HEALTH SERVICE COMMISSIONER

FOR ENGLAND, FOR SCOTLAND AND FOR WALES

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Good is best when soonest wrought,
Lingered labours come to nought.
Works adjourned have many stays
Long demurs breed new delays.

R. Southwell

1 INTRODUCTION

The value of complaints

1.1 In the National Health Service there are clear signs of an increase in the volume of complaints. I regard that as an indication of a public service which is increasing the knowledge of those who use or seek to use it of how to complain and to whom. If patients and their families feel that the service provided has been below the level it should be attaining, the Patient's Charter documents and similar leaflets produced locally should help them to seek redress. Where attention by staff to communications, attitudes and procedures is lacking, and if the handling of a subsequent complaint is unsatisfactory, the patient's perception of what may have been a successful outcome in purely clinical terms can be jaundiced. A service which handles complaints well, which puts right what went wrong in one case and which improves procedures so as to reduce the risk of a similar fault happening again, is doing right by the individual and providing a guarantee for future patients.

1.2 From time to time I am urged to produce consolidated guidance on complaints procedures for the NHS. That is not my responsibility nor, in my view, should it be. The Health Departments are there to ensure that health authorities have effective complaints procedures in place. I believe firmly that it is important for the bodies providing the service to have ownership of complaints procedures—and to monitor compliance with them. What I am prepared to do is to draw upon cases I have investigated and, when invited, to offer advice. The fact that so few complaints reach me in relation to all the treatment given or not given by the National Health Service suggests that complaints which arise are mostly dealt with locally. That is as it should be. Only matters which cannot be sorted out locally should reach an independent investigator.

1.3 Parliament established the Office of Health Service Commissioner in 1973 as a means through which patients, their carers or next-of-kin—or, in certain circumstances, members of staff—could seek independent adjudication of complaints about failure in service. I deal not just with maladministration. Although my role is primarily to investigate individual complaints which fall within my jurisdiction, I regard it as just as important to promote the lessons which can be learned. I do that in a number of ways. First, every six months a selection of cases investigated is published in anonymised form. These show whether complaints have been upheld (and not all complaints are justified), what redress has been achieved and what object-lessons the investigations provide to the NHS. Second, I have regular contact with those professional and regulatory bodies which have an interest in and responsibility for promoting good practice. Of particular value this year was a meeting with the Chairman and senior officers of the United Kingdom Central Council for Nursing,

Midwifery and Health Visiting (the UKCC), which ranged over such matters as complaints by staff and guidance on standards of record keeping. They published a guidance booklet on that in April 1993 and a copy was sent to every professional: I hope it is heeded. My deputy and I were glad to meet representatives of the Joint Consultants Committee when my role, and problems which I have come across in the administration of the clinical complaints procedure, were discussed. Third, we have participated in a number of national and local conferences, including the annual gatherings of relevant health bodies, on topics such as audit, discharge planning and complaints handling. It is dispiriting to find after 20 years that some quite senior NHS staff—even complaints officers—do not know that my Office exists. Fourth, we have also met representatives, both nationally and regionally, of community health councils and in Scotland local health councils. I welcome opportunities to inform members of the public and consumer organisations of the service which my office provides. Why then do the paid officials of some community health councils and health authorities send letters to the Local Government Ombudsman's office or invite patients to raise matters which are quite clearly outside my jurisdiction? I sometimes wonder whether *they* read the leaflet about my work.

Jurisdiction

1.4 Over the past year some organisations have proposed—not always pausing to see if I have views—that the matters subject to investigation by me should be extended or that I should be allotted some kind of supervisory role in respect of complaints procedures in the Health Service. That is for others —the Government and Parliament—to decide. Parliament set up the Office of Health Service Commissioner and it is for Parliament to decide whether, and if so which, changes should be made. The Select Committee on the Parliamentary Commissioner for Administration has begun a review of the functions and powers of my Northern Ireland colleague and of myself. I shall look forward to the outcome of that review and to the response which the Government will in due course make to it. In the meantime I shall be making my views known to the Select Committee. At present, if a complainant believes that I should be empowered to look into a matter which is outside my jurisdiction, I may invite that complainant to raise the issue with a Member of Parliament. Wherever possible I indicate what other option may be available to pursue a matter outside my remit since it is the function of an ombudsman to give whatever help he or she can.

1.5 The cases to which I refer in Chapters 2 and 3 show that my jurisdiction extends beyond maladministration into areas directly concerned with standards and delivery of patient care. In case there may be any lingering doubts on this matter, I can—and do—investigate complaints about NHS trusts, and I expect them to follow the general guidance from the Health Departments on the handling of complaints. What about a service provided to a NHS patient but in a voluntary or private hospital? The test I apply is whether the complaint relates to a service provided *on behalf of* a NHS authority; if it is, I regard it as in principle being open to scrutiny by me. If I find fault in a case which I investigate, I will look to the NHS authority which procured the service in question to implement, or provide for the implementation of, any remedy I consider appropriate. Responsibility for continuing care outside hospital is now changing with implementation from 1 April 1993 of new arrangements set out in the National Health Service and Community Care Act 1990. For that reason my staff and the Local Government

Ombudsmen's staffs attended a joint seminar in March to consider how those changes would affect our respective jurisdictions. I foresee the possibility of an increase in the years ahead in the number of complaints which, because they involve both NHS and local authority staff, will require consultation between us.

Workload, targets and resources

1.6 The past year has produced more complaints about deficiencies in care or administration. For the third year in succession the total of complaints referred to me reached a record level. At 1227 that was 4.3% more than in 1991-92—not as dramatic a rise as in the two previous years. A more detailed statistical analysis of workload is in Chapter 5. There have been two significant changes for which I have found no sure explanation. First, the proportion of complaints which I turned away, either because the matter was outside my jurisdiction or as a result of the exercise of my discretion, fell from 49.4% to 44.9% while my criteria remained stable. Second, of those cases which I referred back to the complainant, 27% more returned to me than did so in 1991-92. The commonest reason for having to refer a case back to the complainant is that the matter has not yet been put to the authority, board or trust concerned. The next commonest reason is that it has been dealt with at a level within that organisation too close to the events or personalities concerned and I consider that the head of the organisation should be given the opportunity to take a more detached view before I intervene. Senior managers, I find, do not always give complaints the careful attention which they deserve. From complaints much can be learned about the perceptions of those who use the services provided. The cases which I describe in paragraphs 2.20—2.21 and 2.24 in chapter 2 are very telling in that respect.

1.7 The unpredictability of workload makes it very difficult to ensure that I have sufficient staff available to cope with changes in the volume or pattern of demand. In 1991-92 I accepted 150 cases for investigation, so in the year now under review I recruited an additional investigating officer to try and ensure that the service to individual complainants did not suffer. At Appendix A are relevant details of workload and targets set out in the three-year rolling management plan published in 1992, with the forecasts amended in the light of more recent trends in workload. Despite the increasing pressure of work, the average time taken to complete an investigation was 45.3 weeks—roughly the same as in the previous year. Only one of the cases still in the office at 31 March 1993 had been under investigation for more than 12 months, compared with 45 such cases three years ago. What of the future? In the year covered by this report I accepted 164 cases for investigation—an all time record—of which 58 arose in the last quarter. If business continues at that rate, that would amount to a 55% increase in investigable complaints in two years. Is that because patients are better informed about how to complain or are complainants becoming more adept at formulating complaints, often with help from community or local health councils—or are they less readily satisfied with some local investigations? What is abundantly clear is that an appreciable increase in my staff resources will be needed to keep abreast of demand and maintain improvements. Wider introduction of new technology over the next two years should provide valuable help but the productivity gains my staff have achieved in the past couple of years are at the point where for them to be taken further would begin to affect the quality of the service I provide. My workload called for, and received, maximum effort from all my staff. Many of the interviews they undertake

are harrowing, some are straightforward, most prove relevant to a dispassionate and independent investigation. Once my report has been issued, my task is at an end, except for the important step of checking that a health authority has made the changes it has promised. My staff are pleased when occasionally a complainant sends thanks for their work. I commend them for their enthusiastic commitment to a task which addresses the essence of a caring public service.

1.8 During the year under review 141 investigations were completed, which was 10 more than the previous record of 131 in 1985-86. The average direct salary cost for each investigation completed in 1992-93 (that is, the total of reports issued and cases which I discontinued—see figure 3 in Chapter 5) was £4,768.93 (£5,102.29 in 1991-92). In January I made procedural changes in my office to reduce duplication of effort, and increase efficiency and job satisfaction at all levels. I have told the Select Committee about one other change. Because Parliament has specified certain things which are entirely outside my jurisdiction, I have no discretion to decide whether to investigate them. To those who send complaints in these categories the head of my screening unit will explain that I am unable to consider the complaint. Since I am not 'rejecting' such complaints, for I cannot investigate them, I now take the view that it is not appropriate in this kind of transaction for me to have to tell the body complained against that I have decided not to conduct an investigation as Section 119(7) of the National Health Service Act 1977 and Section 96(3) of the National Health Service (Scotland) Act 1978 require. I shall continue to inform the body concerned in cases where I exercise my discretion to reject a complaint, that being the purpose of the legislation; and in every case where I have discretion, or where there is any doubt about the matter, either I or my deputy will reply to the complainant.

Themes and issues from complaints

1.9 The publication of selected cases (see paragraph 1.3), and reference in Chapters 2 and 3 of this annual report to particular themes or issues emerging from them, is of little purpose if the lessons are not digested and put into practice. When writing about the volume covering April-September 1992 to health authorities and trusts the NHS Chief Executive in England urged general managers to use the cases and epitomes as 'a positive training aid to ensure that the learning opportunities are fully exploited' and that the sort of poor practice which I described was not repeated. More recently, the UKCC commended my published reports to all nurses. As Ombudsman I welcome these actions and hope—as no doubt users of the NHS do—that they will correct those failures which have given rise to complaints.

1.10 Details of the cases outlined in chapter 2 and 3 are in the relevant volume of Selected Cases—the references show where each case can be found. All those in the first three sections of chapter 2 (discharge procedures, record and communications) relate in one way or another to deficiencies in understanding, or the conveying of information, either among staff or with patients and relatives. Communications lapses are not only careless, they can have serious repercussions and cause real distress to those affected. I cite here, as illustration of that, the case (paragraph 2.13) where for 15 months there was a failure to tell a woman that breast cancer had been diagnosed. I then give three examples of cases where the care and supervision of patients went astray: that can sometimes arise

because pressure of work or low staffing levels prevent nurses from giving enough attention to a patient's needs.

1.11 Those who decide to make a complaint to a health authority are entitled to expect that their concerns will be investigated promptly, thoroughly and with integrity. An opinion survey of patients conducted in 1992 by the NHS Management Executive in Scotland showed that there was a very low level of complaints in percentage terms but that almost none of those who complained was satisfied with the response from local management. If only performance at that level were improved, the number of persons who complain to me would be greatly reduced. The penultimate section of chapter 2 shows how incompetent handling—such as delays, use of jargon, or a poor local investigation—can cause a complainant in despair to turn to me. Finally, the way in which family health services authorities and health boards deal with complaints about the actions of family doctors, dentists, opticians and pharmacists continues to generate a steady flow of complaints to me. I have criticised poor handling of complaints by those bodies where they have used the *informal* procedure—such as inadequate arrangements for lay conciliation, and failure to ensure that the complainant knew the choices of procedure available or to respect the complainant's wishes. The *formal* procedure is outside my jurisdiction but many who write to me complaining about it wish that it was subject to some external scrutiny. I distinguish the administration of the procedure from the actual decision-making appellate functions which are within the ambit of, and the subject of representations by, the Council on Tribunals. I consider that the administration of the formal procedure should come within my jurisdiction. That would be consistent with the philosophy underlying the Courts and Legal Services Act 1990.

1.12 Another area of difficulty has now been resolved. I was concerned that there seemed to be some doubt about whether the actions of the Medical Officer for Complaints in Wales, in discharging functions equivalent to those of regional directors of public health in England—or chief administrative medical officers in Scotland—in deciding whether to grant an independent review of a clinical complaint, were in principle investigable. The Welsh Office have accepted that those actions are open to investigation by me in my other capacity as Parliamentary Commissioner for Administration.

1.13 A selection of six cases which do not fall within a particular category or theme, but are of interest in their own right, is given in Chapter 3. I mention two here. In the first, a woman who had complained to my predecessor about ante-natal care for her first baby—the case was later examined by the Select Committee on the Parliamentary Commissioner for Administration—sought care from consultants at the same hospital when she became pregnant for a second time. I reached the conclusion that care has been denied her as a consequence of her previous complaint and she had had to turn to another hospital. That I considered wholly unacceptable victimisation. In the second case a woman had her operation cancelled three times in succession. The Patient's Charter for England provides for re-admission within a month if an operation has had to be postponed twice. The case of the thrice-cancelled operation is an early example of complaints that a national or local charter standard—for example relating to waiting times or discharge arrangements—has not been complied with and I may well receive more.

To Conclude

1.14 This year Chapter 4 presents in a revised form the remedies obtained as a consequence of my investigations. Chapter 5 also contains an innovation by changing the way in which grievances are classified—by service, staff group and nature of complaint. These departures from previous practice are intended to make the information more helpful and instructive. I do not uphold by any means every complaint put to me. Sometimes setting out information which had not previously been given to the complainant can be enough to satisfy a complaint. My work would be more difficult were it not for the willingness with which health authorities and their staff—with few exceptions—co-operate with my investigating officers in response to demands made upon them on my behalf. I hope that that co-operation will continue to extend also to the secondment of staff to my Office. Particularly given the attention being paid to improving service quality and consumer awareness, a period of some three years spent here should be seen as a valuable career move for the individual and, for the service, an important way of developing insights and skills. If the secondment of staff, and their ready acceptance on return to the seconding authority, were to be impaired that would be a loss all round.

1.15 After completing an investigation in which I upheld a number of the grievances put to me, I received a letter from the patient's widow which read 'My feelings are that as a result of your enquiry my husband's death was not completely in vain and that I can now go forward taking with me the fond and loving memory of happy times'. That is an argument for a complaint, at whatever level, to be dealt with in a thorough, professional and sensitive manner.

W K REID
Health Service Commissioner

June 1993

2 INVESTIGATIONS: MAIN TOPICS

(i) Discharge procedures

2.1 The decision whether a patient is well enough to be discharged is a clinical judgment which statutorily I may not question, but I can and do investigate complaints about the arrangements for a patient's discharge. For these to be handled effectively, and with sensitivity and care, all the parties involved have to know what is expected of them and to communicate in good time on the basis of clear and accurate information. Where that does not happen, the patient's recovery may be put at risk, transport may not be available when needed, relatives and carers may not know what is happening and general medical and community care may not have been arranged. The three cases in this section illustrate how failure to follow established procedures resulted in insufficient attention being given to a patient's needs.

W.689/91-92 on pages 46-53 of HC 704

2.2 An elderly woman understood that she was to be discharged the very day she was told about that, but staff had said nothing beforehand to her daughter, who visited regularly, and no arrangements had been made for home support. The daughter protested to a nurse and discharge was arranged for a week later. I found that in fact immediate discharge had never been in prospect, but that failure to comply with Department of Health (DH) guidelines lay behind much of what went wrong. For example, no nurse had been identified as responsible for monitoring the arrangements made and it was not routine for the hospital's action checklist to be completed in every case. The arrangements for the patient's journey home were a shambles. The district health authority (DHA) agreed to review their discharge procedures and to monitor with the relevant ambulance service (AS) the arrangements which have now been introduced for booking transport.

W.786/91-92 on pages 59-68 of HC 704

2.3 A daughter complained about the way her elderly father was discharged and then taken by ambulance to a nursing home. Staff prepared the man for the journey by 8.30 am. The ambulance did not come until 3.15 pm. The AS could have given an estimate of the collection time, so the man spent seven hours simply waiting for his transport. More was to follow. Nurses did not know that a direct ambulance journey could be requested, so the man was taken on a roundabout route and did not arrive at the nursing home until after 5.00 pm. The DHA agreed to try harder to resolve communication problems between the hospital and the AS and to ensure that their staff knew what the AS could provide.

W.892/91-92 on pages 100-108 of HC 704

2.4 This is the first of two cases (the other is at paragraph 2.12) involving patients with breast cancer—a condition calling for sensitivity and timely action. A woman was not seen for follow-up care as an outpatient until over 15 months after breast cancer had been diagnosed when a breast lump was removed for examination. That omission resulted from failure to include a request for a follow-up appointment in the operation record, and a lapse in communications before the woman went home—her admission had been as a day patient. The woman, believing that the lump was benign, assumed that a decision had been made that she did not need to be seen again. Her general practitioner (GP) was led to

believe that follow-up action was in hand. The error was not discovered until the woman attended an outpatient appointment made as a result of routine arrangements for patients with cancer to have an annual check. The DHA agreed to review discharge procedures to ensure that they dealt adequately with the special circumstances of day patients.

(ii) Records

2.5 Careful attention to record keeping is not just a matter of good practice. It is integral to the provision and continuity of care. Put at its lowest, it is an insurance for a member of staff who may later be accused of negligence. What do I find? In too many cases records are incomplete or lacking in essential detail. In others there is no record of communication with relatives or carers or, as the previous section showed, of discharge arrangements. Even if records are well maintained they are of no use if they cannot be found when they are needed. The four cases in this section are intended to show why, in discharging their professional responsibility for patients, medical and nursing staff should not skimp on the time and effort they devote to the accurate and clear recording of a patient's treatment and care. If staff do not follow established procedures governing handling, transfer and retrieval, records can very easily be mislaid.

W.369/91-92 on pages 64-69 of HC 302

2.6 Risk management should involve a careful assessment of the potential consequences of a particular course of action. In this case management did not give enough thought to the effect of removing afternoon clerical support in the medical wards, relying instead on an informal arrangement that outpatient clerks would, as a goodwill gesture, help when a patient's records were needed. When a woman was admitted as an emergency the admitting doctor asked for her records, but those clerks were themselves hard-pressed because of sickness absence and could not help straight away. The woman died before the records were found, and I attributed that to the hospital's failure to have a proper procedure in place. Immediately after the incident afternoon clerical cover for the wards was reinstated. However, another error had not helped matters. Because she was ill the woman had not attended an outpatient clinic two days previously. The clinic staff sent her records, in error, back to the medical records department, and they were in transit when the woman was admitted. So, even if a search for them had begun immediately, it is doubtful that they would have been found in time. The admitting doctor said that the absence of the records had not been vital to the patient's care, but that was of little comfort to the husband who had known that the doctor had asked for records which could not be found.

W.788/91-92 on pages 68-79 of HC 704

2.7 The second case exemplifies the problem of staff having difficulty in remembering the details of care given to a particular patient, or having a different recollection from that of a complainant. In such cases I look particularly at what is in the patient's clinical and nursing records, but sometimes they lack essential detail. A man died two days after he was admitted to hospital. His wife and other relatives stayed with him in a side room for most of the time, and I received a number of complaints from them about inadequate nursing care (see also paragraph 2.17). His wife asserted that the nurses had expected her to provide much of the care that was needed. I found that the nurses remembered little about the patient, but believed that his wife had wanted to be involved in all aspects of his care. The records provided little information about the care which had

been given, and nothing whatsoever to show what might have been agreed with the relatives. I concluded that much of the care had been left to the patient's family and recommended that nurses be reminded of the importance of agreeing with relatives what care the family are willing and able to provide and of recording that in the nursing plan.

W.890/91-92 on pages 87-99 of HC 704

2.8 A woman with senile dementia was injured in a fall after leaving a lavatory in the hospital where she was a patient. Her daughter complained that her mother should not have been left unattended. I found that the nurse who left the woman in the lavatory had made her decision in the exercise of her professional judgment but knew that the patient was prone to falling. However, the standard of documentation was poor, and in particular there was nothing in the care plan about the woman's propensity to fall. Accident forms had not been completed for the woman's earlier falls, and no assessment had been made—or at least recorded—of preventative measures. Whether the accident would have happened if there had been a plan I could not say, but I recommended that the importance of care planning, and identifying needs relevant to a patient's safety, should be re-emphasised to nurses.

W.486/92-93 on pages 129-131 of HC 704

2.9 When a woman sought information in connection with possible litigation about whether, in 1984, she had been injected with a certain dye, she was told that her records could not be found. Shortly after I had started my investigation the Trust concerned told her that her records had been found. (In a more recent case I asked the DHA concerned to try harder to find some missing records. They found them, but it should not have been necessary for me to prod them.) My enquiries revealed that a higher clerical officer, after establishing that the woman had attended the hospital in 1987, had searched without success where records for that year were stored and amongst records awaiting microfilming. The assistant chief executive, who had not known that the woman had attended in 1987—and who had believed, incorrectly, that records were destroyed after 7 years—had not pressed for further searches. The records turned up amongst those awaiting microfilming, having been put together in a 1984 outer folder. They should have been placed in a 1987 folder, the year in which the woman had most recently been treated. I concluded that the records could have been found much sooner but for the wrong assumption.

(iii) Communications

2.10 Good oral and written communications are essential for the provision of a satisfactory service. Without failures in communications there would be a dramatic fall in the number of complaints to me—and to health authorities themselves. The next four cases illustrate service failures which affected the quality of care given to patients and the trust between them and their doctors and nurses.

W.149/91-92 on pages 13-26 of HC 302

2.11 A woman had varicose vein surgery. She complained to me about having been given contradictory information by two doctors in separate specialties about the timing of her admission and when her anticoagulant medication should be suspended. Two weeks after the operation the wound opened and a consultant advised re-admission to hospital and then went on leave. He failed to tell other staff so, because they did not know

what needed to be done, they sent her home again without treatment. She was later admitted again and yet further problems arose—an ambulance did not arrive to take her to another hospital for tests, and when she finally got there in her own car the professor she had expected to see was not available. Poor communications were behind all these difficulties. A registrar had not seen it as his job to ensure that the woman was informed about her anticoagulant therapy and had not made clear his intentions about the first admission. The fiasco with the visit to see the professor also arose from the registrar making false assumptions about, and not checking, the consultant's wishes for further tests. The abortive second admission had been a direct result of the consultant's actions. In short no-one was in charge. The DHA agreed to remind medical staff of the importance of good communications with patients and between specialties and of writing up their plans in clinical records; take action to tidy up their admissions policy; sort out a policy on the use by patients of their own vehicles; and audit their communications policy.

W.572/91-92 on pages 31-37 of HC 704

2.12 A breast cancer patient was told by a registrar at an outpatient clinic that she needed either a partial mastectomy with radiotherapy or a full mastectomy. The consultant who would normally have seen her to discuss the operation was away, as was the breast care nurse. The woman wanted to undergo the minimum amount of surgery but no-one gave her information about the treatment options. At a subsequent chance meeting with the registrar the woman said that she would agree to a full mastectomy. She then signed a consent form and that was the first real opportunity for her to discuss her concerns—but it was with a house officer. On recovery she found to her concern that her lymph glands had also been removed. I could not determine whether removal of the lymph glands had been discussed with her, but I upheld the complaint because arrangements for counselling before the operation had been inadequate. The DHA agreed to make alternative arrangements for counselling to cover future situations when key staff are unavailable.

W. 892/91-92 on pages 100-108 of HC 704

2.13 I now come to further issues arising in the case to which I referred in paragraph 2.4. Even when the oversight in respect of follow-up care was discovered, three further months passed before the woman was told that malignancy had been diagnosed very soon after her operation. The doctor who first saw the woman as an outpatient was hampered by a lack of information in the records about what she had been told, so I did not criticise him for deciding not to tell her immediately what had happened. But the woman was subsequently seen as an outpatient by the consultant and admitted twice to hospital, once for a biopsy and later for a mastectomy. According to her clinical records she was known still to be under the impression that the lump had been benign, yet she was not told what had happened until she asked about the results of the original histology report when attending for chemotherapy after her mastectomy. It was just as well that no-one sought to justify on clinical grounds the fact that she was not given the full information any earlier. I held the consultant—who retained responsibility for her clinical management throughout—to blame for the delay in informing her of what had happened.

W.401/92-93 on pages 122-129 of HC 704

2.14 After falling at home an elderly woman spent four weeks in the rehabilitation ward of a hospital before being discharged to a nursing home, where she was found to have a fractured ankle. Several friends later said that they had been concerned about her ankle, but they had not

mentioned anything to ward staff at the time. The woman herself had mentioned an incident to at least two members of staff who did not take the matter seriously and made no record of what she said. I found that inadequate communication among the staff had contributed to the failure to diagnose the fracture (I deal with the care and supervision aspects in paragraph 2.18). Finally, although the woman's friend had told a nurse that she acted as the next-of-kin, she was not told when her friend was discharged. No adequate record had been made of the information given by the friend and I upheld the complaint. The procedures for recording information about next-of-kin lacked adequate safeguards.

(iv) Care and supervision

2.15 Although I may not question what I regard as the clinical judgment of doctors and nurses about the nature and extent of care of a patient, I can look at the circumstances in which their decisions were made and whether they were carried out correctly. I give three examples of where the patients suffered lack of care and attention which led to very distressing experiences for them and their relatives.

W.190/91-92 on pages 27-40 of HC 302

2.16 An elderly woman was admitted to a ward after fracturing a hip, having first spent some four hours on a trolley in the accident and emergency (A and E) department. Then the operation she needed was postponed several times. She became depressed, was reluctant to eat and developed a deep pressure sore. She died in the hospital five weeks after her admission. Her daughter complained to me about the pressure sore, inadequate nourishment and insufficient nurses to provide the necessary standard of care. I found that the patient had spent too long on a trolley in the A and E department, that nurses in the ward had not turned her as often as they should have done because of competing demands on their time, and that there had been a shortage of pressure-relieving equipment. All these factors contributed to the development of the patient's pressure sore. Nurses were also unable to spend as much time as they would have wished encouraging her to eat. Before my investigation began there had been improvements in the supply of pressure relieving equipment and in staffing levels. The Trust which now run the hospital agreed to ensure that wards remained adequately staffed to meet the needs of patients.

W.788/91-92 on pages 68-79 of HC 704

2.17 Decisions on staffing levels are normally a matter of local discretion, but I do comment on them where it seems to me that a decision has resulted in a level of care which falls below what any reasonable person could regard as adequate. In the case to which I have already referred in paragraph 2.7, the records were inadequate, and so were aspects of care. The man, who was elderly and had a history of heart attacks, was admitted to hospital for observation. His condition deteriorated overnight and his family were called in the early hours. He died late the next day. The complaints I received—about what checks the nurses had made and that they had failed to respond in time to requests for a commode—all related to how much care had been given. Furthermore, the ward sister was said to have berated a relative about the nurses being overworked and told her to 'relax and stop fussing'. Even in the last stages of her husband's life the complainant had to ask twice for a doctor—and he, showing no urgency, arrived after her husband had died, muttered something inaudible and left the woman on her own without comfort or support. There was plenty of evidence that the ward nurses were very busy on the evening that the man died. Two other patients had

died earlier that day and although, according to the ward sister, extra nurses were requested none was forthcoming. I upheld most of the complaints and was concerned that such a poor service had been provided at the end of the man's life, and so much distress caused to his family. The Trust agreed to review nursing cover for busy periods to ensure adequate standards of care, and that records should be kept of requests for extra staff and their outcome.

W.401/92-93 on pages 122-129 of HC 704

2.18 The care and supervision of the patient also featured in the case mentioned in paragraph 2.14. Attempts were made to encourage the woman to walk on an ankle which was found later to be fractured. The consultant gained the impression—he could not say how—that the ankle had already been x-rayed in casualty (the woman's hip and knee had been x-rayed, but not her ankle) and he had not therefore considered the possibility of a fracture, believing that she had had a deformed ankle for a long time. The ward staff and physiotherapist, in attempting to get the woman to walk, attributed her complaints of pain to stiffness and perhaps placed too much reliance on the medical diagnosis. The woman suffered an unnecessarily painful experience, resulting from a failure in the service brought about by false assumptions and bad communications among staff.

(v) Handling of complaints

2.19 The emphasis in the Patient's Charter on the importance of open, responsive and timely handling of complaints has had no effect in reducing the number of complaints put to me. I notice that some complainants have unrealistic expectations of what the NHS should provide and that others will be satisfied only if their accusations, whether well founded or not, are upheld and disciplinary action taken against staff. Many complainants, however, are justified in their belief that replies to their letters and telephone calls have taken too long, have not dealt adequately with the issues raised and have been written in inappropriate terms. However good may be the quality of treatment and care which they provide, health authorities and trusts will get a bad name if they handle complaints badly.

WW.46/90-91 on pages 135-143 of HC 704

2.20 One case showed how little the DHA had taken to heart the lessons of an investigation carried out by my predecessor. A woman concerned about aspects of her father's care tried without success, when he was still an inpatient, to arrange a meeting with the consultant responsible for his care. Her solicitor then wrote to the consultant, but the letter appeared to have been misplaced. After her father's death the woman wrote to the DHA chairman, copying her letter to her Member of Parliament who referred it to the district general manager. The reply received five months later did not answer her concerns in any depth. She wrote again to the district general manager, enclosing a copy of the solicitor's letter sent originally to the consultant. Another six months passed before she was offered a meeting with the consultant. It took place some eighteen months after she had first asked to see the consultant.

2.21 I found that, although the consultant was to blame for much of the delay which had occurred in dealing with the woman's complaint, the complaints procedure involving the DHA and the hospital operated in a bureaucratic manner with written reminders giving an erroneous impression of action. I considered it disgraceful and dishonest that,

although the woman thought she had been receiving letters written by the district general manager, they were written by staff who dealt with complaints and used the general manager's name when signing letters. Senior management had taken no interest in the case, despite the attention given to it by the Member of Parliament or indeed the possibility that I might investigate. It replicated many of the features in the earlier case in the same DHA, involving the same officers, who had been examined just a year before by the Select Committee on the Parliamentary Commissioner for Administration. I was so concerned that I wrote to the DHA chairman. He gave me a personal undertaking that changes to the complaints procedure would be made to ensure that complaints handling was more closely monitored, including submission of quarterly reports to the DHA; that a non-executive member of the DHA would chair the complaints panel; and that the deplorable practice of using others' names when signing letters would cease. It had better work this time.

W.547/91-92 on pages 13-22 of HC 704

2.22 There is no excuse for insensitivity and use of meaningless jargon when replying to complaints. A woman complained to a hospital's unit general manager about a decision to transfer her elderly father—who had had a heart attack—to another hospital, where he died a few hours later. After three months, having received only an acknowledgment, the woman telephoned the general manager. During their conversation he referred to her father as her husband, and insisted—despite protestations to the contrary—that she was claiming that her father would have lived had he not been transferred. The woman accepted that the conversation had been acrimonious on both sides, and the general manager said that he had been firm and astringent but courteous. He made no record of the conversation—an omission which I criticised—but I was able to conclude that he had adopted a tone more severe than should have been the case in responding to a quite understandable enquiry. The local investigation of the complaint was slow and shallow, and the general manager's written reply was inaccurate and insensitive and contained unexplained technical terms. He also sought to excuse his inability to verify certain information on the grounds that the woman had not complained until some five weeks after her father's death. The DHA later undertook to put the operation of their complaints procedures in order.

W.890/91-92 on page 87-99 of HC 704

2.23 In the case to which I referred in paragraph 2.8, the daughter complained to the unit's operations manager about the care provided for her mother. Some five months later, after meeting her, he wrote 'confirming' that she was satisfied with the outcome of his enquiries, except for two points. Only when the daughter then re-stated her complaint was it registered within the DHA's complaints system. Not surprisingly the daughter was dissatisfied with the unit general manager's response about three months later which repeated the assertion that she was satisfied with the outcome of the original investigation. Ten weeks later the general manager set up a panel to review the operations manager's investigation—not the substance—and told the daughter that they would probably wish to see her. The panel were apparently unaware of that. Even more extraordinary, they did not see the operations manager who had conducted the investigation they were considering. The final letter from the unit general manager to the daughter, sent three months after the panel had met, made no reference to their view of the investigation. What was the point of setting up an 'independent' panel,

for the general manager then to write in the first person without referring to their conclusions? She was the designated officer for complaints and had to my mind displayed throughout an unacceptably aloof and uncaring approach to a serious complaint. I criticised the DHA also for avoidable delays and failure of their monitoring procedure, and they agreed to put right the haphazard approach revealed by this case.

W.938/91-92 on pages 108-114 of HC 704

2.24 A particularly distressing case shows how much room there is for improving the handling of complaints. The parents of a six year old boy, who had had treatment for leukaemia, complained to a Trust that a senior registrar had ordered an x-ray of his right leg even though it was in his left leg that a limp had developed. They believed that that had resulted in delayed treatment. They were promised a reply within four weeks but, despite reminders, they waited for over four months and were not satisfied with the reply. My investigation revealed manifest failures in the handling of a serious grievance. The investigation had been left initially to a management trainee who had little authority. Later many different staff became involved but the senior registrar who had ordered the x-ray was not even asked for his comments. The local investigation was delayed because the child's clinical records were held at another hospital where his treatment was continuing—more determined efforts could have been made to obtain their release. The Trust's final reply to the parents used over-technical clinical terms and contained no apology for the excessive delay. An invitation to the family to make further contact if they remained dissatisfied was contained in a postscript which smacked, to me, of an afterthought. I noted that the Trust's chief executive had already taken action to improve the handling of complaints, but the Trust agreed to monitor the effectiveness of the new procedures and take whatever action was needed to improve performance.

(vi) Family health services authorities

2.25 Complaints about the actions of general medical practitioners, dentists, opticians or pharmacists are outside my jurisdiction. Complaints *by* such practitioners against family health services authorities (FHSAs) remain outside my jurisdiction in the light of the decision of the Court of Appeal in the case of *Roy v Kensington and Chelsea and Westminster Family Practitioner Committee* (1990) 1 Med LR 328. Actions taken by FHSAs in England and Wales and health boards (HBs) in Scotland also escape my scrutiny where they investigate such complaints under statutory regulations, usually known as the formal procedure. I can—and do—investigate complaints where the informal procedure has been used. This section shows how much improvement is needed to ensure that complainants are given correct information and impartial advice about their rights and about the options open to them.

W.496/91-92 on pages 73-77 of HC 302

2.26 A woman wrote to a family practitioner committee, as it then was, seeking information about her late mother's medication. She was told how the information could be obtained and was asked how she wished to proceed. She opted for initial handling under the informal procedure, but she was invited to attend a hearing under the formal procedure. An officer of the committee had incorrectly presumed that, as there was no lay conciliator for the area in which the woman lived, informal handling was not an available option. The woman was not told what had been decided or given the chance to object. The committee—later FHSA—

agreed to make lay conciliators available throughout their area and to remind staff of the need to explain to complainants how it was proposed to deal with their cases.

W.663/91-92 on pages 37-41 of HC 704

2.27 A FHSA took an unacceptably long time to deal with a man's complaint about his, and his wife's, dental treatment, and in doing so largely ignored DH guidance. They did not explain adequately the procedures or the choices open to the man. In effect they denied him his statutory rights under the Regulations. They neither followed properly the informal procedure nor invoked the formal procedure. The procedures are formidable enough to the complainant without the added confusion which can arise where staff do not operate them properly—or do not understand what is required of them. The man was also told that his complaint had been considered by the chairman of the dental service committee. That was quite simply not true. The FHSA accepted that they had not dealt properly with the complaint and agreed to take immediate steps to do so.

W.778/91-92 on pages 53-59 of HC 704

2.28 A man complained to a FHSA about the actions of a GP and was told that the matter would be dealt with under the informal procedure. A lay conciliator arranged to visit him but went to the wrong address. An acrimonious telephone conversation with the man's wife ensued, after which the case was referred to a different lay conciliator. Because the second conciliator was ill, and remained so, no further action was taken. The handling of the complaint by the informal procedure extended over more than 23 weeks—well outside the target of one month in DH guidance. Such monitoring of progress as occurred was prompted only by the wife's enquiries, so what merit was there in having a follow-up system which did not produce action? I upheld the complaint about handling and also criticised the FHSA for not following the guidance in offering a choice between the informal and formal procedures.

3 CASES OF SPECIAL INTEREST

3.1 Some cases do not fall neatly into any particular category but repay attention to them. This year I have chosen to highlight cases which illustrate concerns ranging from failure to meet the standards in the Patient's Charter to health authorities' responsibilities for registering private nursing homes.

SW.2/91-92 on pages 107-115 of HC 302

3.2 A woman was denied the opportunity of having her maternity care at the hospital of her choice because she had exercised her right to complain to my predecessor about incidents which had occurred during an earlier pregnancy. I did not find proven, as the woman had alleged, that the consultant involved in her earlier complaint had put pressure on his colleagues not to accept her as a patient. Nonetheless, when her GP referred her to two other consultants at the hospital, both refused to accept her. That was because the hospital consultant duty rota system could have led to her coming under the care of the original consultant if she was admitted on a day when he was in clinical charge of the hospital. Both the HB and I considered that, with five consultants in the specialty at the hospital, it was unreasonable that the woman should have been refused care because of the lack of trust which existed between her and one of them. The HB have since issued an instruction to all their consultants that, should a similar situation arise in future, the hospital chief executive and if necessary the chief administrative medical officer (CAMO) must be consulted.

W.41/92-93 on pages 114-118 of HC 704

3.3 Postponement of a patient's planned admission causes extra worry to someone already anxious at the prospect of going into hospital. The National Charter Standard provides that an operation should not be cancelled on the day the patient is due to arrive in hospital, although that can happen because of emergencies or staff sickness. If exceptionally a patient's operation is postponed twice, the patient should be admitted within one month of the date of the second cancelled operation. In this case—which occurred before the Standard was introduced—a woman's knee operation was cancelled three times. A lack of beds was the cause of two of the cancellations—that confirmed what she was told when she telephoned on the day of admission to check that she should come in. On the other occasion the woman was admitted and given pre-operative medication but her consultant had insufficient theatre time to complete the operations listed for that day. The woman had not been warned that such cancellations might occur. The consultant said that patients whose operations were cancelled were put on his next theatre list—for three weeks ahead, and the chief executive of the Trust concerned said that no patient should have an operation cancelled on three successive occasions. My enquiries showed that because of communication failure it was not realised that the woman had had previous cancellations. The Trust agreed to review and monitor their procedures in order to meet the National Charter Standard and to ensure that patients were warned, when placed on a waiting list, that their operation might be cancelled at short notice.

W.525/91-92 on pages 91-97 of HC 302

3.4 One highly unusual case involved the actions of a patient, in a psychiatric unit for assessment, who became very disturbed and in the early hours of the morning threw himself naked through a window. He then crashed through the window of a nearby home, subjecting the family to a very distressing ordeal and causing damage to the property and to

himself. Later that day a nurse manager from the hospital told the family by telephone that, as the man was an informal patient, the hospital was not responsible for his actions. No help or reimbursement for the damage caused was offered, and the DHA staff believed that for them to have visited and provided support to the family could have implied acceptance of responsibility. I regarded that as an over cautious approach for a public body. I found it difficult to understand why—irrespective of any question of liability—as a matter of common humanity, let alone courtesy, a visit could not have been made on the day of the incident in view of the serious and disturbing damage seen by nurses who had collected the patient. My investigation also revealed that the DHA had been given legal advice that, because of the informal status of the patient, they had no legal duty to pay compensation, but they could safely make an *ex gratia* payment. The chairman chose not to do that. The patient's mental state had not been established and in my view until that was done the DHA had a higher duty of care than for a patient whose condition and status had been assessed. I then invited the DHA to make an *ex gratia* payment to meet the costs of the complainant's uninsured loss. They agreed to do so only to the extent of half the amount involved: I noted that response without enthusiasm.

SW.73/91-92 on pages 116-121 of HC 302

3.5 In Scotland the decision whether to offer an independent professional review (IPR) rests solely with the CAMO. It is not for me to substitute my judgment for his, but when a complaint is put to me on the matter I have to consider whether he acted appropriately in reaching his decision. I criticised one CAMO for departing from the laid-down procedure in reaching a decision to refuse a woman an IPR—under the clinical complaints procedure. If arrived at properly, his opinion—that her clinical complaint was not substantial, so did not merit an IPR—would have been a valid basis for his decision of rejection. However, because he lacked experience in dealing with such matters and did not have the relevant clinical expertise, before reaching a final decision he obtained expert advice informally from another HB's CAMO and a consultant working in the specialty. Their views coincided with his, but he said that, if they had not done so, he would have been prepared to depart from his view. I considered that the process by which he reached his decision was flawed. He was in effect substituting the advice of doctors who would not necessarily have been seen as independent for the views which might have been formed by two independent consultants in an IPR. The HB agreed to ensure that the procedure was correctly implemented in future—but not before trying unsuccessfully to argue that the nationally agreed procedure was not binding upon them.

W.508/91-92 on pages 85-91 of HC 302

3.6 Twice within one month ambulance transport which an elderly woman's GP had booked to take her to an appointment at a pacemaker clinic failed to arrive. The second time her son took her to the clinic by taxi at a cost of £23. He complained to the AS several times about the failures in service and asked for reimbursement of the taxi fare. The complaint dragged on for nearly twelve months before the AS gave a final, unsatisfactory, response. The chief executive acknowledged to me that the level of service provided had been unacceptable. My investigation also showed that, despite what the AS had said to the woman's son, there was a record of the first request for transport but they had not acted upon it. Transport for the second appointment had been cancelled at short notice because no ambulance was available. The advice

which the AS had given about reimbursement for the taxi fare was wrong. I found that there was no guidance for staff about handling requests for *ex gratia* payments, even though some had been made on other occasions. The AS's investigation of the complaint was inadequate and slow. The remedies I secured were an *ex gratia* payment for the complainant to cover his expenses, the issue of guidance to staff about such payments and an agreement that the staff involved in complaints work would be trained in operating the revised procedures which had been introduced.

W.569/91–92 on pages 22–31 of HC 704

3.7 This case highlighted the responsibility of health authorities to assess visitors from overseas for liability to pay charges for NHS hospital treatment. A DH circular and manual provide detailed guidance on the procedures to be followed. A woman received an invoice for £2,634.50 for abdominal surgery for her father, who usually lived abroad. She complained that her father should not have been liable for the charges, since she had not been told before his operation of that liability and neither she nor her father had signed an undertaking to pay. It was not for me to assess whether the man should have to pay the charges but rather to see whether the DHA had acted properly in arriving at their decision. I concluded that they had. While there was a conflict of evidence between the man's daughter and an administrative assistant about what had been said, I believed that the woman had been told clearly that her father was liable for these charges, before his operation was undertaken. As to whether an undertaking was given to pay, the manual makes clear that that is not a pre-condition for insisting upon payment of overseas visitors' charges, although it is considered good practice. Some confusion might have arisen because, although overseas visitors may register with a GP, that does not entitle them to hospital treatment free of charge. I did not uphold the woman's complaints, but I was concerned to find that, contrary to DH guidance, several staff had believed that a complaint might arise but had not recorded their discussions with her at the time.

W.819/91–92 pages 79–87 of HC 704

3.8 A woman complained that a DHA had not carried out adequately their responsibilities as a registering authority for a private nursing home, and had failed in particular to take account of her complaints about the standard of care which her late mother had received as a private resident. The statutory requirements governing the registration and inspection of private nursing homes are contained in the Registered Homes Act 1984 and the Nursing Homes and Mental Nursing Homes Regulations 1984. DHAs have a duty to inspect registered homes in their district at least twice a year and in certain circumstances they may cancel or vary the conditions of registration, but they are not responsible for the administration of the homes. In respect of complaints about the standard of care or facilities, a DHA's responsibility is to ensure that there has been no breach of the registration requirements. My investigation showed that the nursing home inspector had found some shortcomings during her visit shortly after the complaint was received but had made arrangements for them to be put right. In other respects she considered the care at the home to be good and wrote to the woman to that effect. The inspector's letter might have explained matters more fully, and I found that the DHA could have done more to ensure that the proprietor then wrote to the complainant—as he had agreed to do—within a reasonable time. I did not find that the DHA had failed to take sufficient account of her representations.

4 REMEDIES

4.1 Many of the cases I investigate present several areas of concern, as I explain in paragraph 5.9. I deal with each issue separately on the basis of the relevant evidence, and I consider what remedy might be appropriate in each instance. As I have frequently pointed out, very often a complaint would not come to me if a genuine and timely apology had been made. Most complainants want no more than a genuine apology and explanation, though they expect that any problems identified will be put right for the benefit of future patients.

4.2 In paragraph 1.15 I referred to a change this year in the way in which the information in this chapter and chapter 5, and the associated appendices, was being presented. My aim in doing so has been to display information in topics or categories which the reader can more easily identify. The summary of remedies is now put into classifications which relate as closely as possible to those given in appendices C and D. Numbers do not tally because some grievances have more than one dimension—such as communications and records—each of which calls for a separate remedy.

4.3 In the first part of this chapter I set out topics relating to the substance of the complainant's concerns, and the remedies which I obtained. Topics later in the chapter relate to the handling of complaints. A complaint which is essentially about a failure of service can become more acute if there is incompetence in the way the complaint is dealt with by local management. Sometimes a complaint put to me is solely about handling aspects. That is particularly so in respect of family health services authority (FHSA) and clinical complaints since the substance is generally outside my jurisdiction. What I can secure in these cases is not only an apology but an improvement in the way complaints are handled at local level and monitored at the top level of management. Mishandling of complaints by health authorities, boards and NHS Trusts can take various forms. Where there are no procedures, I recommend their introduction and monitoring. Where procedures are failing I look for a radical overhaul. In some instances staff are not adequately trained or supported, monitoring arrangements are not observed and senior managers take insufficient interest in complaints handling. That is despite the requirements of the Hospital Complaints Procedure Act 1985 and policy guidance from the Health Departments and in the Patient's Charters.

4.4 The summary analysis in this paragraph uses the following letters to identify where there is a fuller, published account of the case:

(a) — full text of report published, in anonymised form, in the volume of selected investigations completed April-September 1992 (HC302)

(b) — as above, but in the volume for October 1992-March 1993 (HC 704)

(c) — case features in either chapter 2 (investigations: main topics) or chapter 3 (cases of special interest) in this report.

In some of the categories of fault relating to complaints handling there are so many examples that to list each one would blur the essential message (for example, delayed response). In those categories I itemise only cases which have been published in a selected case volume or are mentioned elsewhere in this report.

Admission and discharge arrangements

W.4/91-92	Discharged in evening and visit by community nurse not arranged. Procedures for communicating discharge decisions to be reviewed.
W.160/91-92	Admitted direct to ward instead of through A and E department, then waited three hours to be seen by doctor. Staff reminded of admissions policy, and guidance given to nurses on what to do if doctor delayed.
W.255/91-92 (a)	Two abortive attempts to admit patient. Admission procedures, and arrangements for transfer between consultants, reviewed.
W.260/91-92	Discharge not reviewed in the light of relevant developments, and woman was not sent home in the warm clothing provided by her family. Procedures to be reviewed.
W.274/91-92	Woman discharged without adequate arrangements being made for her care at home. Record of case conferences and agreed actions to be kept; national and local guidance on discharge procedures to be followed.
W.341/91-92	Day patient returned home before being seen by doctor. Medical cover to be reviewed.
W.466/91-92	Elderly woman, told she had to move to a part of a ward she had found to be cold, took own discharge so not all arrangements for after care in place. Apology given.
W.491/91-92	No enquiries made or help given regarding transport home or from ward to hospital entrance. Nurses reminded of their obligations to arrange discharge and assistance with mobility.
W.547/91-92 (b) (c)	Patient transferred to another hospital against daughter's wishes. Admission policy in respect of elderly patients clarified.
W.689/91-92 (b) (c)	An elderly patient's family not adequately consulted about her discharge, and arrangements on the day of discharge inadequate. Procedures to be reviewed and monitored.
W.892/91-92 (b) (c)	Care of breast cancer patient not followed-up. Day patient discharge procedures to be reviewed, and staff reminded to record and act upon essential information.

	W.87/92–93	Woman called for laser surgery before equipment was available. Procedures for selecting patients from the waiting list reviewed.
	W.539/92–93	Insufficient consideration given to how woman would get home from A and E department. Responsibility clarified for acting on information about home circumstances.
	WW.11/91–92	Delay in responding to letters contributed to unsatisfactory discharge of elderly patient. DHA to ensure that urgent replies to correspondence are not left unattended while staff are on leave.
Staff attitudes	W.423/91–92	Woman denied opportunity properly to express her concerns and consultant left her with impression that she had to go elsewhere for second opinion. Apology given.
	W.427/91–92	Nurse irritated by dietitian's intervention let her annoyance show. Apology given.
	W.457/91–92	Nurses' hostile attitude pressurised patient into leaving hospital. Apology given.
	W.473/91–92	Doctor lacked sensitivity towards patient. Apology given.
	W.593/91–92	Midwife's remarks on telephone seen as offensive. Staff reminded of need for care in telephone consultations; DHA to consider introducing log of telephone calls and checklist of questions for ante-natal patients.
	W.778/91–92 (b) (c)	Lay conciliator rude and unhelpful. Apology given.
	W.788/91–92 (b) (c)	Ward sister told dying man's wife to 'relax and stop fussing' and berated her about low staffing levels. Apology given and health authority agreed to review staffing.
	W.965/91–92	Insensitive remark caused terminally ill patient's wife distress. Staff reminded of need for tact; policy clarified on recording incidents where relatives are upset.
	W.58/92–93	Woman upset by consultant who refused her an abortion. DHA apologised for consultant's manner.
	W.63/92–93	News of a terminal illness given to a patient in a hospital corridor. Apology given.

	W.602/92-93	An intimidating and uncaring manner displayed by consultant at meeting with complainant. Apology given.
Care and treatment	W.4/91-92	Inadequate assistance with washing and teeth cleaning. Nurses to be more sensitive to patients' needs.
	W.190/91-92 (a) (c)	Elderly woman's hip operation delayed; not adequately fed and developed pressure sore; prescribing of drugs for depression delayed. Allocation of theatre time to be reviewed; food to be made available for patients whose operations are unavoidably delayed; improvements made in the supply of pressure relieving equipment; staffing levels increased; and nurses reminded to keep comprehensive records of care given.
	W.341/91-92	Lack of medical attention before an operation, and patient given dressing despite awareness of allergic reaction. Policy clarified for pre-operative assessment by anaesthetist; guidance issued to staff to ensure that details of known or suspected allergies are adequately documented.
	W.466.91-92	Elderly woman left in a bath unable to reach the call bell. Siting of call bells reviewed.
	W.507/19-92 (a)	Inadequate monitoring of patient's condition. Improved consultant supervision introduced.
	W.593/91-92	Maternity patient left without sufficient bed clothes after delivery, and nurse call buzzer left unanswered. Nurses reminded to respond promptly, and DHA asked to consider changing the buzzer installation.
	W.618/91-92	Maternity patient left bleeding for an hour after delivery before being stitched, and then left unwashed and in blood-stained clothes. Apology given.
	W.630/91-92	Terminally ill man admitted for respite care not adequately monitored for incontinence and then discharged with some soreness. DHA apologised.
	W.681/91-92	Unsupervised patient fell; anxiety and oral thrush not monitored; and ward stocks of sedative ran out. Medical staff reminded to examine patients as soon as possible after a fall (and to make timed entry in the records); staff reminded to make accurate and meaningful records; procedures for re-stocking drug supplies reviewed.
	W.728/91-92	Doctor unfamiliar with equipment caused pain and bleeding during a woman's treatment; nurse did not provide after-care advice, dressings or clear

		instructions. All staff reminded to familiarise themselves with equipment before giving treatment; DHA to ensure that patients obtain all necessary dressings and advice and that nursing cover is provided at late-running clinics.
	W.789/91–92	Nurses failed to ensure that a patient wore his glasses, incorrectly administered two different eye-drops simultaneously, and left soiled clothing at bed-head. Relevant procedures to be tightened up by Trust.
	W.947/91–92	Complaints about inadequate staffing and care not upheld, but DHA agreed to instruct staff not to leave the ward without adequate cover at meal breaks.
	W.401/92–93 (b) (c)	Because of poor communications between staff, patient's fractured ankle undiagnosed and untreated in hospital. Apology given.
	WW.21/91–92	Patient developed severe pressure sore and given an unsuitable wheelchair; also catheter bags changed infrequently. Staff reminded of need to keep records up-to-date; review undertaken of nurses' role in provision of wheelchairs and cushions.
Communications with patients/relatives	W.141/92–93	Parents not kept fully informed about young woman's treatment. DHA apologised.
	W.196/91–92	Daughter left to attend to father without offer of assistance. Nurses to record in care plans extent of relatives' involvement.
	W.260/91–92	The family not told risk of pressure sores when elderly patient was discharged. Reminder to nurses.
	W.341/91–92	Lack of information about operation and after-care. Apology given.
	W.358/91–92 (a)	A man felt that a medical secretary had misinformed him about his mother's position on a waiting list and not passed on his concerns to the consultant. Induction and skills training introduced for medical secretaries.
	W.359/91–92	Patient not offered counselling or given clear information about her condition. Review of guidance to junior medical staff.
	W.427/91–92	Delays in meeting relative's request to see consultant. Staff to be reminded of need to respond quickly and sympathetically to such requests.
	W.482/91–92	Lack of information about a scan. Apology given.

W.491/91–92	Failure to tell a woman's husband about the spread of her cancer. Guidance introduced for staff about conveying difficult information.
W.524/91–92	Relatives not informed promptly of deterioration in patient's condition. Apology given.
W.525/91–92 (a) (c)	DHA did not visit after mentally disturbed patient jumped through window of nearby house. Apology given. (**See also Property/expenses**)
W.572/91–92 (b) (c)	Full implications of breast surgery not discussed before mastectomy. DHA to ensure adequate arrangements for when key personnel are absent.
W.643/91–92	Man not told x-ray result or given full explanation of why he was to be admitted. Reminder to medical staff.
W.675/91–92 (b)	Relatives not given advice in time about assistance with funeral expenses. Guidance to staff and for relatives reviewed.
W.680/91–92	Contradictory decisions about withdrawal of facility to take meals in a psychiatric hospital. Apology given.
W.703/91–92	Man not told of the terminal nature of his wife's illness. Respective responsibilities of nursing and medical staff for giving such information to be reviewed.
W.772/91–92	Failure to tell woman about need to attend on the day before admission. Admission arrangements to be reviewed.
W.779/91–92	Lack of information to wife of patient who had attempted to commit suicide. Apology given. Clarification of guidance for where two clinical teams are involved in a patient's care; action to ensure compliance with DH guidance on discharge planning.
W.788/91–92 (b) (c)	Dying man cared for by wife, which nurses believed to be her preference. Patient's daughter, unaware of father's admission, notified when his condition deteriorated. Nurses reminded of need to agree and record that part of care to be provided by relatives. Policy on contacting next-of-kin reviewed.
W.806/91–92 (a)	Delay in tracing and notifying next-of-kin of patient's death. New system for tracing relatives introduced.

	W.818/91-92	Family not told of seriousness of patient's condition. Staff reminded of the importance of conveying such information, subject to patient's wishes.
	W.892/91-92 (b) (c)	Delay in conveying diagnosis of breast cancer. Apology given.
	W.906/91-92	Wife stayed with husband in hospital and provided much of care. Nurses reminded of importance of discussing and recording what was agreed the relative's responsibility should be.
	W.965/91-92	Woman not called to hospital in time to be with husband before he died. Guidance on obtaining details of next-of-kin clarified.
	W.353/92-93	Consultant's suspicions about possible malignancy and his treatment plans not communicated. No finding, but patients/relatives to be told that urgent treatment can be obtained without opting for private care.
	W.401/92-93 (b) (c)	Failure to heed or record information about next-of-kin. Recording procedures to be reviewed.
	SW.122/91-92	Man given inaccurate information about daughter's condition, and the daughter misinformed about nature of her operation. Importance of good communication emphasised to staff.
	SW.9/92-93	Patient given unduly optimistic information about condition. Apology given.
	SW.62/92-93	Man's expressed concern about his father's mental state not noted or acted upon. Nurses to be alert to information provided by relatives and to record significant contact with them.
Communications among staff	W.57/91-92	Poor communication between theatre and ward staff. Difference in expectation about post-operative care resolved.
	W.149/91-92 (a)	Medical staff in different specialties gave contradictory advice before surgery; failure to inform colleagues of purpose of admission; contradictory advice given about using patient's transport for appointment at another hospital. Responsibilities between specialties defined and use of own transport by in-patients clarified.
	W.160/91-92	Delay in carrying out an x-ray. Guidance re-issued to medical staff on the procedures to be followed when ordering x-rays.
	W.341/91-92	No information given by hospital to GP; information given to district nurse inadequate. Apology given.

	W.507/91–92	Nurses passed on requests from a relative who wanted to discuss his wife's illness with a doctor, but no action followed. Apology given. Nurses to record such requests and pass to higher authority when necessary.
	W.580/91–92	Delay by consultant in giving information to GP. Also poor communication between specialties about tests undertaken. Apology given.
	W.714/91–92	Unclear instructions on x-ray request form. Relevant clinical information in future to be attached.
	W.779/91–92	Concerns expressed by wife not recorded or communicated to consultant. Apology given.
	W.786/91–92 (b) (c)	Inadequate consideration given to a patient's needs in arranging transfer to nursing home. Hospital/ambulance service communication improved and staff made aware of what service ambulance service could provide.
	W.822/91–92	Misunderstanding between junior doctors in different hospitals led to delay in patient's admission arrangements. Junior doctors reminded of extent of their responsibilities and importance of following agreed admission procedures.
	W.906/91–92	Consultant going on leave failed to pass on patient's wishes to colleague providing cover. Staff reminded of the need to record patients' expressed wishes.
	W.163/92–93	Information given to relatives by different clinical teams caused confusion and misunderstandings. Apology given.
	SW.9/92–93	Poor communication between a surgeon and a pathologist led to delay in giving further consideration to patient's treatment. Apology given.
Delay, waiting lists, appointments	W.359/91–92	Patient's name overlooked on waiting list for admission. Apology given.
	W.474/91–92	No drink given during long wait in A and E department, then long delay in ward before doctor administered pain relief. A and E staffing levels to be reviewed, and new medical staffing arrangements to be kept under review.
	W.563/91–92	Promise that patient would be seen personally by consultant not kept. Apology given.

W.728/91-92 Two-hour wait resulted in review of out-patient appointments system and improvements to computerised 'booking-out' procedure.

W.930/91-92 In-patient waited one and a half hours in x-ray department before being attended to. Apology given.

W.41/92-93 (b) (c) Woman's operation cancelled three times. Procedures reviewed to meet National Charter Standard.

W.231/92-93 Consultant's arrival approximately one and a half hours after the start of his clinic not unprecedented. Authority undertook to monitor his attendance at clinics.

W.420/92-93 Misunderstanding and other errors delayed provision of surgery. Action to prevent elective surgery being booked for dates of NHS statutory holidays.

SW.45/91-92 Delays in providing treatment for an elderly woman. Apology given.

Ambulance services (including complaints handling)

W.101/91-92 Ambulance twice failed to collect patient for clinic. Guidance for deciding priorities and for recording information in control room reviewed. Complaint inadequately investigated, and staff reminded to investigate fully.

W.225/91-92 Delayed response to emergency ambulance request; Ambulance Service (AS) to consider how to prevent misrecording of addresses. Delayed investigation and poor replies to complaint; procedures to be rigorously monitored.

W.383/91-92 and W.390/91-92 Failure by hospital staff to request ambulance; ordered for wrong day; ambulance late collecting patient before and after out-patient appointment. Guidance to staff on action to be taken whenever patient cannot use transport booked for return journey; staff reminded to document transport requests.

W.414/91-92 and W.561/92-93 Confusion over patient's status led to failure to arrange inter-hospital ambulance transport. AS taped records to be kept for a longer period. *Ex gratia* payment of £210.00 made to cover cost of private ambulance.

W.508/91-92 (a) (c) AS failed twice to provide booked transport and refused re-fund the £23 incurred by woman's son in getting her to hospital the second time; response to complaint also delayed. Service levels to be monitored, training arranged on new complaints procedure and *ex gratia* payment made.

	W.633/91-92	AS twice made visits to collect though the complainant's wife had died some time earlier. All requests to be double-checked, and request form to be re-designed.
	W.689/91-92 (b) (c)	Family understood elderly woman would have ambulance and nurse escort to go to another hospital, but car used with no escort. Procedures for arranging transport to be reviewed.
	W.793/91-92	Patient not taken to nearest emergency hospital and ambulance driver unfamiliar with route. Training policies to be re-examined.
	W.124/92-93	Delay in arrival of ambulance to transfer patient from doctor's surgery to hospital. Apologies given about that and inadequate response to complaint.
	SW.45/91-92	Inappropriate ambulance ordered to take elderly and infirm patient home from hospital. Revised guidance issued on the ordering and use of ambulances.
	SW.117/91-92	Delayed ambulance response time. Apology given.
Failure to follow guidance/procedures	W.149/91-92 (a) (c)	Identification bracelet not used. Policy reviewed and notified to nurses.
	W.284/91-92	Failure to consult local residents about property converted to accommodate persons with a learning disability. Apology given.
	W.562/91-92	No assistance to help patient and husband leave ward. DHA to review guidance on providing aid to patients on discharge.
	W.569/91-92 (b) (c)	Dispute over information about overseas visitors charges for NHS treatment. Complaints not upheld, but DHA to review local procedures.
	W.774/91-92	Local personal clothing policy not followed. Policy to be monitored more closely.
	W.789/91-92	Eye-drops administered after expiry date. DHA to ensure written instructions to staff are clear.
	W.818/91-92	Levels of observation not increased after elderly woman suffered fall; nurses failed to warn relatives about appearance of body after her death. Guidance on observation of vulnerable patients to be reviewed, and nurses reminded to prepare bodies for viewing by relatives.
	W.890/91-92 (b) (c)	Woman with senile dementia fell after being left alone in lavatory; delay before she received medical attention. DHA to re-emphasise importance of

care planning and identification of patients needs, and make clear what staff should do in event of accident.

W.147/92–93 — Relatives received no adequate explanation for falls, and thought incorrectly that drugs had not been administered when found on patient's locker. Trust to review procedures for communication about accidents, and guidance on drug administration.

Failure to provide service

SW.2/91–92 (a) (c) — Woman denied opportunity of having maternity care at the hospital of her choice because of previous complaint. Apology given and undertaking by Health Board to obviate recurrence of failure in service.

WW.7/91–92 — Special care baby unit unable to provide care for premature baby who died when mother transferred to another hospital. DHA to ensure decisions to 'close' the unit to new admissions are properly documented and communicated effectively.

Records/test results (see also 'care and treatment')

W.369/91–92 (a) (c) — Medical records of woman admitted as emergency not found by the time she died some $1\frac{1}{2}$ hours later. Clinic staff reminded of need to ensure that records are correctly dispatched.

W.562/91–92 — A blood test repeated because of loss of earlier test results. Staff reminded to make permanent entries in the records.

W.563/91–92 — Patient's records missing at two out-patient appointments. Apology given.

W.618/91–92 — Hospital records said to be inaccurate and to have been altered. Not so, but found to have been made retrospectively. Staff reminded of importance of writing up records promptly.

W.633/91–92 — Lost records and brain scan results resulted in three-month operation delay. DHA to review follow-up procedures and produce guidelines on communicating abnormal test results.

W.772/91–92 — Inadequate recording of information relevant to discharge and failure to pass on information. Staff reminded of need to attend to these matters.

W.789/91–92 — Times of administration of drugs incorrectly recorded. Procedures to be reviewed.

W.486/92–93 (b) (c) — Records of patient considering litigation mislaid. Level at which searches conducted to be reviewed, and staff made aware of policy on timescale for destruction of records.

	SW.73/91-92 (a) (c)	Test results not brought to attention of consultant. New induction training introduced for medical secretaries.
Property/expenses	W.384/91-92 (a)	Patient not told he would have to pay for report given to dentist along with x-ray. *Ex gratia* payment made of £30.00.
	W.525/91-92 (a) (c)	Man claimed compensation for the damage caused when mentally ill patient jumped through his window. DHA made *ex gratia* payment equal to half the uninsured loss. (**See also Communications with patients/relatives**)
	W.636/91-92	Difficulty getting reimbursement of travelling expenses to visit a specialist clinic. Procedures relevant to the Hospital Travel Costs Scheme to be introduced, clarified and reviewed.
	WW.11/91-92	Pension book and accumulated money not returned to patient on discharge. DHA to amend financial instructions for dealing with disposal of pension books on discharge.
Hospital environment	W.906/91-92	Blood spots uncleaned and samples of body fluids left uncollected for several hours. Apology given. Cleaning responsibilities clarified, and standard introduced for removal of used containers.
	W.930/91-92	Ward in a poor state of repair and lacked sufficient privacy. Apology given and improvements being made to patients' washing arrangements.
	W.349/92-93 and W.443/92-93	Inadequate standard of maintenance and pest control in ward. DHA to comply fully with Department of Health guidance on pest control.
Clinical complaints procedure	W.827/90-91	Confusion between DHA and RHA over extent of a previous investigation gave rise to misleading explanation for rejection of refusal to grant independent professional review (IPR). Apology given.
	W.423/91-92	Ineffective monitoring at hospital caused delays before medical records were submitted to RHA for consideration of IPR. Apology given.
	W.529/91-92	Independent assessors incorrectly led complainant to believe that she would receive a full copy of the IPR report. Report did not cover all issues raised during the IPR. RHA to raise with Joint Consultants Committee the question of giving further guidance to assessors.
	W.539/91-92	Delay in submitting report. Apology given.

	W.757/91-92, W.769/91-92, and W.189/92-93	Delays in, and confusion as to responsibility for, reporting the results of IPR. DHA and NHS Trust apologised.
	W.834/91-92 (a)	Excessive delay in arranging IPR due to insistence that complainant should first meet consultant involved. IPR arranged later, and apology given.
	W.58/92-93	DHA failed to forward to RHA a woman's request for an IPR of a consultant's refusal to carry out an abortion. Apology given.
	W.602/92-93	Needless delays in reaching a decision about an IPR. Procedures introduced for monitoring the handling of clinical complaints and ensuring that complainants kept informed of reasons for unexpected delays.
	SW.73/91-92 (a) (c)	Failure to follow proper procedure in reaching a decision to refuse an IPR. Board to ensure procedures are properly implemented in future.
Complaints handling by FHSAs and dental practice boards	W.354/91-92	Complaint about dental charges not properly investigated, and response delayed and inaccurate. Complaint to be referred to the chairman of dental service committee, and new complaints procedures to be monitored.
	W.453/91-92	Response to woman's request for advice about dental treatment delayed and unhelpful. FHSA apologised and agreed to monitor new arrangements.
	W.496/91-92 (a) (c)	A woman's request for informal procedure disregarded. FHSA to arrange for lay conciliators to cover the whole of their area and remind staff to tell complainants how their complaints are to be handled.
	W.663/91-92 (b) (c)	Failure to follow procedure; inadequate and misleading information given to patient. FHSA to take immediate steps to conclude properly the handling of the complaint.
	W.778/91-92 (b) (c)	Complaint not investigated because of lay conciliator's illness. Monitoring procedures to be made effective, and a standard letter revised.
	W.132/92-93	FHSA refused investigation under the formal procedure believing, incorrectly, that complaint did not involve a breach in terms of service. Agreed to introduce monitoring procedures to prevent recurrence.

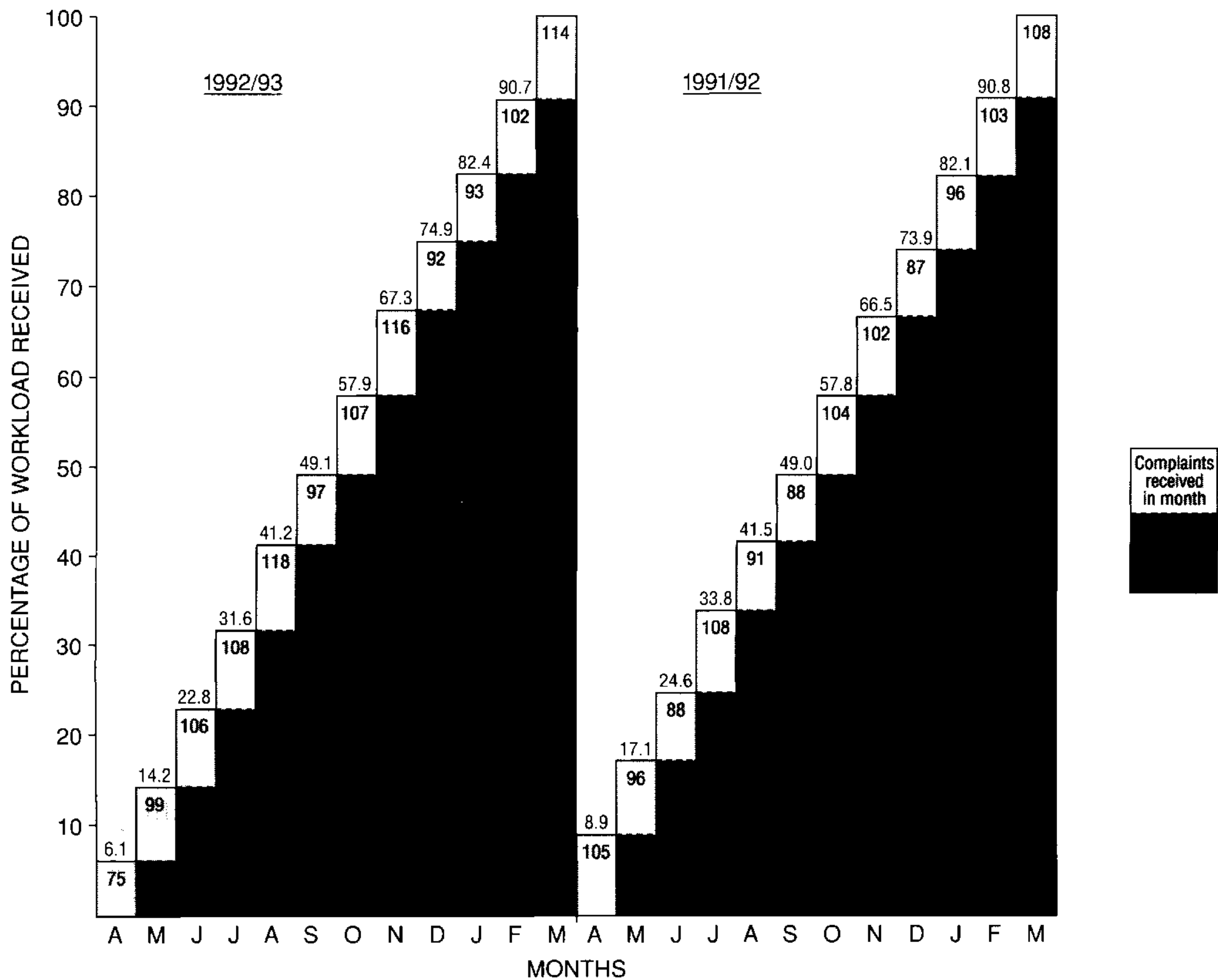
	W.278/92-93	Imperfect understanding of nature of complaint led to inappropriate handling. Apology given.
	W.416/92-93	Clumsily worded letter caused offence to patient. Apology given.
	SW.14/92-93 (b)	Patient mistakenly believed that treatment undertaken after independent examination arranged by dental practice board formed part of earlier course of treatment, and he was aggrieved at having to pay for it. In conjunction with other bodies involved, Board to consider, introducing a procedure for informing a patient of the outcome of an independent dental examination.
Delayed response	W.547/91-92 (b) (c), W.806/91-92 (a), W.890/91-92 (b)(c), W.892/91-92 (b) W.938/91-92 (b) (c) and WW.46/90-91 (b)(c)	Dilatoriness in responding, for various reasons including failure in monitoring and follow-up procedures or to accord due priority to complaints handling, in these and 20 further cases.
Not all items addressed	W.255/91-92 (a)	In 13 cases, including this one, there was a failure to deal with all the points of concern—whether from lack of rigour, a selective approach or simple oversight.
Tone of reply	W.284/91-92, W.547/91-92 (b)(c), W.572/91-92 (b), W.819/91-92, W.938/91-92 (b)	Reply was either skimpy, or couched in discourteous, insensitive or technical terms which the lay reader cannot understand.
Inaccurate reply	W.547/91-92 (b)(c), W.689/91-92 (b), W.786/91-92 (b), W.892/91-92 (b)	Inaccurate, misleading or incomplete reply in these and eight further cases.

Signing of letters	W.786/91–92 (b), WW.46/90–91 (b)(c)	Misleading the recipient by, for example, signing in another person's name or not giving the correct date of the letter's despatch.
Undertakings not fulfilled	W.4/91–92, W.482/91–92, W.593/91–92, W.779/91–92	Promises of further action or reply not kept.
No formal response	W.190/91–92, W.565/91–92, WW.56/91–92	Failure to answer letters, sometimes despite reminders from the complainant.
No follow-up information	W.160/91–92, W.341/91–92, W.572/91–92 (b)	When a specific assurance about remedial action is not given it is sometimes viewed as a brush-off.
Inadequate local investigation	W.572/91–92 (b), W.806/91–92 (a), W.890/91–92 (b) (c), WW.10/91–92 (a)	Failure to interview key staff, not following up enquiries, making assumptions without checking facts. Ten further cases fell into this category.
Poor records	W.196/91–92, W.292/91–92, W.930/91–92	Local investigation not adequately documented.
Conduct of meetings	W.217/91–92 (a), W.285/91–92, W.779/91–92	Handled badly, a meeting between complainant and key staff can make things worse.
Procedural failure	W.255/91–92 (a), W.703/91–92, W.760/91–92, WW.9/91–92	Local policy either disregarded or non-existent.
No information about procedure	W.28/92–93	No help given about how to complain, and the right to bring matters to Ombudsman.
Staff complainant	W.408/91–92	Health authority confused its responsibilities by inviting a nurse to bring a union representative to discuss a complaint she had made about treatment she had received as a patient.

5 STATISTICS

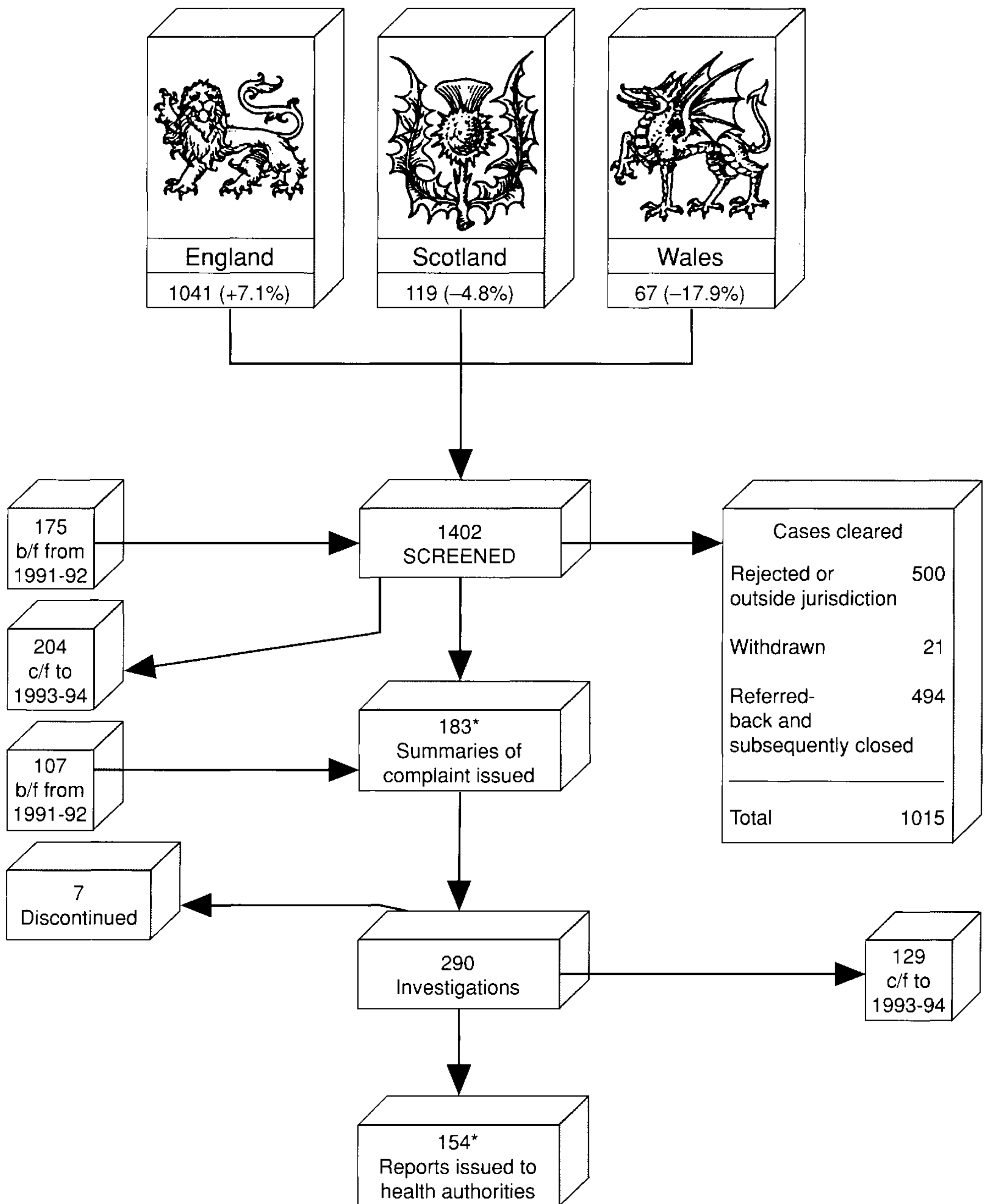
Workload 5.1 The growth in the total number of complaints reaching me continued in 1992–93, although at a reduced rate. Following the very substantial surges in numbers in 1990–91 (up 24.75%) and 1991–92 (up 18.8%), the total of 1227 for last year represented an increase of 4.3%. The flow of complaints is governed by the actions of those who seek my help, and cannot be controlled by me. The diagram at figure 1 demonstrates, over a twelve month period, the pattern in the way work reaches me.

Monthly inflow of new complaints (fig. 1)



5.2 Figure 2 provides more information about the complaints received for England, Scotland and Wales during 1992–93, and how the total workload for the year was dealt with. A new landmark was reached when for the first time in the history of the office more than 1000 complaints were received for England. The total of 1041 (972 for 1991–92) continued, for that country, the growth of recent years. However, as will be seen, complaints from Scotland and Wales moved against that trend, but the falls of 6 and 12 respectively produce deceptively large percentage variations. This information is brought together in figure 3 and at Appendix B.

WORKFLOW
1992-93
(fig. 2)



* These figures are higher than those quoted in paragraphs 1.7 (summaries of complaint issued -164) and 1.8 (investigations completed -141) because some cases related to more than one health authority

Workload and Disposal (fig. 3)

Workload

Workload	
Cases brought forward from 1991-92	282
Cases received in 1992-93	1227
Total	1509

Disposal

Disposal	
Reports issued (see paragraph 5.7)	154
Cases rejected or outside jurisdiction	500
Cases discontinued (or withdrawn)	28
Cases referred back and subsequently closed	494
Cases carried forward to 1993/94	333
Total	1509

5.3 Appendix I provides an analysis of the new complaints received on a regional basis. In England there were marked differences with seven out of the 14 regions showing reductions in numbers compared with 1991–92. In the remaining regions increases ranged from 2 (3.8%) in South Western to 32 (50%) in South West Thames. The share for the four Thames regions (453) held steady at about 44% of all complaints received for England.

5.4 Of the total of 1509 cases which made up the workload for the year, action was completed on 1176 (77.9%). This compares with 1142 (80.2%) of the 1424 cases dealt with in 1991–92. Perhaps more significant was the growth in the number of complainants who sent me supplementary letters following an initial reply which either rejected their complaints or asked for further information. In 1992–93 I received 914 such letters compared with 807 in 1991–92—an increase of 13.3%. I make further comment in this respect in paragraph 5.19. Only 135 written requests were received for information and advice, compared with 191 last year.

5.5 In expectation of a continuation in the growth of my workload I increased the number of staff in my office's screening unit from three to four. The new appointee came in the autumn. The pressure of work during the summer resulted in the loss of some ground in my drive to increase the proportion of complainants who are sent a definitive reply to their letters within 18 days of receipt. That target was achieved in 70% of the cases handled during the year, with an average response time for all cases of 16 days (76% and 14 days respectively in 1991–92).

5.6 In my report for 1991–92 I referred to those who write to me about local campaigns expecting me to support them and intervene on their behalf. That is not my role. The issues they raise usually mean that I can rarely hold out the prospect of being able to help at all. This year I have had several approaches about the fluoridation of water supplies. Where

there are proposals to fluoridate water the local health authority have a statutory duty to publicise the fact and seek views from the community. Although there is no requirement under the legislation for an authority to be bound by the results of the consultation, they are required to consider any views put to them when making their final decision. Those who have written to me have, without exception, objected to fluoridation and mistakenly believe that I can intervene to stop the process. The most common complaint put to me is that the health authority concerned have not been impartial and have promoted the benefits of fluoridation without acknowledging the counter arguments. I have pointed those complainants to the conclusions reached by my predecessor who investigated such a complaint. He found that the consultation process required under the legislation started from a proposal by a health authority to ask the water authority to fluoridate the water supply and, as such, pre-supposed that the authority would have seen the merits of that course. It is only to be expected, therefore, that a health authority, in explaining their action, will set out the advantages seen in fluoridation, and they cannot be expected to draw attention to arguments against fluoridation in which they see no validity. My predecessor did not uphold the complaint put to him, and I have been consistent with his findings in the replies I have sent to those who complain to me.

Reports issued on completed investigations

5.7 Of the 141 investigations concluded during the year, 12 involved two or more health authorities; that resulted in the issue of 154 reports. One was a joint investigation undertaken in my capacity both as Health Service Commissioner and as Parliamentary Commissioner for Administration.

5.8 In paragraph 1.7 I referred to the fact that, despite the increasing pressure of work, the average time taken to complete an investigation was held at 45.3 weeks (45.1 weeks in 1991–92). Although the average time for investigation did not improve further the table at figure 4 shows the better performance against reducing timescales. No case took longer than 67 weeks. The report for the quickest investigation was issued within eight weeks of receiving the complaint. I consider these to be significant achievements by my staff during a difficult year when a record number of cases was completed.

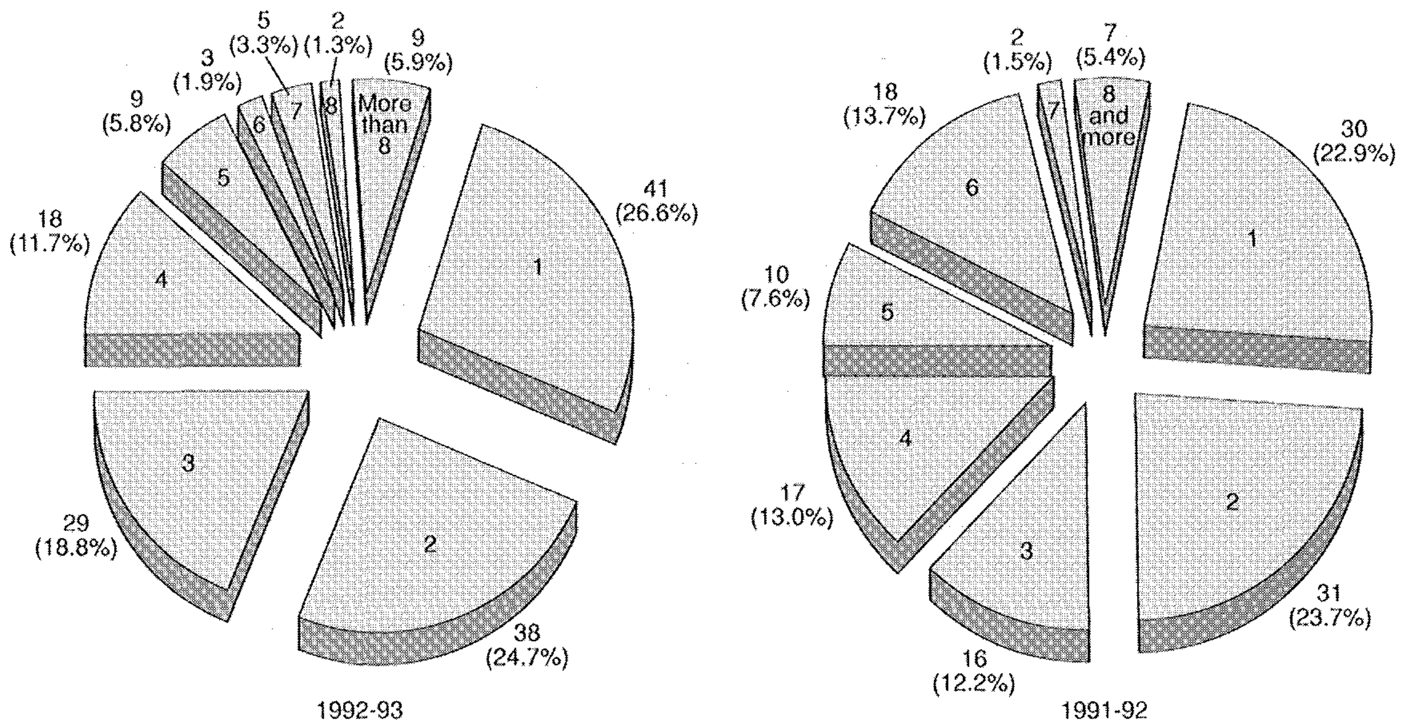
5.9 During 1992–93, 476 separately identified grievances were investigated, an average of 3.09 for each report issued (3.37 in 1991–92). The policy has been maintained of trying to ensure that each investigation has a sharp focus by excluding matters which are incidental or peripheral to the complainant's main concerns. This further reduction indicates continuing progress in that direction, but each case is judged on its merits and I investigate wide ranging complaints where there is justification for doing so. Figure 5 shows the distribution of the grievances among the 154 reports issued (paragraph 5.7). In 70% of cases (compared with 59% in 1991–92) I investigated three or fewer individual grievances. In four cases ten or more grievances were involved.

5.10 I found some justification in 60% of the grievances investigated in 1992–93, compared with 55% in 1991–92. In my annual report for 1991–92 I referred to a new system of classification which was to be tried out during the year under review. That system has allowed investigated grievances to be classified according to the NHS service area complained about, the health service staff involved and the subject matter of the

Time Bands for Investigations (fig. 4)

Time band	Proportion of investigations concluded		
	1990-91	1991-92	1992-93
Under: 40 weeks	15.6% (19)	35.5% (44)	29.1% (41)
50 weeks	37.7% (46)	68.5% (85)	61.0% (86)
60 weeks	55.7% (68)	88.7% (110)	92.9% (131)
70 weeks	77.0% (94)	96.8% (120)	100% (141)
80 weeks	85.2% (104)	99.2% (123)	
100 weeks	100% (122)	100% (124)	

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



Figures in Black: No. of Reports

Figures in Red: No. of Grievances per Report

Total No. of Reports: 154 (131 in 1991/92)

complaint. The tables at Appendices C and D provide detailed analysis of the results. For the purposes of comparison I have provided at Appendix E a parallel analysis of investigated grievances using the 'old' system. Owing to the radical change in the way complaints have been analysed under the new system there is no way of making absolute comparisons between the two sets of information. The old system was not very good at reflecting the true nature of grievances, and I am satisfied that the new approach provides fuller and more meaningful information. I shall no longer record information under the old system.

5.11 267 (56.1%) of the grievances investigated related to hospital acute services, and I upheld 137 (51.3%) of those. Services for the elderly and mentally ill accounted for 8.4% of all grievances, and it was a change to be asked to look into only 9 (1.9%) complaints about maternity care. There were 127 grievances about health authority administrative services, which accounted for 26.6% of the total; I upheld 72.4%, which was similar to the findings in 1991–92. The greater part of those grievances (99) related to the handling of complaints, including the administration of independent professional reviews under the clinical complaints procedure; I upheld 67 of these (67.7%).

5.12 The grievances have been classified according to the complaints I was asked to investigate. The analyses do not reflect all the shortcomings which I might have found. To illustrate the point, when investigating a grievance about poor nursing care ('care and treatment') I may have found contributory errors in record keeping or established that there were failures in communication between staff which gave rise to the problem. Such shortcomings would have been addressed in my report but those particular issues do not come out in the analyses of the grievances put to me. This type of detail is available from the published volumes of selected anonymised investigation reports.

5.13 Complaints about doctors (108) and nurses (167) accounted for 57.8% of all those I investigated. I upheld 138 (50.2%). There were 181 (38%) grievances about health authority administrative staff. It is very discouraging to note that 73.5% had some justification. Apart from the poor handling of complaints, the most common grievances put to me related to admission and discharge arrangements (8.8%); poor attitudes (9.5%); poor communications (16.8%)—though that aspect is found in many other complaints; and aspects of the care and treatment of patients (25.4%).

5.14 I consider it a significant fact that in 51 (33.8%) of the 141 completed investigations the complaints had been made on behalf of individuals who had died while in hospital or after receiving hospital or community based care. This answers a question put to me in January this year by the Select Committee. My officers are often required to take evidence from relatives or friends of patients who have been affected deeply by their bereavement, and that calls for great sensitivity and understanding. I believe the figure I have given serves to emphasise the need for health authority staff to show concern and compassion in their dealing with complaints which emerge after the death of a patient. Greater care and candour in the handling of such cases might well benefit families and prevent complaints from finding their way to me.

5.15 During the year I met representatives of the Patient's Association

which has an interest in the setting of standards for the care of patients. One particular aspect they were looking at was pressure sores. I have dealt with a number of cases where complaints have in part related to patients who have developed pressure sores while in hospital or nursing home care. In the year 1991–92 I investigated six such cases, and five in 1992–93. I cannot say whether these figures hold any real significance in relation to the care of patients generally, and it is perhaps insufficiently known that such sores can develop quickly.

Cases rejected, outside jurisdiction or discontinued

5.16 The totals of 500 'rejected' cases (some because a grievance was outside jurisdiction, others because I exercised my discretion not to investigate—see paragraph 1.8) and 28 discontinued (or withdrawn) cases (figure 3) combine to account for 44.9% of all cases concluded during the year. The equivalent proportion for 1991–92 was 49.4%. The year to year variations in the numbers of rejected cases are affected by the subject matter of the complaints put to me and the completeness or otherwise of the information provided by complainants about their grievances.

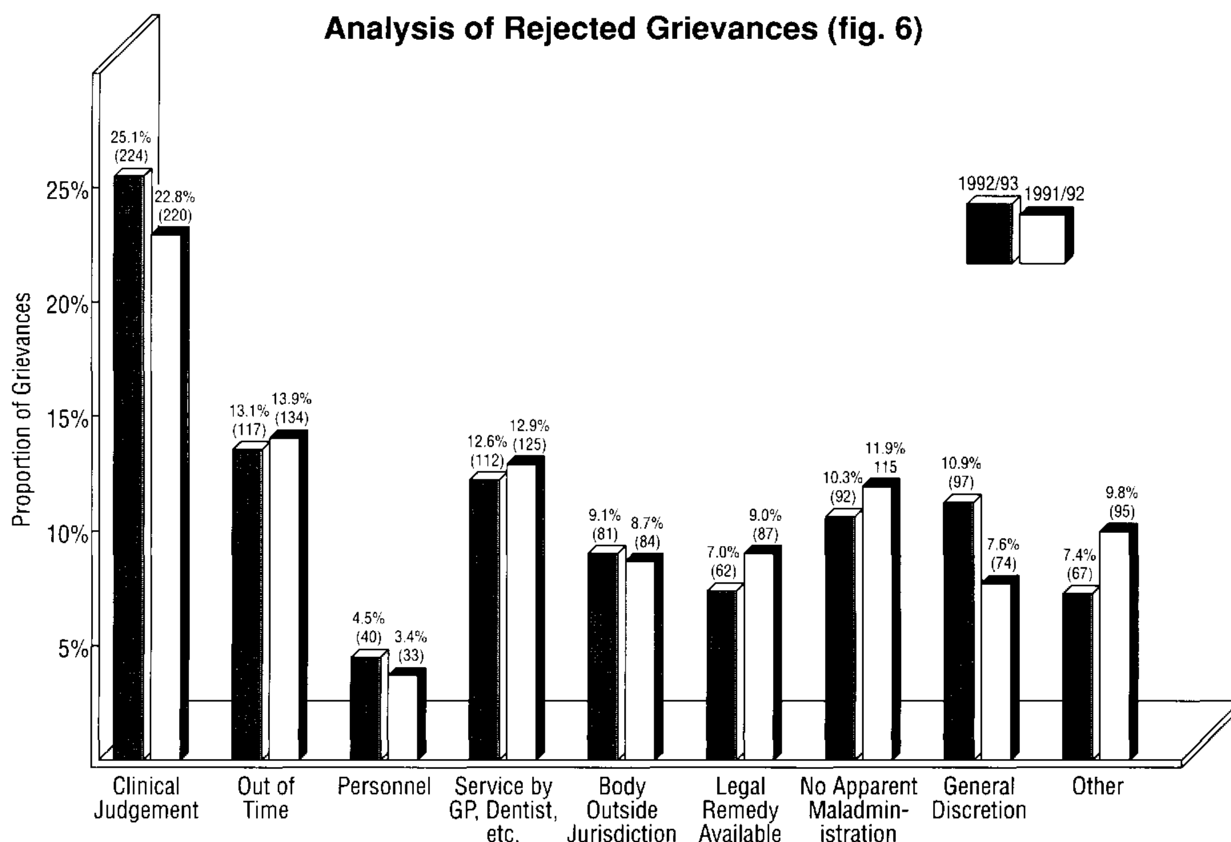
5.17 In my annual report for 1991–92 I explained that, because some complainants approach me prematurely (that is, before they have given the authority which is the subject of their complaint the opportunity to investigate it) I may not at that stage be in a position to say whether or not I can help them. That has remained the case during 1992–93 (see paragraph 5.19). The fact that I have rejected a smaller proportion of cases suggests that complainants—or those who advise them (such as community health councils)—may be more aware of what I can and cannot do, and the subjects put to me are not so obviously outside my jurisdiction. Where appropriate I give individuals a full opportunity to develop their complaints rather than turn them away on less than complete evidence, even if eventually I have to conclude that I cannot help.

5.18 I rejected a total of 892 individual grievances—an average of 1.78 per rejected case, many complainants bringing to me several aspects of concern to them. This compares with 967 and 1.79 respectively in 1991–92. The main reasons for rejection are shown in figure 6 and a fuller analysis is provided at Appendix H.

Cases referred back

5.19 Many complainants still approach me before they have taken up their complaints with the relevant health authority (or other body) or without allowing the authority reasonable time to respond to their concerns. Complainants often have to be asked to send me all the background papers before I can consider their concerns. Such action was taken for 672 of the new complaints received in 1992–93. That represents 54.8% and is the highest proportion recorded except for 1990–91 when, because the Department of Health had distributed to all households a booklet about the NHS reforms containing my address but no other, I was for a period inundated with complaints which had not been pursued in the proper ways. In that year I referred back 57.6% of cases—normally the proportion has been about 47%.

5.20 This year the number of responses to complaints which I had referred back for more information increased to a record 516 letters. That compares with 414 in 1991–92 and an average of 284 for each of the years 1988–89 to 1990–91.



5.21 In 1992-93 there was a sharp increase in the number of complaints accepted for investigation. Of those 164 cases, 105 (64%) had required reference back before I concluded that I should investigate. Since 1990-91 there has been marked increase in the number of investigations where the matter had first been referred back to the complainant. I always tell the persons complaining to me what needs to be done before I can consider an investigation. Perhaps they are increasingly ready to follow that guidance or determined to press their grievances with me where they cannot gain satisfaction locally.

5.22 Where, having referred back to a complainant, I hear nothing further within three months I close the file. I took that action on 494 complaints during 1992-93, representing 42% of all concluded cases (447 and 39% respectively in 1991-92). Some complainants may then have received a satisfactory reply from the authority against which they had a complaint, others perhaps have sought legal redress. Some no doubt simply give up.

Cases carried forward

5.23 Of the total of 333 cases carried forward (282 in 1991-92) 129 were under investigation, 155 had been referred back within the final three months of the year on which no concluding action was taken by 31 March, 16 were being considered actively for investigation and 33 awaiting attention.

Output and performance targets

The workload forecasts are based on estimates made early in 1993–94, and the projected increase in staff numbers is dependent on funding approval. No account is taken of any changes in jurisdiction which arise from the Select Committee's review (see paragraph 1.4)

	Actual 1991–92	*Forecast 1992–93*	*Actual 1992–93*	*1993–94*	*Forecast 1994–95*	*1995–96*
Complaints received	1176	1200	1227	1400	1500	1600
Percentage accepted for investigation	12.8	12.5	13.4	16	16	16
New investigations begun	150	150	164	230	240	256
Average time taken (weeks) to complete investigation	45.1	45.0	45.3	45	43	41
Percentage of new complaints screened in 18 days	76	80	70	75	80	85
Investigations completed	124	150	141	156	220	245
Length of reports (pages)	16.6	16	16	16	16	16
Staff in post:						
All investigative staff	24.5	26	26	27	37	37
Investigating officers	14.5	16	16	17	24	26
Screening staff	3	3.5	3.5	4	4.5	5
Investigations/total investigative staff	5.1	5.8	5.4	5.8	5.9	6.6
Investigations/investigating officers	8.6	9.4	8.8	9.2	9.2	9.4
Cases screened/staff in post	392	343	351	350	333	320

Summary of workload

England		Scotland		Wales		Totals		
1991/92	1992/93	1991/92	1992/93	1991/92	1992/93	1991/92	1992/93	
221	239	15	19	12	24	248	282	Brought forward from previous year
972	1041	125	119	79	67	1176	1227	**Add** received in current year
1193	1280	140	138	91	91	1424	1509	Total considered
239	287	19	26	24	20	282	333	**Deduct** carried forward to next year
954	993	121	112	67	71	1142	1176	Concluded
459	442	69	57	36	29	564	528*	Complaints rejected or discontinued
377	415	43	45	27	34	447	494	Complaints 'referred back'
118	136	9	10	4	8	131	154	Results reports issued
954	993	121	112	67	71	1142	1176	Totals
150	121	25	10	16	4	191	135	Written enquiries/advice sought

*This figure includes 28 discontinued cases of which 21 were discontinued at the request of the complainant before a decision was taken on whether or not to investigate.

Analysis of investigated grievances 1992/93—by service areas and subjects

Service Areas	Subjects of complaint: Admission and Discharge arrangements (incl. transport)	Attitudes	Breach of Confidence	Care and Treatment	Communi-cations	Delay/ Waiting lists/ Appointments	Dental Practices Board	Failure to follow guidance/ procedures	Failure to provide a service	FHSAs Informal procedures	Hospital Environ-ment	IPR Administra-tion	Patients' property/ expenses	Records/ test results	Hospital complaints handling	Totals: Upheld wholly or in part / **Not upheld**
Hospital acute —In patient	16	7	—	43	29	2	—	—	1		3	1	4	2	7	115
	8	**18**	**2**	**61**	**14**	**1**	—	—	—	—	—	—	—	—	—	**104**
— Out patient	1	3	—	1	7	3	—	2	—		—	—	—	3	1	21
	—	**1**	—	—	**8**	**3**	—	—	—	—	—	—	—	**2**	—	**14**
A & E	—	—	—			—	—	—	—	—	—	—	—	—	1	1
	3	**1**	—	**5**	**2**	**1**	—	—	—	—	—	—	—	—	—	**12**
Geriatric	2	—	—	3	1		—		—	—	—	—	—	—	—	6
	—	—	—	**2**	—	—	—	—	—	—	—	—	**2**	—	—	**4**
Mental Health		—	—	2	10		—	1	—	—	—	—	2	—	5	20
	—	**2**	—	—	**3**	—	—	—	—	—	**2**	—	**1**	**2**	—	**10**
Maternity		—	—	1	—	—	—	—	—	—	—	—		1		2
	—	**5**	—	**2**	—	—	—	—	—	—	—	—	—	—	—	**7**
Ambulance	9			—	—	2	—	1	—	—		—	—		6	18
	—	**1**	—	—	—	—	—	—	—	—	—	—	—	—	—	**1**
Other Community Health		—	—	—	—	—		1			—		—	—	1	2
	—	—	—	—	—	—	—	**1**	—	—	—	—	—	—	—	**1**
Administrative (excl. FHSAs)	3	5	1	1	6	2	3	—	—	1	1	9	—	2	58	92
	—	**1**	—	—	—	**1**	**1**	—	—	—	—	**3**	—	—	**29**	**35**
Family Health Services	—		—		—		—	—	—	10	—		—		—	10
	—	**1**	—	—	—	—	—	—	—	—	—	—	—	—	—	**1**
Totals Upheld	31	15	1	51	53	9	3	5	·	11	4	10	6	8	79	287
Not upheld	11	30	2	70	27	6	1	1	—	—	2	3	3	4	29	189

Analysis of investigated grievances 1992/93—by professions and subjects

Professions involved in complaints		Subjects of complaint: Admission and Discharge arrangements (incl. transport)	Attitudes	Breach of Confidence	Care and Treatment	Communications	Delay/ Waiting list/ Appointments	Dental Practices Board	Failure to follow guidance/ procedures	Failure to provide a service	FHSAs Informal procedures	Hospital Environment	IPR Administration	Patients' property/ expenses	Records/ test results	Hospital complaints handling	Totals
																	Upheld wholly or in part / Not upheld
Medical and Dental	Upheld	8	6		12	30	4	—	—	1	—	—	1		1	2	65
	Not upheld	1	8	—	13	15	5	—	—	—	—	—	—	—	1	—	43
Professions allied to medicine	Upheld	—	—	—	—	—	—	—	—	—	—	—	—	1	—		1
	Not upheld	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	1
Nursing, midwifery and health and visiting	Upheld	13	5	—	37	14	—	—	—	—	—	—	—	1	2	1	73
	Not upheld	8	18	2	56	8	—	—	—	—	—	—	—	2	—	—	94
Scientific, technical and professional	Upheld	—	—	—	—	—	—	—	—	—	—	—		—	—		—
	Not upheld	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2
Ambulance crews	Upheld	4	—	—			1		1	—	—	—	—		—	4	10
	Not upheld	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Maintenance and auxiliary staff	Upheld	—	—	—	—	—	—	—	—	—	—	4	—	—		—	4
	Not upheld	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Health authority administrative staff	Upheld	6	3	1	2	9	4	3	4	—	11	—	9	4	5	72	133
	Not upheld	2	3	—	—	4	1	1	1	—	—	2	3	1	1	29	48
FHSA lay conciliator	Upheld	—	1	—	—	—	—	—	—	—	—	—		—		—	1
	Not upheld	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Totals Upheld		31	15	1	51	53	9	3	5	1	11	4	10	6	8	79	287
Not upheld		11	30	2	70	27	6	1	1	—	—	2	3	3	4	29	189

Analysis of categories of investigated grievances, 1991–92 and 1992–93, using 'old' classifications (paragraph 5.10)

Upheld wholly or in part	Not upheld	Sub Total	Total 1992–93	1991–92	
					Nursing
43	66	109			failure in care
20	8	28			lack of or incorrect information
7	18	25			attitudes
—	1	1			maltreatment
3	1	4			failure to carry out clerical duties
73	94		167	198	**Total**
					Medical
19	14	33			lack of or incorrect information
8	12	20			attitudes
15	10	25			failure in non-clinical procedures
42	36		78	89	**Total**
					Administration
5	2	7			policy decisions (manner in which reached)
21	11	32			day-to-day (hospital in-patient)
14	5	19			day-to-day (hospital out-patient)
3	5	8			day-to-day (hospital casualty)
12	1	13			day-to-day (family practitioner services)
55	24		79	38	**Total**
					Failure in service
12	2	14			ambulance
3	—	3			community
3	2	5			laboratory/technical/house-keeping
1	2	3			paramedical
19	6		25	34	**Totals**
98	29		127	83	**Handling by authority**
287	189		476	442	**Totals**

Number of grievances investigated and upheld, 1983/84 to 1992/93

Number investigated			Number upheld	
Year	Total	No. of grievances per report issued	No.	% of (ii)
(i)	(ii)	(iii)	(iv)	(v)
1983/84	350	2.94	167	47.71
1984/85	443	3.54	209	47.18
1985/86	526	3.84	302	57.41
1986/87	483	3.69	290	60.04
1987/88	525	3.94	321	61.14
1988/89	556	4.00	322	57.91
1989/90	345	3.88	177	51.30
1990/91	487	3.50	236	48.46
1991/92	442	3.37	243	55.00
1992/93	476	3.09	287	60.29
Totals	4633	3.58	2554	55.13

Analysis of main categories of grievances investigated 1983–84 to 1992–93

Year	Total number of grievances	Nursing		Medical		Administration		Failure in service		Handling of complaint	
1983/84	350	136	39%	61	17%	101	29%	15	4%	37	11%
1984/85	443	153	34%	101	23%	87	20%	32	7%	70	16%
1985/86	526	236	45%	111	21%	76	14%	36	7%	67	13%
1986/87	483	179	37%	112	23%	108	22%	19	4%	65	13%
1987/88	525	205	39%	101	19%	102	19%	27	5%	90	17%
1988/89	556	204	37%	130	23%	109	19%	21	4%	92	17%
1989/90	345	153	44%	66	19%	54	16%	15	4%	57	17%
1990/91	487	169	35%	108	22%	78	16%	22	5%	110	22%
1991/92	442	198	45%	89	20%	38	8%	34	8%	83	19%
1992/93	476	167	35%	78	16%	79	17%	25	5%	127	27%
Totals	4633	1800	39%	957	21%	832	18%	246	5%	798	17%

Analysis of rejected grievances 1992/93

England		Scotland		Wales		Totals		
1991/92	1992/93	1991/92	1992/93	1991/92	1992/93	1991/92	1992/93	
65	68	11	10	8	3	84	**81**	Body complained of outside jurisdiction
92	89	19	16	14	7	125	**112**	Complaint against GP, dentist, pharmacist, optician
27	31	4	1	2	1	33	**33**	Service Committees and Tribunal Regulations
184	189	24	23	12	12	220	**224**	Clinical judgment
74	56	10	4	3	2	87	**62**	Legal remedy available
25	37	7	2	1	1	33	**40**	Personnel matter
108	99	20	15	6	3	134	**117**	Out of time
1	2	—	—	—	—	1	**2**	Right to appeal to tribunal
—	—	8	1	—	—	8	**1**	Action subject to the protective functions of the Mental Welfare Commission (Scotland)
98	75	10	8	7	9	115	**92**	No prima facie failure/maladministration
7	9	—	1	2	—	9	**10**	Contractual/commercial transaction
64	89	7	6	3	2	74	**97**	General discretion
15	18	1	—	—	2	16	**20**	Complainant not aggrieved or acceptable as complainant
28	1	—	—	—	—	28	**1**	Complaints from local authority, other public body or nationalised industry
788	763	121	87	58	42	967	**892**	Totals

Geographical distribution of complaints received for 1992/93

Region of Origin	Number of complaints received	Proportion of total (%)	Nominal population (000s)	Population (000s) per complaint
Northern	37 (45)	3.0 (3.8)	3,075	83 (68)
Yorkshire	72 (54)	5.9 (4.6)	3,656	51 (67)
Trent	58 (53)	4.7 (4.5)	4,705	81 (88)
East Anglia	28 (40)	2.3 (3.4)	2,059	73 (50)
London and Home Counties:				
North West Thames	117 (119)	9.5 (10.1)	3,499	30 (29)
North East Thames	115 (117)	9.4 (9.9)	3,803	33 (32)
South East Thames	125 (126)	10.2 (10.7)	3,658	29 (29)
South West Thames	96 (64)	7.8 (5.5)	2,979	31 (46)
Wessex	69 (58)	5.6 (4.9)	2,940	43 (50)
Oxford	49 (31)	4.0 (2.6)	2,564	52 (81)
South Western	55 (53)	4.5 (4.5)	3,262	59 (60)
West Midlands	85 (86)	6.9 (7.4)	5,219	61 (60)
Mersey	50 (39)	4.1 (3.3)	2,403	48 (62)
North Western	85 (87)	6.9 (7.5)	4,016	47 (46)
Totals for England	1041 (972)	84.8 (82.7)	47,838	46 (49)
Scotland	119 (125)	9.7 (10.6)	5,120	43 (41)
Wales	67 (79)	5.5 (6.7)	2,881	43 (36)
Overall Totals	1227 (1176)	100.0	55,839	45 (47)

†The comparable figures for 1991/92, but relating to a slightly different population base, are shown in parenthesis

Geographical distribution of investigations completed in 1992/93

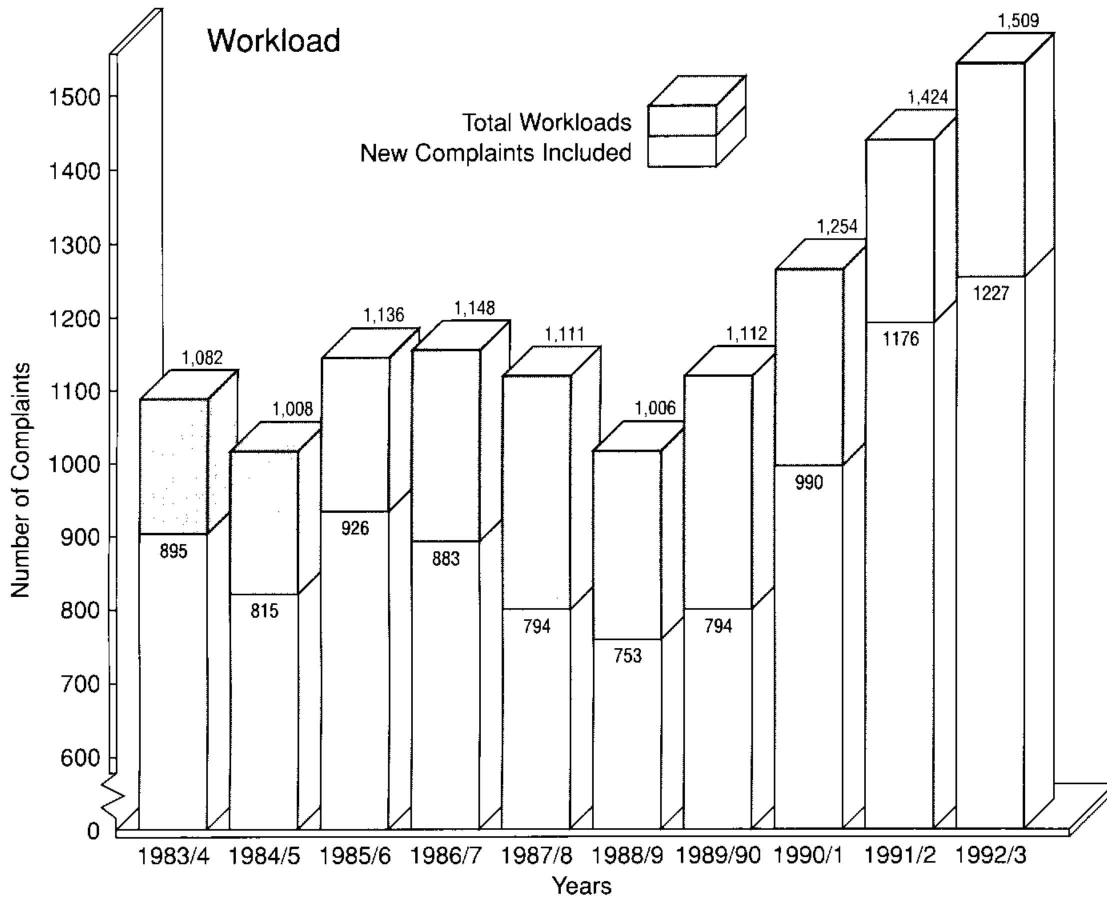
English Regions	Investigations Completed
Northern	5
Yorkshire*	9
Trent	5
East Anglia	1
London and Home Counties:	
North West Thames	15
North East Thames	18
South East Thames*	25
South West Thames*	13
Wessex*	4
Oxford	—
South Western	6
West Midlands	9
Mersey	7
North Western	9
Total England	126*
Add: Scotland	9
Add: Wales	8
Overall Total	143

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

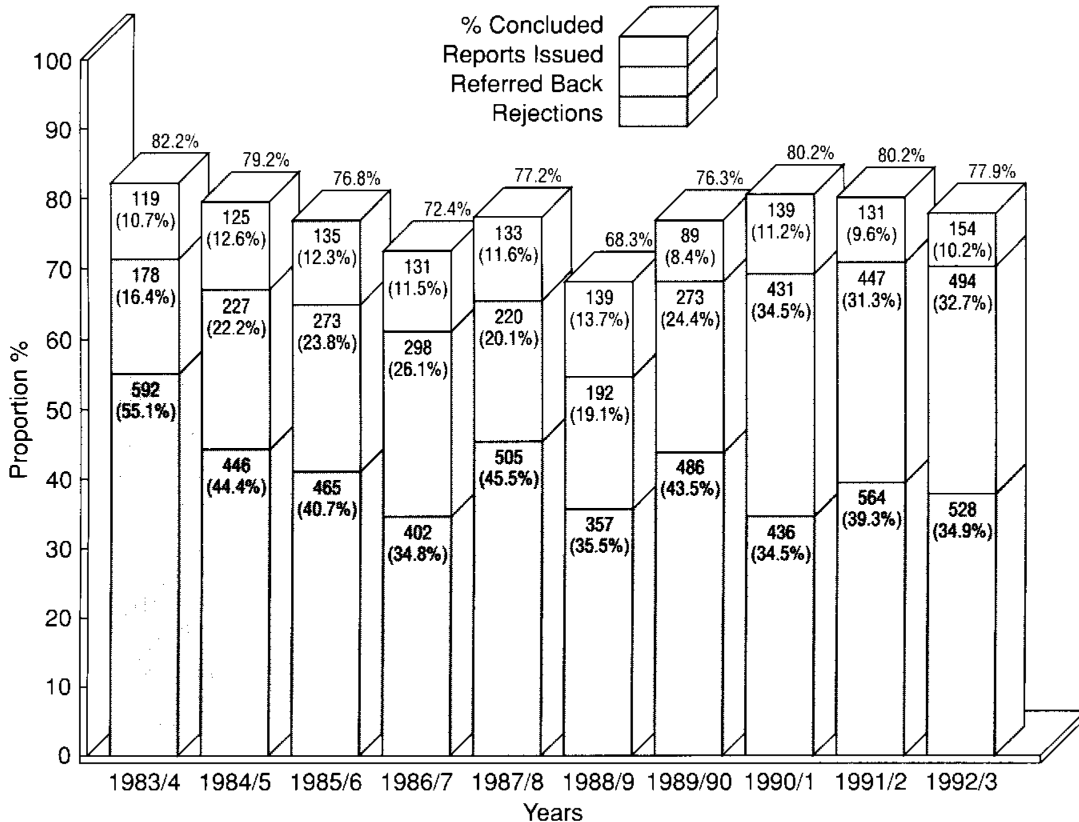
2. 26 investigations of complaints about English health authorities were conducted by the Investigation Units in Edinburgh (16) and Cardiff (10).

3. 98 investigations were conducted by the London based Investigation Units: 70 (71%) related to the four Thames Regions, of which 44 (63%) involved health authorities within the Greater London area.

Analysis of Workloads and Disposal 1983-84 to 1992-93



Disposal of Workload concluded within each year



Glossary of acronyms used in this report

A and E	Accident and emergency
AS	Ambulance service
CAMO	Chief administrative medical officer
DH	Department of Health
DHA	District health authority
FHSA	Family health services authority
GP	General practitioner
HB	Health board
IPR	Independent professional review

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