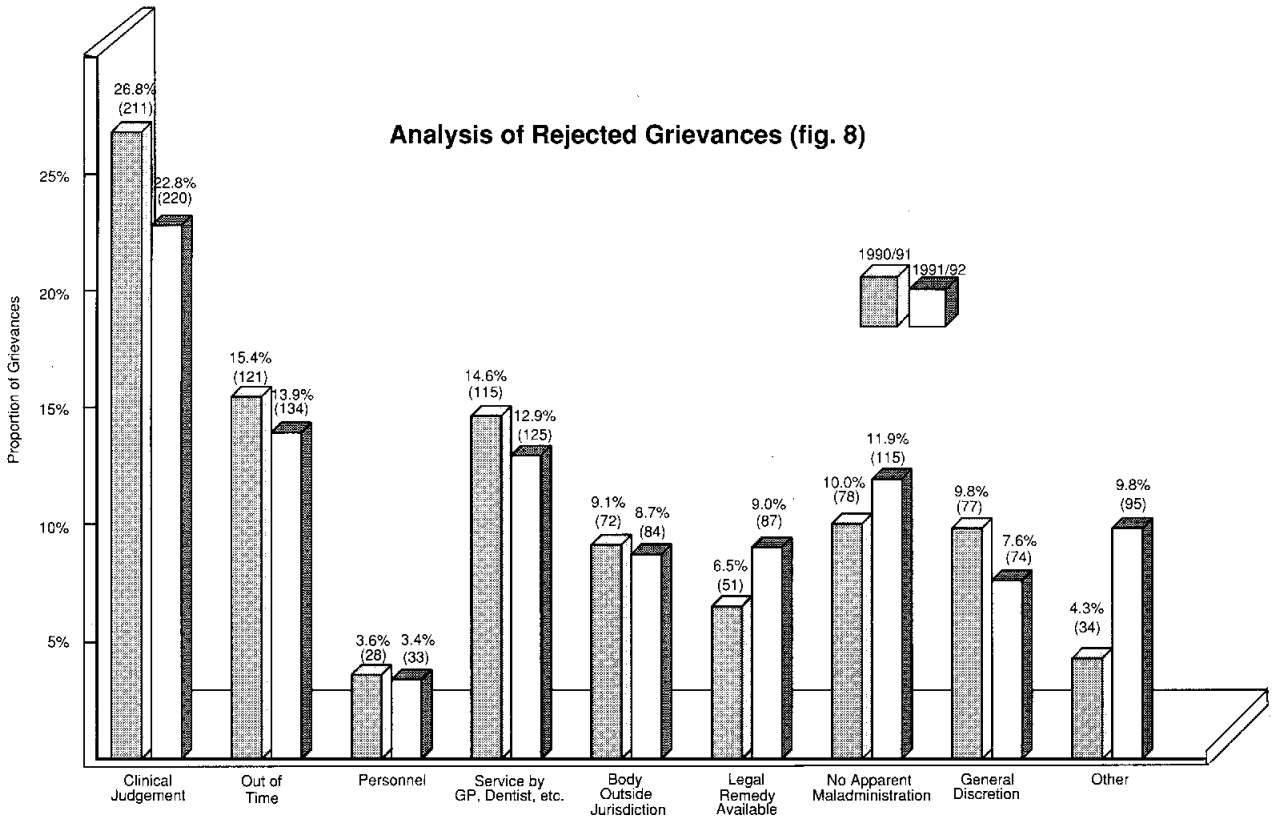
78. During this year I have reviewed the system used for classifying complaints for statistical purposes. I have concluded that the information recorded about the grievances I investigate could be structured differently so as to provide a better understanding of their make-up. The heads of analysis used at present (Appendix C) do not reveal much about the subjects which gave rise to the complaints, the service areas complained about or the health service staff involved. With that in mind I have arranged for a new system of classification to be tried out during 1992-93, and I hope that in my next annual report I shall be able to provide more comprehensive and meaningful information about the complaints I investigate.

Cases rejected or discontinued

79. The 540 rejected and 24 discontinued cases (figure 3) represent 49.4% of all cases concluded during the year. This compares with 43.3% in 1990-91. The previous year's figure was exceptionally low because of the higher than average number of complaints received in 1990-91 which had to be referred back (see paragraph 81). While the year on year increase of some 6% in the proportion of rejected cases moves the figure closer to the general average (about 60%), more complainants are approaching me direct before exhausting their opportunity for redress from the health authority or board. That means that I am not in a position at the outset to say definitively whether or not I can help.

80. I rejected 967 individual grievances, an average of 1.79 per rejected case (compared with 787 and 1.87 respectively in 1990-91). The main reasons for rejection are shown in figure 8, and a full analysis is provided at Appendix F.

Analysis of Rejected Grievances (fig. 8)



Cases referred back

81. Despite the increase in public awareness of my Office, many complainants still do not appreciate that I cannot consider a complaint until the health authority—or other relevant body—concerned has first been given a reasonable opportunity to look into the matter and reply. I also need to see all the background correspondence. So I frequently have to refer a case back to the complainant to take further action. Many do not approach me again: in any case where I have not received a reply within three months I close the files, sometimes after checking with the correspondent. I took this action on 447 complaints during 1991-92 representing 39% of all concluded cases (431 and 43% respectively in 1990-91). I only hope that the individuals concerned have found redress from their approach to the relevant body.

82. While I am always glad to provide guidance to complainants where they approach me prematurely, it continues to trouble me that so many do not write to me again. If, as a result of following my advice, a complainant writes to a health authority and is eventually satisfied without my further intervention that is an entirely satisfactory result. It would be a pity if many complainants feel defeated by the system. A continuing process of publicity and education should help the public to make their complaints more effectively and draw on my services where it is appropriate for them to do so.

Cases carried forward

83. A total of 282 cases was carried forward (compared with 248 brought forward from 1990-91). There were 107 under investigation, 157 had been referred back within the final three months of the year on which no concluding action was taken before 31 March, 7 were being considered actively for investigation, rejection or reference back and 11 awaited attention.

Appendix A

Output and performance targets

* calculated from receipt of investigable complaint (see paragraphs 74-75)

	Actual 1990–91	*Forecast 1991–92*	*Actual 1991–92*	*1992–93*	*Forecast 1993–94*	*1994–95*
Complaints received	990	850	1176	1200	1200	1200
Percentage accepted for investigation	11.9	15	12.8	12.5	12.5	12.5
New investigations begun	118	125	150	150	150	150
Average time taken (weeks) to complete investigation*	58	52	45.1	45	42	39
Percentage of new complaints screened in 18 days	75	—	76	80	85	90
Investigations completed	122	126	124	150	150	150
Length of reports (pages)	19	18	16.6	16	16	16
Staff in post:						
All investigative staff	24	24	24.5	26	26	26
Investigating officers	14	14	14.5	16	16	16
Screening staff	3	3	3	3.5	4	4
Investigations/total investigative staff	5.1	5.3	5.1	5.8	5.8	5.8
Investigations/investigating officers	8.7	9	8.6	9.4	9.4	9.4
Cases screened/staff in post	330	283	392	343	300	300

Summary of workload

Appendix B

England		Scotland		Wales		Totals		
1991/92	1990/91	1991/92	1990/91	1991/92	1990/91	1991/92	1990/91	
221	235	15	21	12	8	248	264	Brought forward from previous year
972	844	125	95	79	51	1176	990	**Add** received in current year
1193	1079	140	116	91	59	1424	1254	Total considered
239	221	19	15	24	12	282	248	**Deduct** carried forward to next year
954	858	121	101	67	47	1142	1006	Concluded
459	363	69	52	36	21	564*	436	Complaints rejected or discontinued
377	367	43	41	27	23	447	431	Complaints 'referred back'
118	128	9	8	4	3	131	139	Results reports issued
954	858	121	101	67	47	1142	1006	Totals
150	164	25	16	16	4	191	184	Written enquiries/advice sought

*This figure includes 24 discontinued cases of which 19 were discontinued at the request of the complainant before a decision was taken on whether or not to investigate.

Upheld-wholly or in part	Not upheld	Sub Total	Total 1991/92	1990/91	
					Nursing
61	72	133			failure in care
25	17	42			lack of or incorrect information
8	14	22			attitudes
–	1	1			maltreatment
94	104		198	169	**Total**
					Medical
17	19	36			lack of or incorrect information
15	13	28			attitudes
10	15	25			failure in non-clinical procedures
42	47		89	108	**Total**
					Administration
5	3	8			policy decisions (manner in which reached)
3	5	8			day-to-day (hospital in-patient)
8	4	12			day-to-day (hospital out-patient)
3	1	4			day-to-day (hospital casualty)
4	—	4			day-to-day (family practitioner services)
1	—	1			day-to-day (community health)
1	—	1			day-to-day (other)
25	13		38	78	**Total**
					Failure in service
6	3	9			ambulance
6	3	9			community
7	4	11			laboratory/technical/house-keeping
2	3	5			paramedical
21	13		34	22	**Totals**
61	22		83	110	**Handling by authority**
243	**199**		**442**	**487**	**Totals**

Number of grievances investigated and upheld, 1982/83 to 1991/92

Appendix D

Number investigated			Number upheld	
Year	Total	No. of grievances per report issued	No	% of (ii)
(i)	(ii)	(iii)	(iv)	(v)
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
1991/92	442	3.37	243	55.00
Totals	4525	3.60	2427	53.63

Analysis of main categories of grievances investigated 1982/83 to 1991/92

Appendix E

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
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%
1991/92	442	198	45%	89	20%	38	8%	34	8%	83	19%
Totals	4525	1736	**38%**	980	**22%**	812	**18%**	257	**6%**	740	**16%**

Analysis of rejected grievances 1991/92

Appendix F

England		Scotland		Wales		Totals		
1991/92	1990/91	1991/92	1990/91	1991/92	1990/91	1991/92	1990/91	
65	61	11	8	8	3	84	72	Body complained of outside jurisdiction
92	90	19	19	14	6	125	115	Complaint against GP, dentist, pharmacist, optician
27	17	4	1	2	1	33	19	Service Committees and Tribunal Regulations
184	178	24	25	12	8	220	211	Clinical judgment
74	46	10	4	3	1	87	51	Legal remedy available
25	21	7	7	1	–	33	28	Personnel matter
108	106	20	8	6	7	134	121	Out of time
1	–	–	–	–	–	1	–	Right of appeal to tribunal
–	–	8	2	–	–	8	2	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
98	72	10	3	7	3	115	78	No prima facie failure/maladministration
7	8	–	–	2	1	9	9	Contractual/commercial transaction
64	66	7	9	3	2	74	77	General discretion
15	3	1	–	–	–	16	3	Complainant not aggrieved or acceptable as complainant
28	1	–	–	–	–	28	1	Complaints from local authority, other public body or nationalised industry
788	669	121	86	58	32	967	787	Totals

Geographical distribution of complaints received for 1991/92† Appendix G

Region of Origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint
Northern	45 (34)	3.8 (3.4)	3,077	68 (91)
Yorkshire	54 (57)	4.6 (5.8)	3,605	67 (63)
Trent	53 (47)	4.5 (4.7)	4,646	88 (99)
East Anglia	40 (36)	3.4 (3.6)	2,014	50 (56)
London and Home Counties:				
North West Thames	119 (82)	10.1 (8.3)	3,488	29 (43)
North East Thames	117 (104)	9.9 (10.6)	3,772	32 (36)
South East Thames	126 (75)	10.7 (7.5)	3,636	29 (48)
South West Thames	64 (73)	5.5 (7.4)	2,960	46 (41)
Wessex	58 (63)	4.9 (6.4)	2,906	50 (46)
Oxford	31 (34)	2.6 (3.4)	2,502	81 (74)
South Western	53 (50)	4.5 (5.1)	3,206	60 (64)
West Midlands	86 (64)	7.4 (6.5)	5,198	60 (81)
Mersey	39 (41)	3.3 (4.1)	2,409	62 (59)
North Western	87 (84)	7.5 (8.5)	3,991	46 (48)
Total for England	972 (844)	82.7 (85.3)	47,410	49 (56)
Scotland	125 (95)	10.6 (9.6)	5,094	41 (54)
Wales	79 (51)	6.7 (5.1)	2,836	36 (56)
Overall Total	1176 (990)	100.0	55,340	47 (56)

† The comparable figures for 1990/91 are shown in parenthesis

Geographical distribution of investigations completed in 1991/92 Appendix H

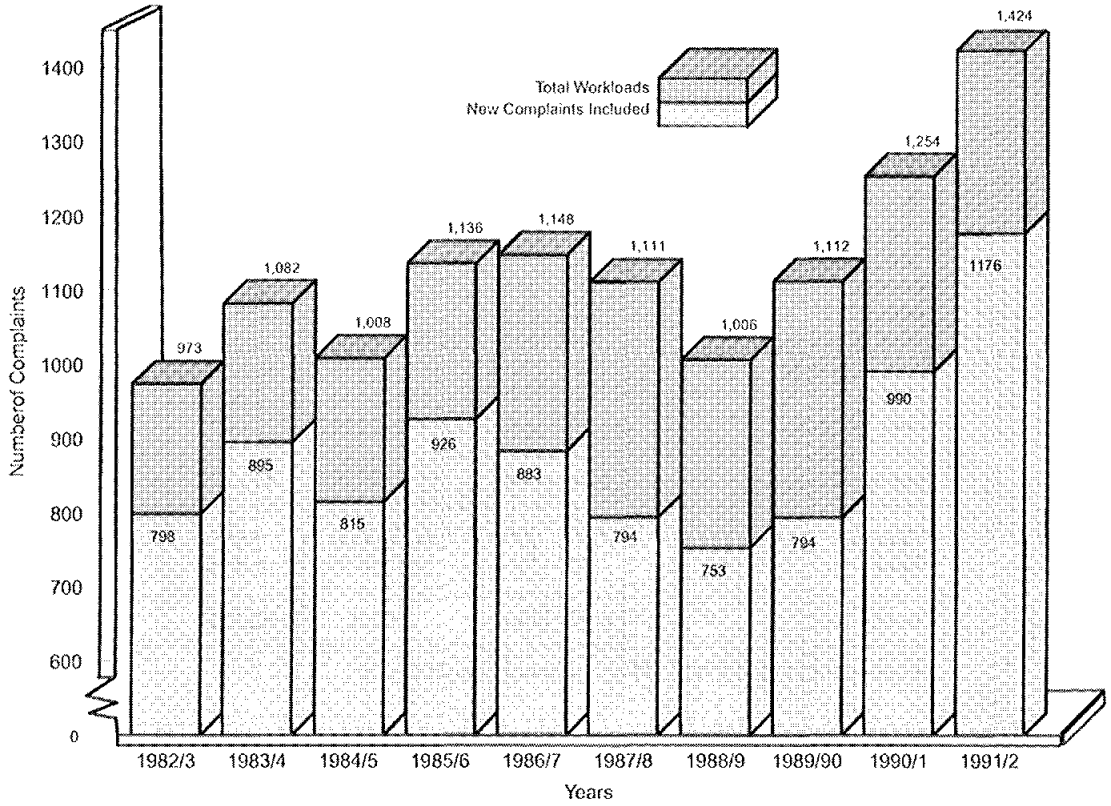
English Regions	Investigations Completed
Northern	3
Yorkshire	10
Trent	8
East Anglia*	7
London and Home Counties:	
North West Thames*	9
North East Thames	16
South East Thames*	12
South West Thames*	10
Wessex*	7
Oxford	1
South Western	9
West Midlands	8
Mersey	7
North Western	7
Total England	111*
Add: Scotland	9
Add: Wales	4
Overall Total	124

Notes: 1.*Three investigations involved two health authorities situated in different regions.

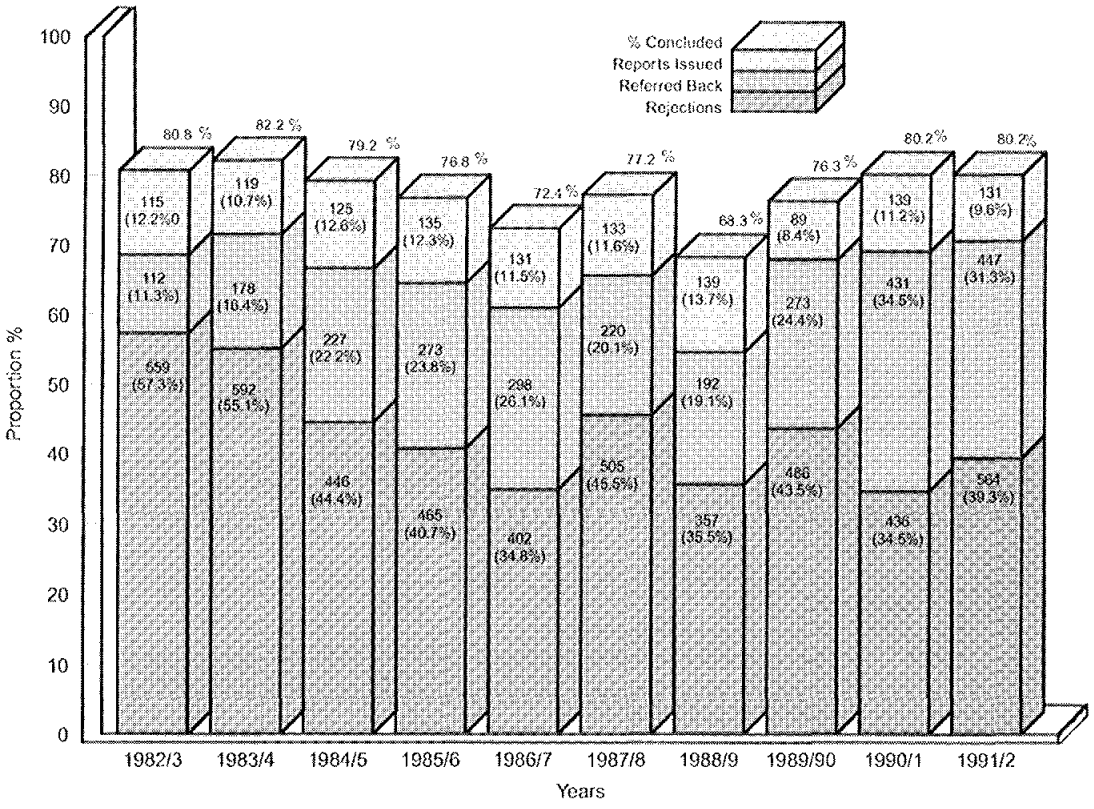
2. 22 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (9) and Cardiff (13).

3. 89 investigations were conducted by the London based Investigation Units: 45 (51%) related to the four Thames Regions, of which 35 (78%) involved health authorities within the Greater London area.

Analysis of Workloads and Disposal 1982-83 to 1991-92



Disposal of Workload concluded within each year



Glossary of acronyms used in this report

A and E	Accident and emergency
AS	Ambulance service
DH	Department of Health
DHA	District health authority
FHSA	Family health services authority
GP	General practitioner
HB	Health board
IPR	Independent professional review
RHA	Regional health authority
RMO	Regional medical officer
SHO	Senior house officer
SWD	Social work department

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