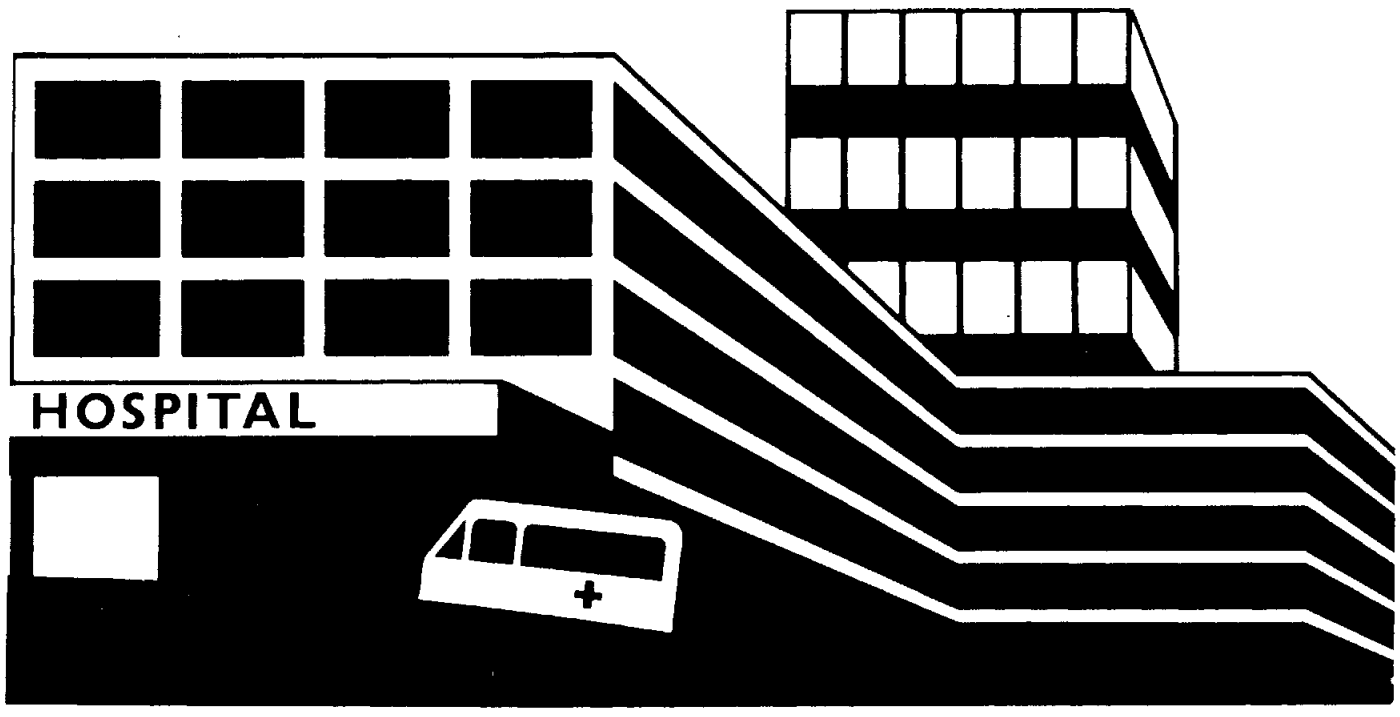
Health Service Commissioner

Annual Report for 1989-90



Health Service Commissioner

Third Report for Session 1989-90

Annual Report for 1989-90

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Introduction

Chapter 1

1. This is my first Annual Report as Health Service Commissioner for England, for Scotland and for Wales. I am following well established practice in submitting a single report for the three Offices. Much of the work on the cases to which I refer was undertaken during the term of office of my predecessor Sir Anthony Barrowclough QC, and many of the investigations were completed before I took up office at the beginning of January; but in using the first person singular I draw no distinction between the actions of my predecessor and my own.

2. I have already given evidence to the Select Committee on the Parliamentary Commissioner for Administration, which also oversees my work as Health Service Commissioner. I am grateful for the concern and interest shown by Members in the work of the Office. That a serious complaint can ultimately be examined in the Palace of Westminster can only promote the aims which Parliament had in mind when creating the Office – which are to provide redress for justified complaints and to contribute to improving the service. Any service which is not open to criticism, or is not prepared to learn when things have gone wrong, is failing in its duty to respond to the needs of its consumers. Sometimes an indifferent or careless local investigation or even the lack of an apology for an obvious mistake are all that is needed to send the complainant along a stressful – and perhaps increasingly exasperating – path to my door. Fear of litigation may at times lie behind defensiveness on the part of a person complained against, but that is quite possibly the last thing that the complainant had in mind when looking for an explanation.

3. I have not felt myself bound by tradition in rearranging this year the chapters in the Annual Report. Although statistics on workload have in the past featured as Chapter 2, and are an important part of the account of my work which I make to Parliament, they can be deferred to a later part of the document in Chapter 5. Of more immediate interest to users of the service, and to staff who provide care or who work in management, are the lessons emerging from the investigations themselves. Medical terms baffle many patients. Mysterious sets of initials can be equally puzzling. I have therefore added, as Appendix I, an explanation of the acronyms used in the text of this report. These changes are part of my commitment to make my Office as approachable and my work as understandable as possible. The Select Committee voiced in the last Session some concern about making the Office, and what it can do, better known to the public. With the same aim in mind, I am revising the general leaflet about the Health Service Commissioner to make it easier to follow and to help people through the procedures involved in making a complaint to me. I am conscious that some may be deterred from making a complaint by what they see as an obstacle course. For that reason I do not favour the straitjacket of a complaints form: while such a form might eliminate some of the procedural difficulties, more would in my view be lost by unduly inhibiting complainants from expressing what they are really concerned about. The length of individual reports can sometimes be a hindrance, and my staff have been set targets to make reports shorter and easier to read but without sacrificing thoroughness in the investigation which I undertake.

4. 1989–90 was an unusual year in that there was a change both of Commissioner and of Deputy Commissioner, Mr Richard Oswald having come to the Office at the end of May last year in succession to Mr Gordon Marsh. Eight of the fourteen investigating officers left, a significantly higher number than normal, because several staff left for maternity leave. These departures took their toll on workload and continuity, but despite this I found a staff with high commitment and morale when I arrived. The abnormal turnover, and the fact that the previous year saw a record number of completed investigations, contributed to an output of only 89 reports on 82 cases for the year. My staff are now working towards a much higher target for 1990–91. Chapter 5 shows that the carryover of cases from last year was lower than before, but the number of new cases accepted for

investigation is – at 99 – still at the relatively low level experienced in 1988–89. Whether the changes which I am making to documentation and the profile of the Office will result in more referrals to me remains to be seen.

5. My predecessor expressed the hope last year that the upward trend in time taken on investigations had been arrested. That hope has been fulfilled, but not as much as I – or the Select Committee which has voiced deep concern about this – would wish to see. The average for cases completed in 1989–90 was 68.9 weeks, compared with 69.4 weeks in 1988–89. As in previous years, some cases took a very long time to complete, eight taking two years or more. (The longest case lasted some 172 weeks – this was a particularly complex and sensitive case involving allegations of child sexual abuse. I was not concerned with the allegation of abuse itself but rather with a complaint about attendant maladministration, and some of the delay arose from the need to await publication of the report of the Butler-Sloss Inquiry.) Some 46 per cent of last year's cases needed to be referred back for one reason or another before I could decide to go ahead with an investigation: that compared with 61 per cent in the previous two years, and the average time per case involved was 8.2 weeks, a reduction of 1.5 weeks since 1988–89. I have decided in future to compute time taken from the date of receipt of a complaint acceptable for investigation, as this is a truer reflection of the time attributable to the Office. To enable comparison to be made across the transition, I shall keep records by both methods for the next year. I do not doubt that, for an anxious or angry complainant, the prospect of a long wait for a report acts as a deterrent. I have set my staff specific targets for a significant reduction in time taken in the current year, and I will make a personal check on progress with each case after six months. The Select Committee can therefore look for a marked improvement by March 1991.

6. Twice a year I submit to the Health Departments' Secretaries of State a volume of the anonymised reports of selected investigations. For 1989–90, these covered the periods April to October and November to March respectively. These volumes are published in order to inform Parliament, to show the public something of my work and to help staff in the Health Service in their aim of improving the service. I know that they are used by the more enlightened trainers of doctors, nurses and administrators as teaching aids. In the year under review, I selected a total of 29 cases for publication – a considerable reduction from the 51 chosen the previous year. There were fewer from which to select, but my main aim has been to reduce the bulk – and cost – of these publications as part of the drive towards more ready access to my work. I also produce brief epitomes of each selected case which are circulated widely across the NHS. I hope that those concerned with management of the service, and training of staff, will look upon the biannual volumes as helpful teaching material and barometers of service quality.

7. In Chapter 2 I have focused attention on seven of the main topics emerging from investigations completed during the year. Several of these are all too familiar. Four cases are concerned with observation and supervision of patients, and in three of these – where the patient died – the added distress must have been hard for the relatives to bear. Inadequate discharge procedures are a recurrent theme and, in March last year, the Department of Health issued guidance to health authorities; I cite two cases involving serious failures in telling relatives – or even fellow professionals – what was intended. Staff directly involved in patient care often bear the brunt of criticism, but fault often lies further up the line in management. I have selected five examples of failures in procedures and management. I have grouped together as a separate category three cases which all involved inappropriate charges for treatment. The Select Committee takes a keen interest in how health authorities deal with complaints, and every year produces a crop of glaring deficiencies – two are quoted in section (v) of Chapter 2. These are followed by two complaints about the clinical complaints procedure; for all that complaints about the procedure occasionally arise, it does provide an opportunity for independent review of concerns about treatment by hospital doctors and dentists. The final section is devoted to two very different complaints about Family Practitioner Committees, soon to be retitled, one of the complaints revealing a disturbing lack of accuracy in information about the number of patients on a doctor's list. Chapter 3 describes, in outline, six very diverse cases which raise topics of special interest. Then, in Chapter 4, I list all the remedies which I secured for complainants during the year.

8. Occasionally I hear suggestions that, because my role is 'very limited', it is often not worth putting a complaint to me. Parliament has indeed set limits to my powers, but the Annual Report and Selected Cases should demonstrate beyond argument that the scope of my jurisdiction is in fact very wide. Anyone who has doubts about whether to complain to me should write in so that I may assess what the complaint is about and let the writer

know if I can help. It is a matter of considerable gratification to my staff when letters of appreciation are received for the work they have done in investigating a complaint. Perhaps I may also record that I do not uphold every complaint and that some of my investigations reveal that on rare occasions devoted staff are the object of complaint from those of 'factious, peevish and perverse spirits'.

9. The Government's changes in the NHS, both current and proposed, are likely to engage the attention of the general public and of staff over the coming years. Any NHS trusts set up under these plans would come under my jurisdiction, and they would also be subject to the Hospital Complaints Procedure Act 1985. I trust that day-to-day patient care, and observance of good practice, will remain in the forefront of managers' endeavours during this period. Clinical audit is one of the practices which should in my view contribute very directly to the quality of service. Peer review is a hard taskmaster, and I welcome its further development as a force for ever improving standards of care.

10. This Report provides me with the opportunity to express appreciation to all those who help me fulfil the task expected of me by Parliament. I greatly appreciated the courtesy of the President of the General Medical Council, Sir Robert Kilpatrick, in inviting me to meet him soon after I took up office in order to give me a better understanding of that Council's work; and I look forward to contact with other professional bodies in the field of health. All those in my Office – whether managerial, investigative or support staff – make a particular and valuable contribution, and I thank them for their hard work and enthusiasm and Sir Anthony Barrowclough for handing over an effective machine to me. When I took office, all my predecessors were alive; and it was a particular sadness that Sir Alan Marre, who held the post of Health Service Commissioner from 1973 to 1976, died in March 1990. The authorities and organisations which I investigate, although required to help me with written and oral evidence, nevertheless do so with courtesy and co-operation. Much advice and help is, I know, given to complainants by Community and Local Health Councils, Citizens Advice Bureaux and other groups in the community, and without their concerned interest my task would be that much more difficult. Finally I pay tribute to the able help given by Mr Richard Lambert, Clerk of the Select Committee, and to the labours of the liaison officers for my Office in the three Health Departments.

(i) Observation and supervision of patients

11. Complaints arising from worries about the level of care provided in hospital – and in particular about how much time staff can devote to observing and supervising individual patients – continue to be one of the more prevalent themes. Relatives may be concerned about care which seems to fall short of what they would expect, or they may not understand – or have been told – what the staff are trying to do. In some cases, I suspect that a complainant may be prompted by adverse publicity or debate in the media about resources. In his report last year my predecessor referred to some cases on this topic, and I have selected four cases which demonstrate different aspects of inadequate supervision.

(a) W.526/88–89 on pages 108–120 of HC 457

12. Ward layout can affect a patient's sense of well-being. A woman was terminally ill in hospital with cancer, and her husband did not think that she should have been left, inadequately attended, in a chair for periods of up to 17 hours. He claimed that she was frightened to use her call bell to obtain help – indeed that she was frequently told not to use it. The woman had, I found, been nursed in a room with two other patients at the extreme end of a very long ward of pavilion design. As is common with chest patients, she was often nursed in a chair. The ward staffing levels were below what they should have been, and this restricted the amount of time nurses could spend with individual patients – and the speed of their response to call bells. I was told that patients were asked to ring their bells once only, and then to wait. Emergency help had to be summoned by ringing the bell three times, and a patient ringing repeatedly for a more routine need could have triggered the full emergency drill.

13. I thought that the woman had probably remained in her chair longer than she wished but I did not find that she had been inadequately attended, or that she had been told not to use her call bell. I concluded that it was the design of the ward and the shortage of staff which had contributed to the woman's anxiety and sense of isolation. All in all, was it surprising that she had qualms about ringing the bell – or indeed was sometimes reluctant to ask if she could return to bed? The difficulties in supervision which I encountered led me to question the suitability of the ward for very ill, dependent patients, and the DHA agreed to review its continued use for that purpose.

(b) SW.59/88–89 on pages 150–160 of HC 457

14. In another case, a severely mentally handicapped young woman was found to have unexplained bruises and minor abrasions when she was collected after two weeks' respite care. Her parents' concern about this turned to annoyance when no-one appeared to know how the injuries had come about. I could not establish precisely how the injuries had occurred – apart from one incident when the woman's knee was bumped – but I found no evidence that her care had been inadequate. Many of the nurses had known her from previous admissions, and they demonstrated concern for her. At the time of admission, the parents had asked that pads – which they provided – be fitted to their daughter's wheelchair. That had not been recorded, and the consequent failure to fit the pads had, in my view, led to some of the bruising. Staff were expected also to examine patients on admission to check, among other things, for injuries, and the nurse concerned had not done so. It seemed extraordinary to me that many of the staff involved in the care of the woman, who was totally dependent, had not been aware of her bruises, and I criticised those staff who had noticed them for not having recorded the injuries or ensured that the parents were told about them. I was pleased to note that the need to follow proper procedures had been firmly brought to the attention of staff by the Health Board following the parents' complaint.

(c) W.12/88–89 on pages 107–141of HC 199

15. One of the most disturbing cases which I investigated revealed an absence of effective monitoring of standards of care, and poor staff discipline, in a hospital. An elderly man was admitted, to a hospital due for closure (it has now closed), for treatment for his severe heart condition. He died within a few days, and that tragically highlighted the cumulative effect of fundamental failures in basic nursing care and professional standards. The curtains had been drawn around his bed, and no one was able to account

for the last half hour or so of his life before he was discovered collapsed on the floor. His son was dissatisfied with the explanation given to him about his father's death.

16. The DHA's documentation was woefully inadequate, but I was far more concerned about the facts revealed by my investigation. Several trained nurses had overlooked basic nursing procedures. Shortcomings in the handover from one shift to another were largely to blame for what had happened on the evening in question. Those finishing work had not told their colleagues coming on duty about the man, and the nurse taking charge had not made a tour of the ward straight after the ward report. These matters illustrated far more profoundly than any training manual why basic nursing procedures were required, and why they need to be respected and vigorously applied. What is more, the evidence persuaded me that these were not just isolated occurrences but had been prevalent for some time, due to a general laxity in standards. How could such a deterioration not have been apparent to senior nursing staff? The causes were, in my opinion, a lack of effective monitoring and a degree of fatalism in the face of the hospital's closure. I severely criticised both the ward staff involved and senior management. The DHA drew up new care and management procedures for the new ward in another hospital, and, just as important, they agreed to ensure that the arrangements for managerial and professional oversight of standards operated effectively there.

17. Finally, under this heading, a woman visited her husband in hospital and found him collapsed – in a darkened room – in a chair beside his bed. Attempts to resuscitate him were sadly unsuccessful. The woman believed that, as her husband would not have sat in the dark – and it had been dark for some time before her arrival, supervision could not have been sufficient. I was unable to establish precisely when the patient had last been seen by nursing staff, but he was one of the first to have been prepared for visiting time. The nurses had then worked their way around the ward but, as they were completing that task, one of the other patients needed a complete change of bedding. That had caused a delay – possibly of about 15 minutes – before the visitors could be allowed on to the ward. The husband had been considered well enough to be out of bed; when last seen, he had offered no complaints and there had been no reason to visit him again on medical grounds. However, given the interruption to the tour of the ward, I considered that it would have been a wise precaution for the nursing staff to carry out, before the visitors were allowed in, a quick check on the patients who had been prepared first. That would at least have spared the woman the shock of finding her husband in the way that she did.

(d) W.424/88–89 on pages 232–239 of HC 199

(ii) Discharge arrangements

18. Pressure on beds means that hospital doctors do not usually want to keep patients in hospital longer than is really necessary and, in general, patients who have adequate facilities and support – whether professional or from carers – are eager to return home. However, hospital staff have to be satisfied that the home environment is suitable for the patient's condition on discharge, that any carers are alerted to the part they may have to play, and that general medical and community support is, where necessary, available. The decision that a patient is well enough to be discharged is clinical and I may not question it, but I can and do investigate complaints about alleged failures in discharge arrangements. In this section I refer to two such cases.

19. In the first case an elderly woman, who lived alone, was discharged from hospital after two weeks following a fall. She was taken home by ambulance and cared for that evening by a neighbour. The neighbour was worried about the woman's condition and contacted the woman's GP. The next day the woman was admitted to another hospital and found to have suffered a stroke. The woman's daughter complained, on the strength of the neighbour's concerns, that her mother had been sent home seriously ill – incoherent, incontinent, and lapsing into a coma – and that no support had been organised.

(e) W.421/88–89 on pages 215–232 of HC 199

20. The decision to discharge the woman had been taken in the exercise of clinical judgment. I concluded, too, that the woman's condition had deteriorated – although it was not clear when – after her discharge. Medical and nursing staff told me that the woman would not have been discharged in the condition alleged by her daughter. Her claim was also disputed by the ambulanceman who took the woman home and by a doctor employed by the GP's deputising service – who saw her on the evening of her discharge.

21. A decision about what should be done is rarely the end of the story. Just as important is a clear plan of action and, as in this case, I often find failures in understanding or communications. The decision about what support the woman needed after discharge had also been a matter of clinical judgment, but those who needed to

know had not been put in the picture. The GP had not been warned of the woman's discharge, and community and home help services had received incorrect information. The nursing discharge form should have recorded details of the arrangements made, but that had been done inadequately. I found, however, that these errors would not have made much difference to what happened after the woman's discharge. The DHA had already decided to review their discharge procedures and they agreed to include instructions on completion of the nursing discharge form. They also apologised to the daughter for the shortcomings I had identified.

(f) W.254/88–89 on pages 188–215 of HC 199

22. Elderly women living alone seem, from the complaints reaching me, to be particularly vulnerable – as in my second case in this section. A woman aged 85 was admitted to hospital following a fall at home. About six weeks later, she visited her home with an occupational therapist and a community liaison nurse (the CLN) for a discharge assessment. The woman's daughter, who was the main carer, was herself convalescing after an operation, so she asked the CLN to delay her mother's discharge until she was well enough to look after her – and she believed that he had agreed to find a bed in a rehabilitation ward. A week or so later the daughter was telephoned by the hospital and told that her mother was on her way home. Her mother was readmitted to hospital the following day with a broken femur after several falls at her home, and she died two weeks later. The daughter complained that her mother had been discharged despite the CLN's agreement that he would find a bed, and that hospital staff had not made adequate discharge arrangements or informed her of the discharge until her mother was already on the way home by ambulance. (She also complained, among other things, that the staff had not given sufficient notice of the discharge to enable her mother to be visited by a district nurse, but I did not uphold that aspect.)

23. The CLN denied that he had promised to find a rehabilitation bed, and there seemed to me to have been a genuine misunderstanding about the arrangements. That would not have happened if he had written to the daughter confirming the outcome of their discussion. I noted with approval that the DHA took steps to ensure that the plan of action arising from home visits was in future recorded, and then confirmed with the patient or carer. But the problems did not end there – the ward staff erred in not following their normal practice of identifying the appropriate relatives and liaising with them about the discharge. I upheld this part of the complaint and criticised all the senior ward staff for not identifying one person as responsible for liaison with the relatives: indeed, they did not seem even to know that they should have done so. Senior management did not escape criticism, as they had not ensured that all ward sisters, at the very least, were aware of the policy, nor had they monitored its application. I was pleased that the DHA subsequently introduced new procedures for discharging patients.

(iii) Procedures and management

24. To do their job properly, health authorities need a wide range of operational procedures – and a system of management for implementing them. They are responsible also for ensuring that the staff know what they are supposed to do. In this section I have put together five cases where necessary procedures did not exist, were inadequate or were not complied with. They involve, respectively, the management of waiting lists, care of the bereaved, patients' property procedures, issue of guidance about a scheme for maternity care and destruction of clinical records.

(f) W.222/88–89 on pages 158–172 of HC 199

25. Delayed operations are a regular feature of complaints to me. I cannot normally look into them, as they involve discretionary local decisions about the use of resources and clinical assessment of priority. That was not so in my next case which concerned – among other things – the management of an orthopaedic waiting list. A man's name was added to a waiting list for an operation to have a bolt inserted in his hip, and he understood that he would be admitted within a few months. He was next seen more than a year later and told that early surgery would be required because of a deterioration. Another 13 months passed, when he learned that a joint replacement operation would be necessary because of yet further worsening of his condition. Furthermore, on arriving eventually for admission, he was told that operations of the type he had been advised to undergo were not carried out at the hospital, but he underwent urgent surgery there on the following day.

26. I accepted that the consultant's initial decision that the man needed routine admission for surgery had been taken solely in the exercise of clinical judgment. However, the consultant should not have allowed the man to leave with the erroneous belief that surgery would take place quite soon. The registrar who next saw the man, and

decided that early surgery was needed, had then done nothing about it. I also found that another registrar – who had recommended an operation of a type not carried out at the hospital – had worked there for a short time only when he saw the man. When the man finally came to the hospital for admission, he had been faced with the difficult choice between an immediate operation at that hospital, or an operation – of the type recommended by the second of the registrars – at another hospital some time later. That seemed to me wholly unacceptable, and I upheld the complaint about that.

27. I regarded management of the waiting list in question as unsatisfactory. Medical staff had only limited involvement in selecting patients for admission. This ran contrary to DOH guidance on the management and review of waiting lists – and indeed to what I think patients would expect. I criticised the lack of clinical guidance for the administrative staff, who drew up admission and operating lists.

28. I referred in the previous section to a case about discharge arrangements for an elderly woman who died soon after she was readmitted to hospital. What happened then to the family can only have added to their distress. On the day of the woman's death, her family were escorted by a nurse to the porters' lodge to collect the mortuary keys. A porter then took them to the mortuary chapel. The woman's daughter thought the journey to the lodge unnecessary, and I agreed with her. To expect a shocked and grieving family to walk such a distance, when that was entirely unnecessary, demonstrated a surprising lack of sensitivity. Bereaved relatives should not have had to traipse around the hospital for the keys or be accompanied to the chapel only by a porter. The arrangement appeared to have arisen from custom and practice, with no basis in logic. I upheld the complaint but was pleased that the DHA introduced a new procedure to prevent such an occurrence in the future. The daughter also felt that the porter – a woman – had been insensitive to the family's plight. Although she had clearly been unequal to the situation, I did not find her to have been deliberately rude or tactless. The DHA reminded porters that care should be taken to support and comfort bereaved relatives but, in any event, their new procedure provided for nurses to escort families to the mortuary. That seemed to me to be much more appropriate.

(g) W.254/88–89 on page 188–215 of HC 199

29. I investigated a case where the DHA failed to safeguard a short stay patient's property. At the time of admission it was not known whether the complainant would have to stay overnight, as that depended on how she was after her operation. She therefore kept the suitcase with her. She was told to put it behind her locker, which was the normal practice on the ward. The following day she found that her suitcase was under her bed – which had been lowered on to it, perforating the lid. How the suitcase had come to be there I could not discover, but it was not disputed that the damage had been caused, albeit inadvertently, by a member of staff.

(h) W.480/88–89 on pages 84–94 of HC457

30. The DHA said they were not responsible for any loss or damage unless the property was handed in for safe keeping, and they refused the woman's claim on these grounds. I could not accept that. I considered that the ward staff had a general duty of reasonable care for property which patients were permitted to retain on the ward. Beyond that, the DHA's procedure left much to be desired. The woman's claim had been supported by unit management but refused by senior DHA officers – and yet no attempt had apparently been made to resolve matters through discussion. The officers concerned instead resorted to a prolonged exchange of letters and memoranda. Two years previously the DHA had issued general procedures for dealing with patients' property, asking units to produce operational guidance for ward and other staff. I was concerned that none had been prepared for the ward in question, even though the particular difficulties of a short-stay ward had been recognised. I was pleased to record that at the time of my investigation – and not before time – action was being taken in this respect and, on my recommendation, the DHA agreed to compensate the complainant for the damage that had been caused.

31. Under the 'domino' maternity scheme, a woman who might otherwise rather have a home confinement can have her baby in hospital, staying under the care of the community midwife who provided the ante-natal care. The mother would then normally return home after only a short stay, and there would be little – if any – medical involvement in the labour. In a case which I reported on last year, the scheme had developed locally through evolution as patients requested it. No one had apparently thought to prepare formal guidance for all those staff who might be involved in it.

(i) SW.48/88–89 on pages 143–150 of HC 457

32. A woman complained that the Health Board concerned had introduced the 'domino' scheme without ensuring that there were adequate procedures for abnormal deliveries.

She felt there had been uncertainty about who was responsible for her and, when problems arose, a doctor had been reluctant to become involved. Not surprisingly, that had shaken her confidence in what was going on, and she did not think that medical staff clearly understood their responsibilities in such circumstances. I found that there were some guidance notes, but they appeared to have been intended only for the midwives. The midwives understood their role within the scheme but the doctor involved, who had never received any formal guidance, did not. Although I did not consider that had caused any delays or significant difficulties, doubt and uncertainty would have been apparent to her at a time when she most needed trust in those looking after her. I was glad to note that, following her complaint, a draft protocol was quickly produced. The Health Board agreed to ensure that all medical staff likely to be involved in the scheme were aware of their role.

(j) W.473/87–88 on pages 11–21 of HC 457

33. The final case I have selected under this heading is about the destruction of medical records. The problem revolved around a lack of storage space for accumulated records – a phenomenon which many hospital managers will recognise. A woman whose daughter had been born with severe disabilities complained that a DHA had destroyed her obstetric records, and her daughter's paediatric records, several years before expiry of the minimum period recommended in DOH guidance. That had made it impossible for her to discover if she had grounds for taking proceedings against the DHA for negligence. I established that these records with others had been destroyed, in the full knowledge that this was contrary to DOH guidance, to overcome hospital storage problems at the time. The minimum retention periods proposed in the guidance were advisory, but that did not in my view provide exoneration for the DHA's actions. It seemed to me that the character of the advice was such that they would have been justified in departing from it only after consideration at the highest level, and for quite exceptional reasons. I was not satisfied that the DHA had sufficiently pursued alternative means of storage or thought enough about the legal implications of what they were intending to do. Having seen no evidence to persuade me that the DHA were justified in their departure from DOH guidance, I upheld the complaint.

(iv) Charges for treatment

34. Sometimes patients write to me alleging that they have had to pay for private care out of anxiety after a long time on a NHS waiting list. Many such cases I cannot, for one reason or another, investigate. In this section, however, I refer to three cases where, in response to my recommendations, the DHAs concerned agreed to reimburse the complainants for charges for treatment. In two cases the charges had been made because the patients were considered ineligible for NHS treatment. The third involved the relatives of a severely ill patient who had opted for private treatment in the mistaken belief that NHS treatment would not be available in time.

(k) W.416/87–88 on pages 26–36 of HC 199

35. In the first case a man returned to the UK after an absence of several years and sought treatment for a condition diagnosed and treated while he was overseas. He agreed to pay a deposit covering the cost of his follow-up treatment and thought it would be repaid when he produced evidence showing that he was going to reside permanently in the UK. However, the hospital decided to refund only part of the deposit, keeping most of it to cover treatment provided before the evidence was produced. The man contended that he was entitled to receive free NHS treatment and that the full amount of the deposit should have been refunded.

36. I found that administrative staff at the hospital had regarded the man as a private patient up to the time of his transfer to NHS status, but that he had initially been interviewed – albeit imprecisely – under procedures for dealing with overseas visitors. The man should have been charged, if at all, as a paying NHS patient. However, I was satisfied that he had returned to take up permanent residence in the UK, and that he should have been immediately and wholly exempt from charges. Staff at the hospital had failed at the initial interview to establish the man's intentions, and I criticised them for not following precisely the DOH guidance – which spells things out in some detail – on charges for overseas visitors. The authority apologised for the hardship they had caused and agreed to take steps to ensure that in future their staff followed proper procedures. They also refunded in full the deposit which the man had paid at the outset.

(l) WW.37/88–89 on pages 161–174 of HC 457

37. The overseas visitors procedure also arose in a complaint from Wales, where staff in the DHA concerned only rarely encountered such cases. A South American woman, who could not speak English, was visiting her daughter in the UK for a six month holiday. She was admitted to hospital as an emergency and treated for conditions suspected to be

infective; the tests proved negative. During her mother's ten day stay, the daughter was led to believe that treatment would be provided free under the NHS. On the day of discharge she was told that she might after all have to pay for the treatment, and the DHA subsequently sent her a bill and later began legal proceedings to recover the debt.

38. A series of procedural errors – perhaps stemming from lack of familiarity – was brought to light by my investigation. The officer responsible for establishing liability under the overseas visitors regulations had not been told about the woman's admission until the day of discharge. That was because nursing staff had been unaware that they should have done so. They had thought that the medical records staff normally identified such patients from the routine daily returns. The consultant in charge of the woman's case had also never been approached. Had proper procedures been followed, the woman's treatment – which involved a potential communicable disease – would in my view almost certainly have been regarded as exempt from charges. When interviewed on the day of discharge, the woman's daughter had not been told for certain that her mother was liable to pay charges nor had she been given details of the probable amount. Her reaction on receiving a substantial bill can readily be imagined. I also criticised the DHA's handling of subsequent enquiries, when the treasurer said that he had a statutory duty to collect the charge. He had relied – understandably – on information given to him, but which I found to be inaccurate. In my view the procedural failures threw doubt on whether the DHA could be satisfied that the liability to pay had been established. The DHA agreed to improve their procedures for dealing with charges for overseas visitors and I was pleased that they agreed also to waive the charges for the woman's treatment.

39. Poor communications can result in distress or misunderstanding – or, as in the final case in this section, in considerable expense. A man with severe chest pains was admitted to hospital, and he was found to need urgent coronary angiography (an x-ray examination of blood vessels) with a view to by-pass surgery. These services were not available at the hospital, and the man was told that he would very shortly be transferred to a second hospital. Three days later the transfer had still not taken place, and a consultant cardiologist (the consultant) advised the family that the man's condition was too unstable to risk further delay in treatment. The man was therefore transferred to a private clinic, where angiography and by-pass surgery were carried out the following day. The family later complained to me that the NHS had failed to provide the treatment required.

(m) W.533/87–88 on pages 36–51 of HC 199

40. The irony of the situation was that, if the family had not decided on private care, the man would almost certainly have been transferred to the second hospital on the same day as his transfer to the private clinic. What is more, the consultant had not obtained first hand and up to date information – from the only doctor who had been directly involved in the man's care during that admission – before speaking to the family. I concluded that, if he had taken the trouble to find out, he would have received a reasonably reassuring picture of the man's condition. He would also have learned that a bed was expected to become available that day. In these circumstances his advice to the family would almost certainly have been different, and they would probably not have opted for private treatment. On my recommendation, the DHA reimbursed the family for the expenditure incurred, and I was pleased to learn later that they had added a sum representing interest on the not insignificant amount involved.

(v) Handling of complaints

41. The hallmark of a service which cares for its consumers is an open complaints system which provides courteous, critical and thorough investigation of grievances. During the year 57 grievances were investigated about alleged maladministration by health authorities in the way they handled complaints. Most were upheld, and I include two cases demonstrating unacceptable delays by health authorities in responding to complaints.

42. Serious maladministration, with a whole series of delays and administrative errors, came to light in my investigation of a Welsh case. An elderly man was discharged from hospital and died soon afterwards. His son wrote to the CHC expressing his concern at the circumstances of his father's discharge, and the CHC agreed to ask the DHA about this. The son sent two reminders to the CHC – after eight months and then after a further five months. The UGM subsequently wrote to the son saying that he could not trace the earlier correspondence from the CHC and that he could not give answers because the father's medical records were missing. He wrote again, a few weeks later, saying that he had found the correspondence from the CHC but not the medical records. The son

(n) WW.20/88–89 on pages 239–251 of HC 199

complained that the DHA's handling of his complaint had been careless, evasive and unacceptably laggard.

43. I thought the son remarkably patient. An officer at the hospital had acknowledged the CHC's first letter, but had not recorded its receipt as a complaint on the pretext that the son's letter had not been enclosed. He had failed again to record the correspondence received some nine months later. The UGM was the designated officer responsible for handling complaints, but even he – when he became aware of the complaint – did not write to the son for a further seven weeks. I found him to blame for the failures at the outset, as the initial acknowledgement to the CHC had been sent apparently over his signature – but in fact without his knowledge. Had the letter from the CHC been recorded initially as a complaint, prompt action at the time might have led to retrieval of the medical records. That would have enabled the DHA to make a full response. Not only were there failures in operating the DHA's procedures for handling complaints – which meant that correspondence was mislaid and not followed up – but the established procedure for dealing with medical records on the discharge of a patient was disregarded. The DHA's handling of the complaint had lacked the care which the son was entitled to expect – and had indeed been far too slow. I accepted that the DHA had not been deliberately evasive, but I could understand how the son saw their actions in that light. The DHA undertook a review of their handling of the son's complaint, and they produced a 13 page report with recommendations for improving the handling of all complaints. They also apologised unreservedly to the complainant, and agreed to do all they could to satisfy his concerns about the circumstances of his father's discharge.

44. I strongly criticise the practice, revealed in this case, whereby an officer – perhaps not unreasonably – delegates responsibility to a subordinate but permits resulting letters to be sent in his name. That in my opinion is not effective delegation and it deceives the recipient of correspondence.

(o) W.92/88–89 on pages 21–31 of HC 457

45. The next case involved a DHA which had already been criticised in an earlier investigation. A man wrote to me about the attitude of a nursing sister – a complaint which after investigation I rejected – and about the delayed response to his letter of complaint to the hospital. Having received two replies he remained dissatisfied and wrote to them for a third time. Five months later, when he wrote to me, he was still waiting for a reply to that letter. I found that his letter had been misplaced for a month within the hospital. Seven weeks had then been taken by a consultant to give comments, following which another consultant had been asked for his comments – delaying the response by another four weeks. A reply to the complainant had then been drafted, approved but for some reason not immediately sent. The reply was finally posted some six and a half months after receipt of the man's third letter.

46. The hospital was undergoing management restructuring and the complaints workload was high. A sound monitoring system would have helped in such a situation to keep track of complaints – but there was no effective arrangement in place. I said that senior management should have remedied a situation in which individual complaints were not given the prompt attention they required – a predicament I knew to be long standing. My predecessor had investigated a similar case of delays in handling complaints at the hospital and had been told that a revised complaints procedure was soon to be issued. However, I was appalled to find during my investigation that nothing had happened. Indeed, at the time of issue of my report – a year after my predecessor's, that was still the case, and the delays criticised by my predecessor were continuing. I looked to the DHA to take urgent action to remedy the situation. Whatever – and however considerable – the turbulence caused by management restructuring, I do not regard that as an excuse for providing a less than satisfactory service to the consumer.

(vi) Clinical complaints procedure

47. Under the clinical complaints procedure, complaints about care or treatment arising from the exercise of clinical judgment by hospital doctors or dentists can be referred to the Regional Medical Officer (the RMO) – or, in Scotland, the Chief Administrative Medical Officer of the Health Board concerned and, in Wales, the Medical Officer (Complaints) based at the Welsh Office – who will decide whether or not to arrange an independent professional review (IPR) by two independent consultants. That procedure, established in 1981, has provided patients or relatives with an avenue for examination of their concerns about clinical care, which did not previously exist. I am glad to be able to suggest that complainants can, if they have not already done so, pursue in that way clinical matters which I have to turn away. However, complaints about the

administration of that procedure have been a regular feature of my predecessors' reports since the procedure was introduced. The two cases I have selected in this category illustrate two distinct aspects. The first involved refusal by a RMO to arrange an IPR, and the second maladministration by a RHA following the issue of the results of an IPR.

48. The first case, from a woman who had undergone an operation to remove both breasts, concerned an RMO's refusal to invoke the IPR procedure. Before her operation she made clear that she did not wish later to have reconstructive surgery, but afterwards she found excess skin and tissue at the operation site. This caused her discomfort, and it prevented the fitting of breast prostheses. She was told later that the swelling was natural and, later still, that the excess had been left in case she changed her mind about reconstructive surgery. The woman was most dissatisfied with her treatment, and she had plastic surgery for removal of the excess skin. Before doing so she requested an IPR, expecting that she would undergo a clinical examination. She also thought that the RMO would seek information, which she had available, before a decision was made. She complained that, in accepting what the surgeon said about her wishes having been respected, the RMO had substituted his judgment for that of independent assessors.

(p) W.544/88–89 on pages 120–129 of HC 457

49. It was not for the RMO, or his staff, to carry out a clinical examination – he had to make an administrative decision, and not one based on clinical judgment. I found that the RMO had refused the IPR because in his view the clinical facts were not sufficiently grave to place before independent assessors: there was no argument that excess skin and tissue had been left, and the consultant surgeon had assured him that the woman's expressed desire not to have reconstructive surgery had been honoured – and indeed acted upon. I believed that independent assessors could, by reviewing the actions of the surgical staff, have assisted in the decision on whether the treatment the woman had received met acceptable standards, given her wishes on reconstruction. The health circular giving guidance on the clinical complaints procedure makes clear that it is designed to address complaints which are of a 'substantial nature'. It is not for me to substitute my judgment for that of the RMO, but in my view the guidance went wider than the basis on which the RMO made his decision. The RHA agreed to apologise.

50. In the next case an IPR was carried out, but the man who had requested it was dissatisfied with what he was told about the outcome. He sought further information from the regional specialist in community medicine (the SCM), who dealt with clinical complaints for the RMO. The man was unhappy with the SCM's reply and, on writing again, was told that the matter had been referred to the RMO who would answer in due course. The man complained to me that the RMO had not done so within a reasonable period. The RMO agreed that the SCM's letters had been brief, and they were at odds with what he felt should be said to a complainant after an IPR. I concluded that the RMO had not given sufficient guidance to the SCM in that respect. The SCM had retired shortly after passing the man's case to the RMO, and a clinical complaints adviser (the CCA) had been appointed a few months later. The CCA, however, had been asked to deal only with new cases and the RMO, who already had a heavy workload, retained the cases left by the SCM. I criticised that decision, as it led to a further long delay before the man received the information he wanted, and I upheld the complaint. The RHA apologised for the delay and agreed to introduce systematic monitoring of clinical complaints so as to keep delays to the minimum. They also agreed that the RMO would review his policy of holding cases left by the SCM, and that steps would be taken to ensure that appropriate information about the results of an IPR was given to a complainant.

(q) W.44/89–90 on pages 136–143 of HC 457

51. Under the 1981 procedure, it is for the DHA – against which the original complaint was made – to write to the complainant, taking the RMO's advice in respect of comment on clinical matters. I therefore criticised the RMO's practice of writing direct to a complainant about the results of an IPR. I know, from other investigations, that the RMO in this case is not the only one to write direct rather than advise the DHA on an appropriate response. In investigating a complaint put to me, I take account of any official guidance. I question any departure – however persuasive the reasons for doing so – from a procedure which, in the case of IPRs, was negotiated on a national basis. The RMO agreed to review, after any necessary consultation with the DOH, his practice of writing direct to a complainant with the results of an IPR.

(vii) Family practitioner committees

52. I cannot look into complaints about services provided by family doctors, dentists, opticians or pharmacists, nor can I investigate a FPC's handling of such complaints under what is known as the 'formal procedure'. This is not to say, however, that FPCs

escape my jurisdiction, and for the final section of this chapter I have chosen two complaints alleging maladministration by FPCs. The first concerns a FPC's actions following a woman's application to receive dispensing services from her GP, and the other a GP who alleged that maladministration by a FPC had caused him financial loss.

(r) W.504/88–89 on pages 94–108 of HC 457

53. A FPC changed an area's classification from rural to urban, and that meant that, generally, patients living there would no longer receive dispensing services from their GP. However, the FPC had the authority to decide to allow the service to continue in cases of 'serious difficulty'. A woman applied on these grounds, but her application was rejected. She complained to me about the handling of her application and subsequent appeal.

54. The woman had enjoyed the service on moving into the area, but she was not officially entitled to receive it. She was not therefore told in advance of the change by the FPC. However, she approached them herself, and was, I found, able to prepare an adequate application. However, the FPC's procedure for processing the applications resulted in her not being informed of the outcome until after dispensing services had been withdrawn. I criticised that and I also questioned other aspects of the FPC's procedure – in particular the use of a panel of three members to deal with matters of this sort not at a meeting but through correspondence. The 'decision' reflected the balance of opinions received; but that in my view hardly constituted a corporate decision. The FPC referred to their informal procedure for reviewing application decisions as an 'appeal' procedure, and I found that misleading. However, it did not seem to me to have affected the woman's preparation of her case. The FPC apologised to the woman for the shortcomings I had identified and agreed to re-examine their procedures for considering applications and to look again at her case.

(s) W.552/87–88 on pages 51–89 of HC 199

55. The final case in this chapter concerns the filling of a GP vacancy and the information provided by the FPC concerned. A GP was appointed to the vacancy of a single-handed practice, and he complained to me that, because of failures by the appointing FPC, his income had been and would continue to be less than he was entitled to expect. He said that the FPC had not done enough to establish the true number of patients on the practice list; had failed to take account of his interests when they appointed a locum GP to cover the practice before he took up the vacancy; and had sent misleading correspondence to patients, encouraging them to transfer to other doctors.

56. The FPC had given the GP the correct number of patients on the practice list according to their records. However, I found – to my surprise – that there was no requirement, nor was it normal practice, for FPCs to ensure that lists accurately reflected the true number of patients receiving general medical services from particular doctors. I established that the practice list had included 490 'ghost' patients, considerably more than what I was told to be 'normal'. The FPC had known that the list had not been purged for 30 years. As can hardly be wondered, the list included patients whose whereabouts were unknown, and the FPC had not shared this intelligence with the GP. I found, too, that the locum GP had at that time been about to start up her own practice a quarter of a mile from that of the GP's proposed surgery. I shared the GP's concern about this and concluded that, in making the locum appointment, the FPC had not taken account of the likely effect on the GP's practice. Finally, the standard letter used by the FPC to tell patients about the GP's appointment had not been changed to reflect the Regulations, revised in 1985, which were intended to reduce the degree of encouragement to patients to change to another practice. I concluded that, although the FPC could manifestly not be held to account for the fact of the 'lost' patients – and, thereby, a reduced income, they were substantially at fault in not having provided the GP with information about matters which would have enabled him to avoid a situation in which he was bound to incur losses. Accordingly, I recommended that an appropriate *ex gratia* compensatory payment should be made, and the FPC agreed to pay it on the basis which my report advocated.

57. Every case is different, but some raise matters of such a distinct nature, or throw light on something potentially of such general concern, that they merit special mention. By highlighting some of the problems which can arise, my purpose is to promote a better service for future patients who look to the NHS for health care. By no means always do I find the staff at fault. Some patients have unrealistic expectations of what the NHS can provide, and I may commend the staff for their handling of a complainant who has acted unreasonably. In such cases, or where I come across vindictiveness, I have to satisfy myself that this is not part of the grieving process.

58. Fluoridation of water supplies can excite emotions. I have turned away some complaints about this – and similarly about hospital closures – because I cannot intervene in the issue or judge the merits of the case. What I can consider is a complaint about the decision-making process if there seems on the face of things to have been maladministration. In a case which I considered last year, a DHA had decided to apply for the addition of fluoride to the water supply in their area and, in accordance with the Water (Fluoridation) Act 1985 (the Act), consulted the public. In the process, they distributed a leaflet explaining the benefits of fluoridation and incorporating a pre-paid postcard in support, which the public were invited to sign and return. A woman complained that the leaflet presented only one side of the fluoridation argument. She felt that it was designed to manufacture support for the DHA's proposals under the guise of consultation.

(t) W.365/88–89 on pages 78–84 of HC 457

59. The complainant's objections, it seemed to me, really went wider than her criticism of the leaflet and return postcard. She saw the whole consultation process as flawed and believed the DHA had used it to promote fluoridation. However, there was nothing in the Act or DOH guidance to suggest that the DHA should not have done that. Would it have been unrealistic to expect otherwise of them? I decided not – having decided to apply for fluoridation, they had presumably seen merit in it. I doubted the wisdom of using the pre-paid return postcard, but I found it reasonable for the DHA, in setting out the advantages of fluoridation, not to have drawn attention to contrary arguments for which they saw no validity. I did not uphold the complaint.

60. I investigated two cases involving complaints about the care of a body after death. This is a difficult time for relatives and needs handling with great sensitivity. In the first case, a patient had died in intensive care. The patient's wife complained that, when her husband's body was collected by the undertaker, it was badly decomposed. My investigation revealed that the body had deteriorated because an old refrigerator, with a history of unreliability, was not working properly. I found inadequate day-to-day responsibility for the mortuary plant, insufficient measures having been taken to monitor the refrigerator's efficiency. As a result of my investigation the DHA apologised to the complainant for the shortcomings I identified, and they immediately implemented routine monitoring of the temperature of the refrigerators.

(u) W.241/88–89 on pages 172–188 of HC 199

61. In the second case, a man complained that the body of a relative, who had died in hospital during a bank holiday period, had deteriorated because it was not kept in a refrigerator, nor was it released to an undertaker who had such facilities. The body could not, however, have been released to the undertaker without a disposal certificate from the Registrar of Births, Marriages and Deaths – and that could not be obtained because of the holiday closure. I was dismayed to find that this situation, and the number of deaths in the hospital during the holiday, had resulted in as many as 12 bodies being kept on the mortuary floor. I was told that that had occurred several times before. To try and cope with this, the DHA had relied on the mortuary technicians, who were extremely conscientious, attending voluntarily to limit deterioration by putting the bodies in turn into the refrigerator. I regarded that as going well beyond what should have been tolerated. In line with my recommendation, the DHA agreed to prepare more appropriate contingency plans for dealing with any future shortage of refrigerator capacity at the mortuary.

(v) W.34/89–90 on pages 129–136 of HC 457

(w) W.648/87–88 on pages 80–91 of HC 199

62. In another case I concluded that a DHA's community midwives had copied very well with a difficult situation, yet received only criticism from the patient in return. A woman thought undue pressure had been exerted on her to have a hospital confinement. She was also aggrieved about inadequate ante and post-natal care and complained that midwives had brought a police escort to her home – and that she had been falsely accused of having previously assaulted a midwife. I did not uphold any part of this complaint.

63. There was no doubt that, particularly when her baby was in a breech position, the woman had been advised to go into hospital. I found no evidence that undue pressure had been put on her or that her care had been inadequate – the midwives could indeed have been criticised had they not expressed their opinion about a potentially complicated delivery. The woman seemed to have been prepared to believe that anyone who gave advice which was not to her liking was trying to put pressure on her, and her refusal to attend ante-natal clinics had not helped the situation. As if that was not complicated enough, there were conflicting messages from the woman and her partner as to whether or not they wanted midwives to visit. I considered the woman's expectations about ante-natal care both unrealistic and unreasonable, but despite her unco-operative attitude the midwives had provided adequate care. I found well documented evidence of an earlier incident when the woman had assaulted a midwife, although she steadfastly denied this. The woman also suggested that there might be difficulties if certain midwives had to attend her and that she no longer wished midwives to visit. Under the circumstances, I did not think it unreasonable for the midwives to have sought police help so that they could carry out their responsibilities competently and safely.

(x) W.523/87–88 (Unpublished)

64. One case I decided not to publish simply because of its length. It concerned a woman who complained that she had not been adequately consulted about the transfer of her elderly confused mother from a hospital ward to a new residential unit, managed by the DHA. She also thought that poor conditions in the home had come about because of inadequate planning for the move. I found that nurses on the ward had not given her sufficient advice about the move, nor had they told her in advance when it would take place. The evidence clearly showed that conditions in the home immediately after the move had been extremely unsatisfactory. I doubted whether, if there had been a fire or other emergency, the home could have been evacuated safely. The DHA should not in my view have allowed the move to take place before seeing that the building was safe to occupy, or that there were proper standards of food hygiene. I also found evidence of inadequacies in catering, laundry, cleaning and supplies services. The philosophy of care for the home was very different from that on the ward before the move. Was it not therefore essential for the staff concerned to have had the clearest possible understanding of their roles? That they did not was primarily the fault not of the staff who were working in the home immediately after its opening, but rather of the senior management. Those responsible for planning the home had not sufficiently considered the matters later brought to me for investigation. No officer had been identified as being in overall charge of the operation or having the authority to take the difficult decision to postpone the transfer. The DHA apologised for the shortcomings I identified; I was pleased to see that they had the clear intention of approaching any similar project in a co-ordinated and organised manner.

(y) W.141/88–89 on pages 31–41 of HC 457

65. National policy is to move mentally handicapped people from hospital to homes in the community. This can sometimes cause controversy, generally at the expense of those who have just moved into an exciting new environment only to encounter hostility – although that is by no means always the case. My predecessor, in his Annual Report for 1987–88, referred to several cases about this. In a further case which I investigated, the neighbours of a house bought by a DHA as a home for mentally handicapped children complained that they had not been consulted before the house was purchased. The neighbours thought the house unsuitable for that purpose. A senior nurse, who knew the children well, had visited the house and provided advice to the DHA about its suitability. I accepted that the DHA's decision to purchase the house had been made in the full knowledge of the facts, and I saw no cause for criticism in that respect.

66. Like my predecessor, I do not see a DHA as having an obligation to approach the neighbours of a property which they only have in mind to purchase. However, in this case the DHA's practice, when planning permission was not required, was to meet local councillors and residents to discuss any worries or queries they might have after the purchase had been completed. The objective underlying the policy of transfer from a

hospital environment is to integrate mentally handicapped people into the local community. That can hardly have been helped by the belated discussion which I found in this case – it was more likely to generate suspicion. I thought that discussion with the neighbours should have taken place as soon as possible after the DHA's offer to purchase had been accepted. The DHA agreed to review their policy about the timing of approaches to neighbours when purchasing properties.

67. A wrong cannot always be put right, but the promise of action to ensure that the same will not befall other patients provides some comfort. This is why, where I uphold a complaint, an essential ingredient of my report is a remedy for the person aggrieved. In 72 cases in 1989–90 I thought the health authority should apologise, and I conveyed their apologies through my report. Sometimes an apology is all that is required, though even that is not always readily forthcoming. Very often, as was the case in the year just passed, an apology is coupled with a remedy designed to eradicate the cause of the failure. A health authority will occasionally itself have recognised the fault and put matters right before I complete my investigation – and I commend that. Conversely, but very rarely, there is resistance to a remedy and this has to be drawn to the attention of the Select Committee, for whose support successive Commissioners are deeply indebted. I note that, without recourse to the Select Committee, my recommendations were agreed in every investigation completed in 1989–90.

68. 'I think I am entitled to compensation for what went wrong'. If this is what a complainant is really seeking, I have to reject the case because such a remedy – usually linked to an accusation of negligence – is for the courts, and not for me, to decide. This is not to say that I never recommend a financial remedy and, if I find that the complainant has suffered a loss for which reimbursement is an equitable remedy, I recommend that the health authority make an *ex gratia* payment. There were 10 such cases in 1989–90 – more than in recent years. I do not always know the precise amount settled upon, but the total value of known payments last year was over £32,000, ranging from £25 to £20,000. My predecessor's Annual Report for 1988–89 touched, in paragraph 98, on a request from the DOH that health authorities and FPCs refer to them all cases where a financial remedy has been recommended. In February 1990, the DOH told the Select Committee, which had expressed concern about the ruling, that they were proposing to restore to health authorities discretion to make *ex gratia* or compensatory payments of up to £5,000.

69. The cases completed in 1989–90, where a financial remedy was obtained, were:

W.416/87–88 Patient returning from overseas reimbursed charges incorrectly levied.

W.473/87–88 Legal costs incurred by patient to be reimbursed.

W.533/87–88 Family to be compensated for expense incurred on private treatment.

W.552/87–88 General practitioner complainant to be compensated for loss of income.

W.43/88–89
W.315/88–89 Legal costs unnecessarily incurred to be reimbursed to complainant.

W.194/88–89 Compensation to be paid for loss of property.

W.280/88–89 Cost of dressings to be reimbursed.

W.462/88–89 Reimbursement to be considered for the cost of any purchases, after transfer to private nursing home, which would otherwise have been made by hospital.

W.480/88–89 Ex gratia payment for damaged suitcase.

WW.37/88–89 Charges for treatment of overseas visitor waived.

70. My investigations have again this year related to a wide range of procedures and practices which need to be introduced, improved or reviewed by the health authority concerned. In many instances the resulting remedies could benefit the service to patients

elsewhere, which is why I give brief details of some in Chapters 2 and 3 and publish, twice a year, a selection of such cases, duly anonymised. For convenience I have grouped all such remedies in four broad categories:

(i) Administrative practices or procedures associated with medical activity

W.216/87–88 Local guidance on doctors' access to medical notes to be reviewed.

W.495/87–88 Training and counselling to be introduced for junior doctors so that they can deal better with situations of stress.

W.6/88–89 (a) Arrangements for handling calls to on-call doctors to be reviewed.

(b) Procedure to be considered for the handling, by doctors in A and E department, of patients referred by GPs.

W.251/88–89 Arrangements for completing death certificates to be reviewed.

W.274/88–89 Guidance to be introduced on how to respond to requests for private treatment.

W.339/88–89 (a) Respective responsibilities for providing specialised lens care to be
W.434/88–89 considered jointly by two neighbouring DHAs.

(b) The same DHAs agreed to consider who was to be responsible for complainant's future care.

W.367/88–89 Procedures for examining, reporting on and dispatching x-rays to be reviewed.

SW.48/88–89 Arrangements introduced to make relevant staff aware of what is expected of them in the 'domino' scheme for maternity care.

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

W.400/87–88 (a) Policy for writing up details of patients on admission drawn to the attention of all relevant staff.

(b) Policy for providing refreshments to visitors on ward reviewed.

W.495/87–88 Arrangements introduced to write down telephoned pathology results.

W.523/87–88 Procedure introduced to ensure staff know what to do where a patient's close relative dies.

W.12/88–89 (a) Arrangements introduced to ensure that managerial/professional oversight of ward is effective.

(b) Nursing procedures to be clarified to specify the part shaving is to play in total nursing care.

W.107/88–89 Security of a ward in psychiatric unit to be reviewed.

W.170/88–89 Nursing staff to discuss with medical staff significance of test results before disclosing these to relatives.

W.267/88–89 Booklet to be published giving details of facilities available in an elderly care unit.

W.273/88–89 Information to staff and patients regarding the use of television sets on ward to be reviewed.

W.297/88–89 Nursing staff to be made aware that diagnoses should not be disclosed without agreement of medical staff.

W.311/88–89 (a) Guidance to be issued to clarify action to be taken when patient is placed on a diet.

(b) Guidance to be issued about when an accident report form should be completed.

W.424/88–89 Practice introduced of withholding discharge letter and medication until patient is about to leave the ward.

W.480/88–89 Action to ensure that ward practice in dealing with patients' property complies with policy guidance.

W.515/88–89 Nurse rostering to be reviewed to ensure that nurses without the necessary experience are not left in charge of ward.

W.526/88–89 Procedures to be reviewed for conduct of drug rounds.

W.34/89–90 Clearer guidance to be issued about the preparation of bodies for viewing by relatives.

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

W.222/88–89 Management of orthopaedic waiting lists reviewed.

W.280/88–89 Policy for prescribing dressings to outpatients to be clarified.

W.339/88–89 Monitoring of hospital pharmacy stock levels to be reviewed.

W.34/89–90 Contingency plans to be prepared to deal with shortage of refrigerator capacity at mortuary.

(iv) Other administrative practices or procedures associated with recordkeeping, correspondence or complaints

W.400/87–88 Procedure introduced for recording details of lost property and the action taken in investigating loss.

W.92/88–89 Definitive complaints procedure to be issued.

W.286/88–89 (a) Practice of using previous nursing kardex for re-admitted patients to be reviewed.

(b) Practice of recording requests from relatives about extension of a patient's stay to be reviewed.

W.311/88–89 Guidance to be issued about the policy on attendance of CHC representatives at meetings with complainants, and about the application of the Mental Health Acts.

W.421/88–89 Completion of nursing discharge forms to be reviewed.

SW.52/88–89 Procedure for monitoring the handling of complaints to be reviewed.

W.44/89–90 (a) Progress of clinical complaints to be monitored.

(b) RMO to ensure appropriate information is given to complainants following IPR, and to review his practice of writing direct to complainant.

W.142/89–90 Procedure for dealing with complaints to be reviewed.

W.166/89–90 Staff to be provided with clear guidance about how to deal with correspondence and routine business when office-holders and senior officers are away.

71. Sometimes I find that a procedure exists but staff have forgotten, not understood or failed to observe it. Just occasionally they may not even have been told about it. Where that happens, I may decide that action to remind the staff concerned of the procedure is the appropriate remedy. Some examples in 1989–90 were:

W.400/87–88 Staff reminded of need to ensure safety of patients' property.

W.405/87–88 Staff involved in handling complaints reminded of the procedures to be followed.

W.416/87–88 Staff reminded of the need to follow closely the correct procedures when dealing with patients who return from overseas and seek free NHS treatment.

W.495/87–88 DHA to emphasise to junior medical staff the need to give clear information to relatives who are seeking explanations.

W.524/87–88 Staff reminded of need for accurate record keeping.

W.75/88–89 Medical records staff to be reminded of correct procedures when tracing patients' records.

W.105/88–89 Nursing staff reminded of importance of making entries in care plans.

W.251/88–89 Nursing staff reminded of need to provide accurate information and to try to ensure that it is understood.

W.286/88–89 (a) Staff reminded of need to give clear explanations about medication being administered.

(b) Staff reminded of policy regarding the disclosure of information by telephone.

W.297/88–89 (a) Staff reminded of need to record discussions in which information is given to patients.

(b) Staff to be reminded of complaints procedure and their respective roles within it.

W.311/88–89 Nursing staff reminded of procedure to be followed when an incident giving cause for concern is observed.

W.367/88–89 (a) Staff reminded of the need for care in making remarks which might be misunderstood.

(b) Staff reminded of the need to make contemporaneous notes of incidents.

(c) Staff reminded of procedure for bathing patients.

W.421/88–89 Medical staff reminded of importance of maintaining adequate written records.

W.567/88–89 Staff reminded of procedure for reporting accidents.

SW.52/88–89 Staff reminded of importance of recording telephone numbers of next-of-kin.

W.74/89–90 Staff to be reminded that later insertion of entries in records, without making clear that they are not contemporaneous, is unacceptable.

72. Investigations completed in 1989–90 resulted in some remedies which do not fall into any obvious category:

W.526/86–87
W.622/89–90 Copy of the report of my investigation to be attached to patient's clinical notes held in two DHAs to provide, in this particular case, some continuity in the record of assessment and care.

W.92/88–89 Management arrangements at hospital to be reviewed.

W.107/88–89 Offer made to proceed to next stage of clinical complaints procedure in dealing with complainant's case.

W.141/88–89 Policy to be reviewed on timing of approach to neighbours of properties to be occupied by mentally handicapped people.

W.163/88–89 Agreement to ensure future compliance with Regulations governing the removal of a chemist's name from the pharmaceutical list.

W.480/88–89 Arrangements for authorising/refusing compensation payments to be reviewed.

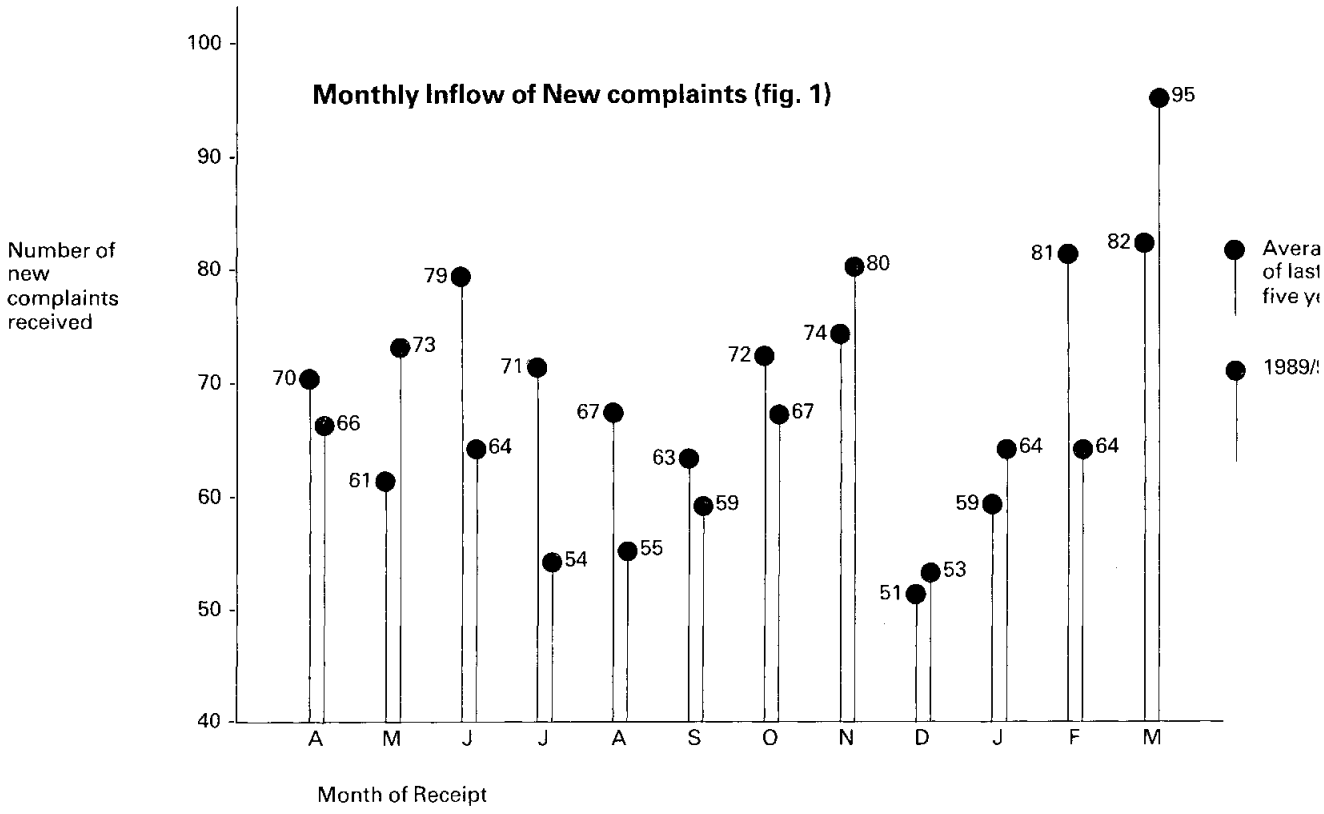
W.506/88–89 Procedures for dealing with 'serious difficulty' applications for surgery dispensing to be re-examined, and complainant's case to be reviewed.

W.526/88–89 Continuing suitability of ward for its current use to be considered.

W.44/89–90 Allocation of IPR cases held by RMO to be reviewed.

Workload

73. 794 complaints were received during the year, representing an increase of 41 (5.4%) over 1988/89 and reversing the downward trend seen since 1985/86. As usual – and for no apparent reason – the highest monthly intake came at the close of the year, 95 complaints being received in March. There is no constant pattern to the inflow of work across the year, and figure 1 below compares the number of new complaints received for each month during 1989/90 with the average intake for each month based on figures for the last five years. This reveals significant fluctuations which have an impact on the organisation of work and on the speed of response to the complainant.



74. Figure 2 shows separately the number of complaints received for England, Scotland and Wales, together with the percentage movement in these numbers by comparison with 1988/89. An innovation last year was to show, on a regional basis, the population per complaint received, and this is given again – in Appendix H – for 1989/90. The four Thames regions continue to produce some 40% of all the complaints received for England. Of the total workload of 1112, action was completed on 848 cases (76.3%) during the year as against 68.3% in 1988/89. Figure 2 also shows their disposal. In addition to the complaints received, the year under review saw 142 written enquiries and requests for advice (173 in 1988/89) and numerous telephone enquiries. There were also 605 supplementary letters either about complaints which had not been accepted for investigation or in response to requests for further information or action – in relation, for example, to a complaint which had to be referred back before I could consider an investigation.

Workload		*Disposal*	
Cases brought forward from 1988–89	318	Reports issued	89
Cases received for:		Cases rejected	472
England – 685 (+6.9%) Scotland – 76 (+1.3%) Wales – 33 (−10.8%)	794	Cases discontinued	14
		Cases referred-back and subsequently closed	273
		Cases carried forward to 1990–91	264
Total	1112	Total	1112

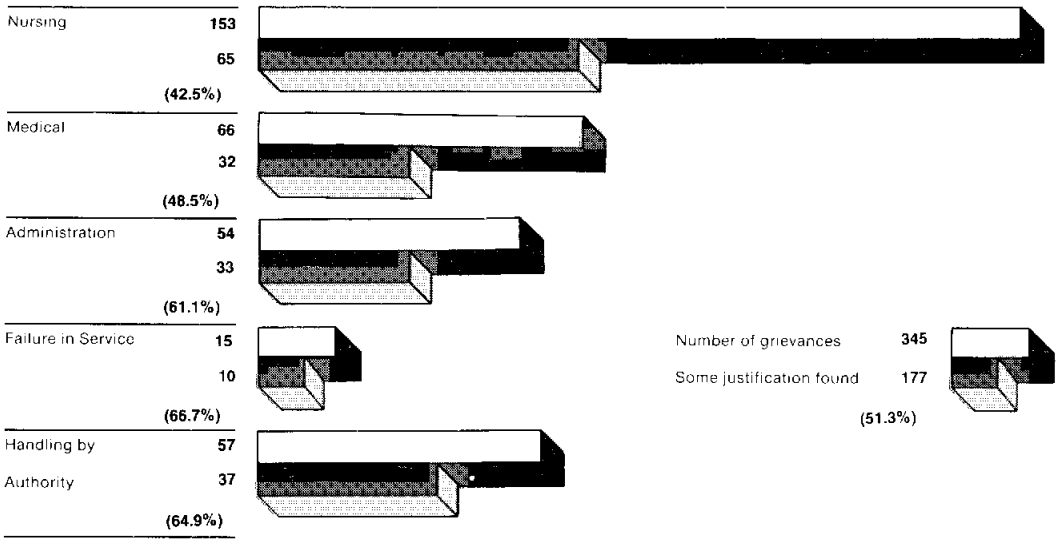
Workload and Disposal (fig. 2)

Reports issued on completed investigations

75. The 82 investigations concluded during the year resulted in the issue of 89 reports, seven cases each having involved two health authorities. I examine in Chapter 1 the reasons for this significant drop in the number as compared with the record number issued in 1988–89. The 89 reports dealt with 345 separately identified grievances, giving an average of 3.88 for each report (4.00 in 1988–89). I found some justification in 51.30% of the grievances, compared with 57.91% in 1988/89. Investigated grievances are analysed in outline in figure 3 below, and in more detail in Appendix C.

76. Nursing and medical staff were at the centre of 219, or 63.5%, of the grievances investigated. Of those, 44.3% were upheld compared with 53.0% the previous year, and this went against the trend of recent years. Grievances about administrative matters represented 15.7% of the total investigated, and 61.1% of these were found to have some justification (19.6% and 65.1% respectively in 1988/89). Failures in service and the handling of complaints accounted for 20.9% of the total investigated, and 65.3% had some justification; this was very similar to the equivalent proportions for the previous year.

Grievances received compared with grievances upheld (fig. 3)



77. During the year I accepted 99 cases for investigation, compared with 101 in 1988/89 and 132 the preceding year, when – as Appendix G shows – the total number of complaints received was the same as that for the year now under review.

Cases rejected or discontinued

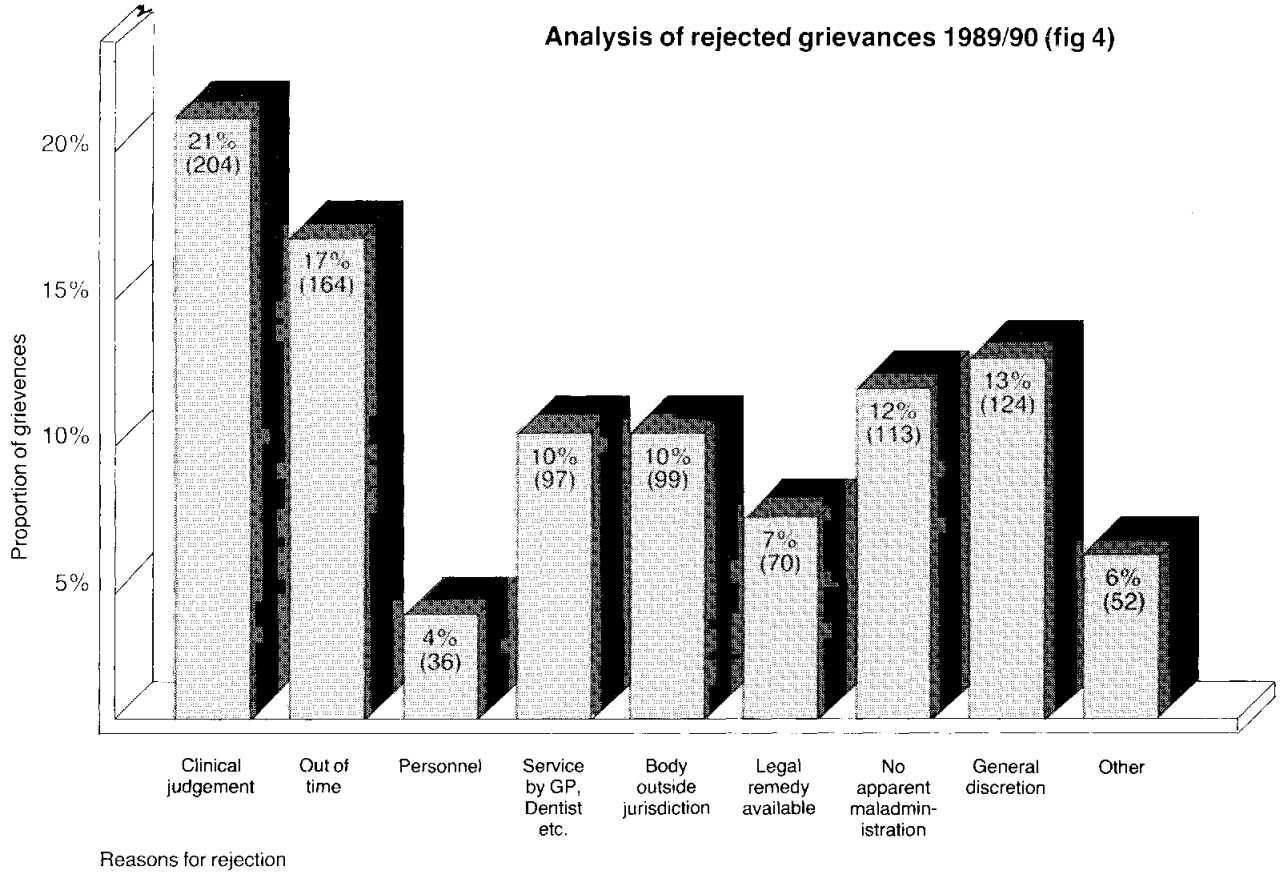
78. The 472 rejected and 14 discontinued cases (figure 2) represent 57.3% of all cases concluded during the year. This was 5.3% higher than in 1988/89, but I attach no significance to such year by year variations. The average since the Office came into existence is 61.7%, and a full analysis of work activity each year since 1973 is provided at Appendix G.

79. Rejections fall into two categories. In the majority of cases in 1989/90, as in previous years, the substance of the complaints was beyond my jurisdiction. In other cases, I decided to exercise the discretionary powers given me by Parliament not to carry out an investigation. Factors leading to such a conclusion might, for example, concern a grievance which could not satisfactorily be looked into in isolation from other rejected grievances, or an allegation of rudeness, where, in the absence of an independent witness, I would be unable to establish with any certainty what had been said. Whatever the cause for rejection, each complainant – and any relevant body involved - received a letter giving the reasons for my decision. 11 of the discontinued cases in figure 2 arose because the complainants withdrew before decisions were taken on whether or not to investigate. In the remaining three, I decided during the investigations that further action on my part was inappropriate.

80. Many complaints involve two or more grievances, each of which may encounter different jurisdictional problems. For example, a complainant might ask me to look into the actions of a GP and an alleged failure by a hospital doctor to diagnose an illness. Both aspects would be outside my jurisdiction – the first because I cannot look into the services provided by family practitioners under contract with FPCs, and the second since matters solely concerned – in my opinion – with the exercise of clinical judgment are not open to investigation by me. In the past, the annual statistics recorded the disposal of rejected cases only according to the reason for the rejection of what was seen to be the principal grievance. This limited the analysis and, because of the inevitably subjective selection of the principal grievance, ran the risk of distorting the true picture. This problem was referred to in paragraph 13 of the report for 1988/89, when a change to a revised system was foreshadowed.

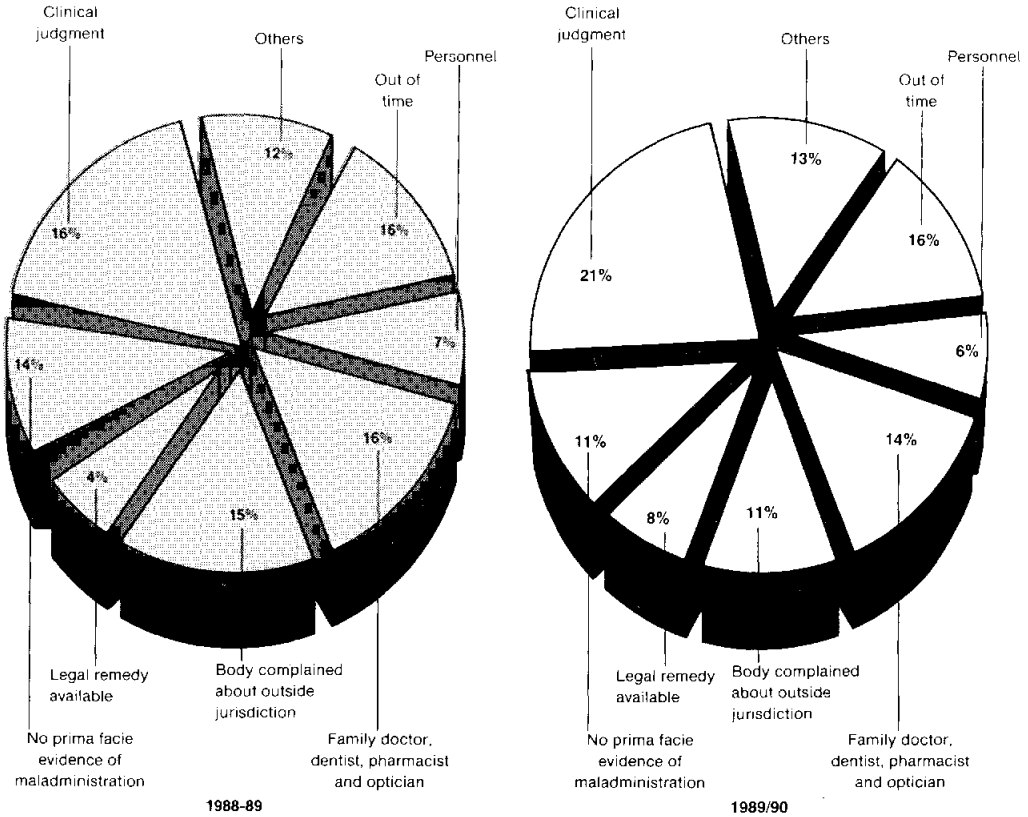
81. During the past year, the individual grievances making up each complaint have been identified and the reasons for their rejection recorded. This revealed that each rejected case contained, on average, 2.03 grievances. I rejected a total of 959 grievances in 1989/90, the main reasons being shown at figure 4. A full breakdown is given in Appendix C.

Analysis of rejected grievances 1989/90 (fig 4)



82. For this transitional year only I have decided also to show in figure 5 and Appendix B, the analysis of rejected cases under the old system. This provides for continuity of comparative information, by both relating back to 1988/89 in respect of principal grievances and analysing individual grievances for reference when my next annual report is published.

Main reasons for rejection (principal grievances only) (fig. 5)



Cases referred back

83. Nearly half of all complaints to my Office have to be referred back to the complainants because further information, or action by them, is needed before I can decide whether to conduct an investigation. Very often a complaint has not first been put to the health authority – or other relevant body – concerned. Complainants may also not have sent to me all the relevant background correspondence, or may not have said what sort of help they seek and why. However, I do not regard an incomplete submission as grounds for delaying rejection if it is clear from the outset that the subject matter lies outside my powers. Normally, where a case is referred-back and nothing further is heard from the complainant within three months, the file is closed. That step is taken in approximately two thirds of all such cases. I hope that many of these will have been resolved locally without need for my further involvement. Some, I suspect, are deterred by what they see as a procedural obstacle-course – a matter which I address in Chapter 1. My officers who screen new complaints will give informally what help they can over the telephone. However, without having first seen the relevant correspondence, they will not give a definitive answer and will suggest that a complainant writes to me. I can then decide – on the basis of the documentation – whether their concerns lie within my jurisdiction.

Cases carried forward

84. The 264 cases carried forward, against 318 brought forward from 1988/89, were made up as follows: 98 under investigation; 99 referred-back within the final three months of the year and on which no further action was taken before 31 March; 27 being actively considered for investigation, rejection or referral back; and 40 awaiting attention.

W K Reid
Health Service Commissioner

July 1990

Summary of workload

Appendix A

England		Scotland		Wales		Totals		
89/90	88/89	89/90	88/89	89/90	88/89	89/90	88/89	
281	220	24	22	13	11	318	253	Brought forward from previous year
685	641	76	75	33	37	794	753	**Add** received in current year
966	861	100	97	46	48	1112	1006	Total considered
235	281	21	24	8	13	264	318	**Deduct** carried forward to next year
731	580	79	73	38	35	848	688	Concluded
421	299	41	38	24	20	486*	357	Complaints rejected or discontinued
230	158	32	23	11	11	273	192	Complaints 'referred back'
80	123	6	12	3	4	89	139	Results reports issued
731	580	79	73	38	35	848	688	Totals
128	155	11	13	3	5	142	173	Written enquiries/advice sought

* This figure includes 14 discontinued cases of which 11 were discontinued at the request of the complainant before a decision was taken on whether or not to investigate.

Main reasons for rejection of principal grievances

Appendix B

England		Scotland		Wales		Totals		
89/90	88/89	89/90	88/89	89/90	88/89	89/90	88/89	
43	41	7	6	2	5	52	52	Body complained of outside jurisdiction
54	46	5	7	8	1	67	54	Complaint against GP, dentist, pharmacist, optician
10	6	3	1	–	–	13	7	FPC Service Committees and Tribunal Regulations
87	45	9	5	4	4	100	54	Clinical judgment
34	10	3	2	–	2	37	14	Legal remedy available
22	19	5	2	2	1	29	22	Personnel matter
69	46	3	7	2	1	74	54	Out of time
–	1	1	–	–	–	1	1	Right of appeal to tribunal
–	–	1	5	–	–	1	5	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
48	45	2	1	4	3	54	49	No prima facie failure/maladministration
6	4	–	–	1	–	7	4	Contractual/commercial transaction
29	15	1	–	–	3	30	18	General discretion
4	7	–	–	–	1	4	8	Complainant not aggrieved or acceptable as complainant
2	–	1	–	–	–	3	–	Complaint from local authority, other public body or nationalised industry
408	285	41	36	23	21	472	342	Totals

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

Analysis of categories of investigated grievances, 1988/89 and 1989/90

Appendix D

Upheld-wholly or or in part	Not upheld	Sub Total	Total 1989/90	1988/89	
					Nursing
29	48	77			failure in care
24	9	33			lack of or incorrect information
12	29	41			attitudes
–	2	2			maltreatment
65	88		153	204	**Total**
					Medical
16	14	30			lack of or incorrect information
7	8	15			attitudes
9	12	21			failure in non-clinical procedures
32	34		66	130	**Total**
					Administration
4	1	5			policy decisions (manner in which reached)
9	10	19			day-to day (hospital in-patient)
5	3	8			day-to-day (hospital out-patient)
1	1	2			day-to-day (hospital casualty)
9	5	14			day-to-day (family practitioner services)
4	1	5			day-to-day (community health)
1	–	1			day-to-day (other)
33	21		54	109	**Total**
					Failure in service
–	–	–			ambulance
–	–	–			community
9	2	11			laboratory/technical/house-keeping
1	3	4			paramedical
10	5		15	21	**Totals**
37	20		57	92	**Handling by authority**
177	168		345	556	**Totals**

Numbers of grievances investigated and upheld, 1980/81 to 1989/90

Appendix E

Year	Number investigated: Total	Number investigated: No of grievances per report issued	Number upheld: No	Number upheld: % of (iii)
(i)	(ii)	(iii)	(iv)	(v)
1980/81	399	3.53	125	31.33
1981/82	407	4.03	152	37.35
1982/83	368	3.20	160	43.47
1983/84	350	2.94	167	47.71
1984/85	443	3.54	209	47.18
1985/86	526	3.84	302	57.41
1986/87	483	3.69	290	60.04
1987/88	525	3.94	321	61.14
1988/89	556	4.00	322	57.91
1989/90	345	3.88	177	51.30
Totals	4402	3.67	2225	50.54

Analysis of main categories of grievances investigated 1980/81 to 1989/90

Appendix F

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
1980/81	399	125	31%	94	23%	79	20%	27	7%	74	19%
1981/82	407	107	26%	136	33%	73	18%	26	6%	65	16%
1982/83	368	103	28%	101	27%	59	16%	36	10%	69	19%
1983/84	350	136	39%	61	17%	101	29%	15	4%	37	11%
1984/85	443	153	34%	101	23%	87	20%	32	7%	70	16%
1985/86	526	236	45%	111	21%	76	14%	36	7%	67	13%
1986/87	483	179	37%	112	23%	108	22%	19	4%	65	13%
1987/88	525	205	39%	101	19%	102	19%	27	5%	90	17%
1988/89	556	204	37%	130	23%	109	19%	21	4%	92	17%
1989/90	345	153	44%	66	19%	54	16%	15	4%	57	17%
Totals	4402	1601	36%	1013	23%	848	19%	254	6%	686	16%

Year 1973/74 from 1.10.73	1974/75	1975/76	1976/77	1977/78	1978/79	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89	1989/90	Totals			
287	402	418	483	494	590	484	556	586	658	770	711	807	752	668	641	685	9992	E	Complaints received	
53	40	43	56	49	70	47	49	62	107	76	67	85	87	87	75	76	1129	S		
21	51	43	43	41	52	31	42	38	33	49	37	34	44	39	37	33	668	W		
361	493	504	582	584	712	562	647	686	798	895	815	926	883	794	753	794	11789	Total		
187	405	422	457	421	594	482	579	603	657	761	686	761	715	719	580	731	9759	E	Cases concluded	
44	42	48	47	43	66	54	56	54	94	90	67	80	76	95	73	79	1108	S		
11	59	35	43	35	52	34	41	42	35	38	45	32	40	44	35	38	659	W		
242	506	505	547	499	712	570	676	699	786	889	798	873	831	858	688	848	11526	Total		
155	239	248	285	267	426	334	398	419	460	520	387	407	338	421	299	421	6023	E	Rejected (inc. discontinued)	DISPOSAL
39	23	34	27	23	47	33	35	38	76	50	38	43	40	60	38	41	685	S		
7	31	26	29	29	35	24	29	27	23	22	21	15	24	24	20	24	410	W		
201	293	308	341	319	508	391	462	484	559	592	446	465	402	505	357	486	7118	Total		
14	64	60	69	59	67	58	83	95	96	145	195	238	262	187	158	230	2080	E	Referred back	
2	9	6	12	10	12	10	11	10	10	20	17	24	25	20	23	32	253	S		
2	12	3	4	1	9	5	7	9	6	13	15	11	11	13	11	11	143	W		
18	85	69	85	70	88	73	101	114	112	178	227	273	298	220	192	273	2476	Total		
18	102	114	102	94	101	90	98	89	101	96	104	116	115	111	123	80	1654	E	Results Reports issued	
3	10	8	8	10	7	11	10	6	8	20	12	13	11	15	12	6	170	S		
2	16	6	10	5	8	5	5	6	6	3	9	6	5	7	4	3	106	W		
23	128	128	120	109	116	106	113	101	115	119	125	135	131	133	139	89	1930	Total		
83	58	61	62	64	71	68	68	69	71	67	56	53	48	59	52	57	62	Rej	Average % 'Disposal' of cases concluded	
7	17	14	16	14	13	13	15	16	14	20	28	31	36	26	28	32	21	R/B		
10	25	25	22	22	16	19	17	15	15	13	16	15	16	16	20	11	17	Inv		

Geographical distribution of complaints received for 1989/90 **Appendix H**

Region of origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint †	
Northern	41	5.2	3,077	75	(147)
Yorkshire	55	6.9	3,605	66	(78)
Trent	43	5.4	4,646	108	(105)
East Anglia	24	3.0	2,014	84	(100)
London and Home Counties:					
North West Thames	68	8.5	3,488	51	(50)
North East Thames	76	9.6	3,772	50	(61)
South East Thames	84	10.6	3,636	43	(43)
South West Thames	61	7.7	2,960	49	(49)
Wessex	31	3.9	2,906	94	(93)
Oxford	20	2.5	2,502	125	(206)
South Western	36	4.5	3,206	89	(118)
West Midlands	52	6.5	5,198	100	(79)
Mersey	38	4.8	2,409	63	(59)
North Western	56	7.1	3,991	71	(71)
Total for England	685	86.2	47,410	69	(74)
Scotland	76	9.6	5,094	67	(68)
Wales	33	4.2	2,836	86	(77)
Overall Total	794	100.0	55,340	70	(73)

† The comparable figures for 1988/89, but relating to a slightly different population base, are shown in parenthesis.

Geographical distribution of investigations completed in 1989-90 **Appendix I**

English Regions	Investigations Completed
Northern	2
Yorkshire	4
Trent	2
East Anglia	–
London and Home Counties:	
North West Thames	15
North East Thames	7
South East Thames	12
South West Thames	4
Wessex	1
Oxford	1
South Western	4
West Midlands	5
Mersey	7
North Western	9
Total England	73
Add: Scotland	6
Add: Wales	3
Overall Total	82

Notes: 1. 24 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (11) and Cardiff (13).

2. 49 investigations were conducted by the London based Investigation Units: 38 (78%) related to the four Thames Regions, of which 34 (89%) involved health authorities within the Greater London area.

CAMO	Chief administrative medical officer
CCA	Clinical complaints adviser
CHC	Community health council
CLN	Community liaison nurse
DHA	District health authority
DOH	Department of Health (or its predecessor, the Department of Health and Social Security)
FPC	Family practitioner committee
GP	General practitioner (family doctor)
IPR	Independent professional review
NHS	National Health Service
RHA	Regional health authority
RMO	Regional medical officer
SCM	Specialist in community medicine
UGM	Unit general manager
UK	United Kingdom

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