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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

19 December 1996

Dear Colleague

REPORTS OF THE HEALTH SERVICE COMMISSIONER

**Summary**

1. This letter covers 2 important reports from the Health Service Commissioner and the Government's response to the Select Committee on the Parliamentary Commissioner for Administration's report on the Health Service Commissioner's Annual Report for 1994/95. They should be distributed widely and used by all Health Boards and NHS Trusts to review performance and take remedial action as required.

**Action**

2. Enclosed are:

2.1 the Health Service Commissioner's Report on Selected Investigations on Access to Official Information in the National Health Service;

2.2 his report of selected cases (April-September 1996);

2.3 epitomes of the selected cases; and

2.4 the text of the Government's response to the Select Committee's Report on the Health Service Commissioner's Annual Report for 1994/95. This is being circulated to complete the process begun with the publication in June 1995 of the Commissioner's 1994/95 Annual Report.

3. Board General Managers and Trust Chief Executives are asked to:

3.1 distribute the Reports as widely as possible;

3.2 ensure that staff are aware of the problems highlighted by the Commissioner and that appropriate action is taken;

**Addressees**

For action:
General Managers,
Health Boards

Chief Executives, NHS Trusts

General Manager,
Common Services Agency

General Manager,
State Hospitals Board for Scotland

For information:
(Epitomes only)

General Manager,
Health Education Board for Scotland

Executive Director, SCPMDE

Chief Officers/Secretaries
Local Health Councils

Deans of Medical Faculties

**Enquiries to:**

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Health Gain Division
Room 52, St Andrew's House
EDINBURGH EH1 3DG

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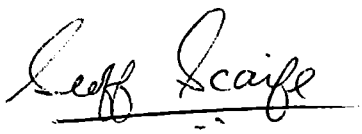
3.3 ensure that they sign all replies to written complaints as required by the new NHS complaints procedure;

3.4 ensure that those who have been appointed as Conveners under the new complaints procedure are following the guidelines relating to the convening of an Independent Review Panel as set out in "Guidance on the Implementation of the new NHS Complaints Procedure" issued under cover of MEL(1996)24 and supplemented by the Training and Information pack for Independent Review Panel Members issued under cover of MEL(1996)66;

3.5 ensure that all staff are aware of the provisions of the Code of Practice on Openness in the NHS in Scotland (issued under cover of MEL(1995)31).

4. The Annex highlights a number of key points in the reports.

Yours sincerely



GEOFF SCAIFE
Chief Executive

ANNEX

KEY POINTS ARISING FROM HEALTH SERVICE COMMISSIONER REPORTS

1. Selected Investigations Completed (April-September 1996)

1.1 The Commissioner's report gives details of 95 cases investigated during the period April to September 1996. Although none was Scottish, the report contains useful lessons to be learned by all NHS bodies and not just those identified in the cases. Publication of the Commissioner's report coincides with the completion of the first 6 months of the new NHS Complaints Procedure introduced from 1 April 1996. It includes 3 reports of the first investigations into complaints against decisions by Conveners about whether to convene an Independent Review Panel under the new NHS complaints procedure. In each case, the Commissioner found that the Convener had not properly complied with the guidance on the new Complaints Procedure issued earlier this year.

1.2 The Commissioner accepts that Conveners are new to their role but is concerned that the guidance issued by the NHS Management Executive appears to have been ignored. It is clearly important that any emerging lessons from the Commissioner's investigations are taken on board at an early stage. Failures include not giving adequate reasons for the decision; not writing personally to the complainant; omitting to seek appropriate clinical advice; and omitting to tell the complainants about their right to complain to the Ombudsman.

1.3 Other issues highlighted by the Commissioner have been the subject of previous reports by him and I have written to you before about them: complaints handling (including "dilatory, tactless and inadequate replies", some of which have not been signed by the Chief Executive); communication (both between staff within NHS organisations and with patients); delays in A&E departments; and inadequate or missing records.

2. Access to Official Information in the NHS

2.1 This is the first report published by the Commissioner covering the first year of operation of his responsibilities in respect of complaints about non-disclosure of information under the Code of Practice on Openness in the NHS. In that time the Commissioner had received only 21 complaints and 10 enquiries about non-disclosure of information. The Commissioner decided that 4 of these cases warranted a full investigation of the complaint and one investigation was stopped when legal proceedings were instigated. One of the 3 remaining cases was a Scottish case concerning a complaint against Forth Valley Health Board. A patient who had complained about the treatment she had received in hospital raised a number of issues with the Commissioner. Among them was a request for the names, clinical specialties and work addresses of 2 specialist clinicians who had carried out an Independent Review, in addition to the summary of its findings which had already been given to her. The Health Board took the view that they should not provide this information

because it had been provided to them in confidence. After further consideration, at the prompting of the Commissioner, they agreed to provide the names and clinical specialities of the clinicians who carried out the review and at a later stage, following further recommendations by the Commissioner, their work addresses. However, they continued to hold that the full text of the independent professional review should not be provided to the complainant, and the Commissioner endorsed their view on that.

2.2 Given the small number of cases, there are no general themes to emerge about the type of information being withheld from the public. However, the Commissioner's impression is that knowledge of the Code and how complaints about non-disclosure of information should be handled is not yet sufficiently widespread among NHS staff; and that NHS bodies need to give more attention to ensuring that staff know about the change. Your particular attention is drawn to page 5 of the Code which makes clear that the NHS should:

> "help the public to know what information is available so that they can decide what they wish to see, and whom they should ask" and
>
> "ensure that there are clear and effective arrangements to deal with complaints and concerns about local services and access to information, and that these arrangements are widely publicised and effectively monitored".

It is particularly important that staff realise that any refusal to disclose information can only be justified by application of one of the exemptions in the Code (pages 9-10).

2.3 Further copies of the Code and guidance on its implementation can be obtained from:

Mr Martin Milarky
Directorate of Human Resources
Department of Health
St Andrew's House
Edinburgh
EH1 3DG.

# HEALTH SERVICE COMMISSIONER
# SECOND REPORT SESSION 1996-97 HC 87
# EPITOMES OF SELECTED CASES FOR THE PERIOD APRIL TO SEPTEMBER 1996

## 1.Case No: E.368/94-95 - Policy on hip operations and handling of complaint

Matters considered

*Hospital policy for giving hip replacements to patients over 55 - denial of NHS treatment - handling of complaint*

Body complained against

Ipswich Hospital NHS Trust

Summary of case

The complainants' ninety year old mother-in-law was admitted to the accident and emergency department (A and E department) of Ipswich Hospital, in June 1993, suffering from what was later diagnosed as a fractured femur. She required a hip replacement. The complainant said that a doctor had told them that it was the Trust's policy to put patients needing such an operation and who were over the age of fifty-five at the bottom of the waiting list but that an operation could be carried out more quickly if the complainant opted for private treatment. The patient's family claimed that as a result of being told this she was forced to seek private treatment, which was carried out the day after her admission. The family were dissatisfied with the Trust's response and did not believe their complaint had been fully investigated.

Findings

I found that the Trust did not operate a policy which put patients over fifty-five at the bottom of a waiting list for hip replacement. The orthopaedic department had decided that the woman did not need emergency treatment; that decision was made in the exercise of their clinical judgment and was at the time outside my statutory jurisdiction. I thought it possible that the family had misunderstood the explanation given them of a clinical protocol for emergency treatment of patients under 55 needing hip repair, and had sought private treatment as a result. I found that the Trust had not investigated the complaint thoroughly; in particular, they had failed to interview the doctor who had given the family the advice about which they had complained, and had failed to recognise and explain the clinical protocol which may have been misunderstood by the family. I recommended that the Trust remind staff of their duty to investigate and reply fully to complaints.

Remedy

The Trust apologised and agreed to remind staff of the importance of fully investigating complaints.

## 2.Case No. E.413/94-95 - Arrangements for admission to hospital

Matters considered

*Short notice and cancellation of arrangements for admission to hospital*

Body complained against

The Royal Surrey County and St Luke's Hospitals NHS Trust

Summary of case

On 16 April 1994 a woman received an appointment for admission to Royal Surrey County Hospital on 18 April for a tonsillectomy. On 18 April she was told that no bed was available; on 20 June she was given a new appointment for 27 June but three days later that was cancelled. She was eventually given an appointment on 29 August. She

complained about the short notice of the first appointment, the second cancellation and the Trust's failure to provide a new date for admission within a month as required by the Patient's Charter.

Findings

The woman had said that she would be prepared to come in if a bed became available due to a cancellation so I did not uphold the complaint about the short notice of the first appointment. The Trust's failure to offer her another appointment within a month breached the Patient's Charter standard and they failed to keep her informed of what was happening.

Remedy

The Trust apologised and agreed to remind staff of the need to keep patients fully informed about arrangements for their treatment and to ensure that offers of appointments were based on a realistic assessment of what beds would be available.

3.Case No: E.583/94-95 - Communications with undertakers

Matters considered

*Wording of Trust's standard letter to undertakers about bodies which may be infectious.*

Body complained against

Preston Acute Hospitals NHS Trust

Summary of case

The family of a man, who suffered from a rare lung disease and died in the Royal Preston Hospital, in April 1993, complained that his body was released to the undertakers with a letter that stated that he had died while suffering from an infectious disease. The statement was subsequently found to be untrue and the family complained to Preston Health Authority about the distress that it had caused. They asked that wording of the standard the letter be amended to say, when appropriate, that the patient had died while *possibly* suffering from an infectious disease. Preston Acute Hospitals NHS Trust who had taken over the management of the hospital refused the request.

Findings

I found that at the post mortem examination there were indications that the patient might have had an infectious condition. The diagnostic tests took some weeks to complete, and the Trust released the body to the undertakers with a standard letter stating that it was infectious. I found that the claim caused the family avoidable distress. The wording of the standard letter was inaccurate when used for bodies that were only suspected to be infectious and the change in the wording suggested by the patient's family was in line with national guidance. I upheld the complaint.

Remedy

The Trust apologised; they revised the standard letter to state, when appropriate, that the patient was suspected to have had an infectious disease, and they added guidance on whom to contact if relatives were concerned about the risk of infection.

4.Case No. E.644/94-95 - Handling of complaint.

Matters considered

*Reply dilatory and failed to cover all points raised*

Body complained against

Airedale NHS Trust, West Yorkshire

Summary of case

In June 1993 a man complained to the Trust about the circumstances of his mother's death in Airedale General Hospital. The Trust did not reply until July 1994 and the complainant considered their letter a 'whitewash'.

Findings

A business manager in the Trust obtained comments from staff on the man's complaint but then failed to take any further action. The file was put in the wrong place and arrangements for checking progress broke down. The reply which the business manager eventually sent to the man was superficial and inaccurate and was misrepresented as being from the chief executive.

Remedy

The Trust apologised. They had already introduced revised procedures under which the chief executive was personally involved in dealing with complaints and agreed to keep them under review to ensure that they fully met national requirements.

5.Case No. E.687/94-95 - Consent to treatment

Matters considered

*Procedures for obtaining consent not followed properly and breaches in Department of Health guidance - particularly that no-one may give consent on behalf of another adult.*

Body complained against

Royal Hull Hospitals NHS Trust

Summary of case

In February and March 1994 a woman who was an inpatient in Hull Royal Infirmary, which is managed by Royal Hull Hospitals NHS Trust, needed several operations. On each occasion a consent form was signed by either the woman's daughter or her son-in-law. In April the need for further surgery was identified, but the consultant concerned with this operation said that consent could only be given by the woman, as he believed she was sufficiently in control of her faculties to make a decision about surgery. The woman did not give her consent.

Findings

I found a number of major failings by the Trust. Staff, unaware of national guidance on obtaining consent, misled the woman's family into believing that relatives could sign consent forms for other adults and used inappropriate forms obtaining consent. I found that staff were inconsistent in their understanding about whether the family were consenting formally or simply not disagreeing when signing the forms for the operations. I criticised the Trust for failing to communicate effectively to staff the national guidance on consent and I upheld the complaint.

Remedy

The Trust apologised and agreed to review their policy on consent to treatment to make sure: that local guidance fully met national requirements; that all staff fully understood their responsibilities; and that the implementation of the policy was monitored regularly.

6.Case No. E.821/94-95 - Care in A and E department and handling of complaint.

Matters considered

*Seriousness of illness not communicated to relative - intravenous drip not administered - complaint handling*

Body complained against

Redbridge Health Care NHS Trust, Essex

Summary of case

In February 1994 a woman took her father to the A and E department at King George Hospital, Goodmayes, because he was having difficulty breathing. When his condition seemed stable she returned home but she was recalled to the hospital shortly afterwards because he had collapsed and died. She was later told that an intravenous drip which a doctor had ordered had not been administered. She also received conflicting information about the circumstances surrounding her father's collapse. She complained through her local Community Health Council, but despite a meeting with the Trust and several letters she remained dissatisfied.

Findings

I found that a doctor gave the woman a proper explanation of her understanding of the patient's condition and I did not uphold that aspect of the complaint. I upheld the complaint that an intravenous drip was not administered. Doctors had assumed nurses would set up the drip although hospital policy placed responsibility for the administration of drugs with the medical staff. I criticised the doctors' ignorance of the policy. I also found that the Trust gave the woman conflicting accounts of the circumstances in which her father collapsed.

Remedy

The Trust apologised and agreed to remind medical and nursing staff of their respective responsibilities for the administration of drugs; to introduce procedures to ensure that prescribed drugs were administered; and to remind all staff of the importance of ensuring that information given to complainants was accurate and complete.

7.Case No. E.926/94-95 - Care of a patient with physical and learning disabilities

Matters considered

*Patient left in hot sun - standard of records - communication with relative - complaint handling*

Body complained against

Canterbury & Thanet Community Healthcare NHS Trust

Summary of case

In June 1994 a woman with physical and learning disabilities spent two days in a community residential home while her suitability for respite care was assessed. When her father came to collect her she was sitting in hot sunlight and unable to move. Staff could not answer her father's questions about what had happened to her and who was in charge and he was not satisfied with the reply to his subsequent written complaint.

Findings

I found that the woman had been left in the sun for between ten and 25 minutes which was unacceptable. There were shortcomings in the home's records which made it difficult for staff to answer the man's questions. The initial investigation of his written complaint was inadequate.

Remedy

The Trust apologised and agreed to issue guidance on the proper completion of records; to remind staff of the need for special care when looking after patients who might be dependent on them for help; and to remind staff dealing with complaints of the importance of dealing with all issues raised.

8.Case No. E.985/94-95 - Discharge to private nursing home care

Matters considered

*Adequacy of communication with relatives - responsibility for cost of long term care and specialist feeding equipment.*

Bodies complained against

Kidderminster Health Care NHS Trust
Worcestershire Health Authority

Summary of case

In December 1993 an elderly woman who had suffered a stroke was admitted to Kidderminster General Hospital, which is managed by Kidderminster Health Care NHS Trust. She became unable to swallow and was fed by means of a gastric tube. In March 1994 she was discharged to a private nursing home, where she died on 29 April 1995, and for which the family met the fees. The woman's son complained that the options for his mother's long term care and the financial implications of that had not been properly discussed with the family before she was discharged. He also complained that North Worcestershire Health Authority (now part of Worcestershire Health Authority) had unreasonably refused to meet the cost of her nursing home care, and had not explained why the family were required to pay for the specialist feeding equipment the woman needed.

Findings

The woman's consultant had wanted to transfer her to a long stay hospital bed but could not do so as the woman did not meet the Health Authority's qualifying conditions in place at the time for long term care. At first the woman's family wanted her to return home and considerable effort was made to inform them about the care she would need there and its likely cost, but when it later became clear that the family were considering discharge to a private nursing home the family were not told clearly or in writing, as they should have been, that they would be responsible for the fees. During my investigation I issued a report of my investigation of another case involving North Worcestershire Health Authority in which I criticised their criteria for funding long term care. In the light of that report the Health Authority agreed that they had a responsibility to meet the woman's nursing home fees. They agreed, too, that they had a responsibility to meet the cost of specialist feeding equipment, which NHS guidance HSG(95)8 says that the NHS has a duty to provide, even where long term care is arranged and funded by other means. They accepted that they had not answered the complainant's enquiries about that.

Remedy

The Trust agreed to revise their discharge procedures to make sure that, in future, patients discharged to private nursing homes and their families are fully informed who should pay the fees. The Health Authority agreed to make an ex-gratia payment to reimburse the family for the expense they incurred.

9.Case No. E.1497/94-95 - Handling of complaint

Matters considered

*Handling of complaint about clinical care given to a patient in A and E who was discharged and subsequently died.*

Body complained against

Newham Healthcare NHS Trust, London

Summary of case

In March 1994 a man was admitted to the A and E department of Newham General Hospital, which is managed by Newham Healthcare NHS Trust, suffering from chest pains. He was examined, two electro-cardiograms were performed and he was discharged, but later the same day he collapsed and died. The man's son complained to the Trust in October 1994 about his father's treatment. He received a number of interim replies which were incorrectly addressed to his late father and he did not receive a full reply from the Trust until six months after he first complained. That reply was again addressed to his late father and contained factual inaccuracies.

Findings

I found the handling of the son's complaint to be dilatory, tactless and inadequate. The Trust acknowledged his letter of complaint promptly but did not send any interim replies from mid November to early February. Most of the Trust's letters, including the final response, were addressed to his late father. Their final reply was sent six months after the son first complained and then only after intervention by my office. That reply contained factual errors about the time

and date the man was admitted; failed to tell the son about the independent professional review procedure for clinical complaints; and misrepresented the reason for the six month delay. The Trust had attributed that, erroneously, to the difficulty the A and E consultant had in contacting the locum doctor who had treated the man. My investigation showed that no attempt had been made to contact the locum and that the delay occurred as a result of poor communication between the consultant and managers.

Remedy

The Trust agreed to review the son's complaint about the clinical aspects of his late father's care. They also agreed to review their administrative practices to make sure that documents were adequately recorded and retained, and to review their complaint handling and monitoring procedures.

10.Case No. E.1501/94-95 - Treatment delay

Matters considered

*Delay in treatment because hospital failed to convey to patient the seriousness of his condition.*

Body complained against

Frimley Park Hospital NHS Trust, Surrey

Summary of Case

A man was given a clinic appointment for 23 February 1993 to hear the results of a biopsy. He cancelled both that appointment and a further appointment arranged for 30 March, and did not attend the clinic until 27 April, when he was told that he had cancer. On 17 May he had an operation to remove the tumour, but the cancer recurred, and the man died on 8 November 1994. Before his death he complained to the hospital that his treatment had been delayed because the hospital had failed to convey to him in February 1993 the potential seriousness of his condition and took no steps to make sure that he attended follow-up appointments.

Findings

I did not uphold this complaint. I found that the consultant had left the man in no doubt about the urgency of his appointments. It would have been unreasonable to expect the hospital to follow up every patient who cancelled. In this case the delay was not crucial, and treatment began promptly once the diagnosis was given to the patient. I agreed with the consultant who said that patients should take responsibility for their own actions in attending appointments, and that there was little a hospital could do to compel them to attend.

11.Case No E.1504/94-95 - Treatment by district nurses

Matters considered

*Communication between district nurses - maintenance of nursing records - communication with the general practitioner (GP) about the patient's condition.*

Body complained against

Ravensbourne NHS Trust, Kent

Summary of Case

In May 1994 a woman developed an infection in her right foot. She was treated at the GP's surgery and latterly at home, by district nurses employed by Ravensbourne NHS Trust. The nurses dressed the woman's foot but her condition worsened. She was admitted to hospital on 3 June 1994 and part of her right leg was amputated. After a second operation she died on 19 July 1994.

Findings

The arrangements for communications between nurses were haphazard and poorly implemented. No one assumed responsibility for the patient when the named nurse went on annual leave, and the nursing notes were not transferred to patient's home. A number of visits were not recorded in the patient's records, and the nurses visiting her had little or no information about her previous condition and treatment. The lack of nursing notes would have made it difficult for the nurses to plan a sensible treatment regime or to know if there was any change in the condition of her foot. I upheld the complaints about communication between district nurses and the maintenance of nursing records. I found no evidence of administrative failings in the nurses' communications with the GP and I did not uphold that aspect of the complaint.

Remedy

The Trust agreed to monitor the implementation of new procedures on record keeping and communication between district nurses about patients.

12.Case No: E.98/95-96 - Childminder's discussion with health visitor

Matters considered

*Breach of confidentiality.*

Body complained against

Wirral Community Healthcare NHS Trust.

Summary of case

In November 1994 a health visitor employed by the Wirral Community Healthcare NHS Trust made what was described as a routine visit to a woman and her 19 month old son. The woman later learned that her childminder had twice approached the health visitor to discuss her concerns about the child's development and that that had prompted the visit. The woman complained to the Trust that she had been misled about the reasons for the visit and that the health visitor's discussion of the child with the childminder constituted a breach of confidentiality. The Trust replied initially that the health visitor's action was correct and that childminders attending clinics with a child could be regarded as acting 'in loco parentis', that is in place of the parent.

Findings

I found that the reference to the childminder being 'in loco parentis' in the Trust's letter was misleading in two respects. First, the childminder had not taken the child to the clinic to be seen, in the absence of one of his parents, but was accompanying a friend. Second, even if the childminder had accompanied the child to an appointment she would not have been acting 'in loco parentis'. That was made clear in guidance from the social services department but the Trust did not seem aware of that guidance. I criticised them for that. The health visitor was in a difficult position when approached by the childminder to discuss matters with the mother. I considered that the health visitor could not properly have ignored the childminder's approach to her but should have sought advice. She then had to tread very carefully to avoid passing confidential information back to the childminder. I judged that she strayed slightly from that narrow path. I criticised the health visitor for passing on certain information which was effectively part of the medical records. I upheld the complaint to the extent of the shortcomings I found. There was some confusion about when visits from the health visitor were due, but the health records suggested that there had been a long gap with no contact and that the health visitor had a backlog of visits and at first was not aware that the child was on her case load. That suggested a poor level of management and supervision of her work which gave me cause for concern.

Remedy

The Trust apologised. They agreed to consider ways to inform parents of their policy on health visitor contacts and to review their systems for supervision of health visitors, in particular for making sure that visits had been carried out at appropriate times.

13.Case No. E.138/95-96 - Handling of complaint

Matters considered

*Handling of complaint - lack of co-operation from consultant*

Body complained against

Guy's & St Thomas' Hospital NHS Trust, London

Summary of case

A consultant rheumatologist at St Thomas' Hospital saw a woman in February 1994 about back pain which she had been suffering for some time. He wrote to her general practitioner suggesting that he consider a psychiatric referral. He did not inform her of that, and she found out only when she saw the GP. The woman complained through her local Community Health Council to the Trust but was not satisfied that their replies answered the points put. She also asked for a meeting with the consultant but her request was refused.

Findings

I found that the Trust's letters to the woman contained a number of errors and left unanswered some questions which in my view warranted a considered reply. The matter was made worse by the fact that the person who wrote the letters was ignorant of some important points in the complaints procedure. The woman had a number of questions about the action of the consultant which she had good reason to want to put to him in person after he had refused to provide written answers. The reasons given by the consultant for not meeting the woman were clinical judgments which were, at the time of these events, statutorily outside my jurisdiction. However, he owed her some explanation and the matter should have been referred to senior management for resolution.

Remedy

The Trust apologised and agreed to make sure that all staff dealing with complaints received clear instructions and training; to give guidance to medical staff on the importance of responding to complaints and the proper handling of requests for meetings; and to review arrangements for ensuring that when senior staff needed to be involved issues were referred to them without delay.

14.Case No. E.334/95-96 - Communication with relatives and post mortem arrangements

Matters considered

*Communication with patient's relatives - lack of understanding about administrative procedures for post mortems.*

Body complained against

Frenchay Healthcare NHS Trust, Bristol

Summary of case

A man was admitted to Frenchay Hospital on 20 December 1994 for diagnostic tests of a lung condition. Several days later the man's family were told that there was no evidence of malignancy and that he could expect to be discharged in a day or two, but his condition deteriorated and he died on 2 January 1995. The family gave their consent to a post mortem examination but before that was done the body was released to a funeral director and the man's daughter had to contact the coroner's office for the body to be returned. The daughter complained that the family had been given inappropriately encouraging information about her father's condition and that arrangements for the post mortem were inadequate.

Findings

The man's consultant suspected that the man had cancer but initial test results did not reveal any malignancy and further tests were planned. I could not be certain who spoke to the man's family but the doctors and nurses who dealt with the man all denied giving them false hope. However, I concluded from the evidence that the man's family were led to believe that his condition was less serious than it proved to be. When the man's daughter asked for a post mortem to be conducted the consultant told her that that was not necessary. Later, a junior doctor asked the man's

son to consent to a post mortem, which he did, but the junior doctor then failed to send the appropriate papers to the pathology department. That resulted in the man's body being released prematurely to a funeral director. I upheld both complaints.

Remedy

By the time of my investigation the Trust had already taken action to improve the standard of communication with patients and relatives, and to make sure that consultants and their junior staff had a common understanding of when a post mortem was required. In the light of my investigation the Trust agreed to remind staff about their policy on communication with patients and relatives, and to consider producing more detailed guidance about post mortem procedures.

15.Case No: E.379/95-96 - Excessive wait in Accident and Emergency department

Matters considered

*Wait in the A and E department - lack of cover by surgical team - inadequate care*

Body complained against

Hillingdon Hospital NHS Trust, Middlesex

Summary of case

In February 1995 a man attended the A and E department at Hillingdon Hospital suffering from acute abdominal pain. He was not admitted to a ward until about eight hours later. The man complained about the delay. He also complained that while he was in the A and E department he received inadequate care and was subjected to insensitive remarks by a radiographer.

Findings

I upheld the man's complaint that because of administrative shortcomings he experienced an excessive wait in the A and E department. The main reason for the delay was the failure of staff to contact a member of the on-call surgical team. The day in question was a 'changeover day' for junior doctors, who change appointments every six months as part of their training programme. The on-call surgical senior house officer had left the hospital as a consequence of that programme before his replacement had arrived. Individual Trusts are responsible for making sure that effective arrangements are in place on 'changeover days.' Because of insufficient evidence I made no findings on the complaint about lack of care and the insensitive remarks. I criticised A and E staff for their failure to record adequately the man's nursing care and the prescription and administration of his medication.

Remedy

The Trust apologised. They agreed to review their arrangements to make sure that appropriate cover was always provided. They also agreed to remind staff about the procedure for calling more senior medical staff when difficulties arise, the need to maintain adequate nursing records and the importance of recording the times of the prescription and administration of drugs.

16.Case No. E.410/95-96 - Lack of pain relief provided and handling of complaint

Matters considered

*Failure to observe a patient was in pain and no pain relief provided when brought to attention of staff- handling of complaint*

Body complained against

Dudley Group of Hospitals NHS Trust

Summary of Case

A woman was admitted to Russells Hall Hospital on 4 August 1994. She discharged herself on 8 August and died on 18 September. Her husband complained to the Dudley Group of Hospitals NHS Trust, which manage Russells Hall Hospital, that during the night of 7/8 August she was in severe pain which went unnoticed by nursing staff until they

were informed by another patient. He suggested that they contact the patient who had told nursing staff about his wife's condition and enclosed a list, compiled by his late wife, setting out the events of the night of 7/8 August. He found the Trust's reply dilatory and unsatisfactory.

Findings

The care plan stated that observations were to be made every two hours to obtain a pain history. However, no observations were recorded and no records were kept of the nature or severity of her pain. Changes were made to the patient's medication, but no record was kept of the reasons for these changes and there was no evidence that her care plan was reviewed. To the extent that there was no evidence that the observations required by the care plan were carried out, I upheld the complaint that the care given to the patient was inadequate. Because of the uncertainty about timings, I could make no finding on the complaint that nursing staff failed to act to relieve the patient's pain. The handling of the complaint was a catalogue of delays, errors and misinformation. No attempt had been made to identify the other patient involved. I upheld fully the complaint that the Trust's handling of the complaints was dilatory and unsatisfactory.

Remedy

The Trust apologised for their shortcomings. They agreed to remind all medical and nursing staff of the importance of following care plans and recording the action taken. They also agreed to make sure that their new procedures for handling complaints deal with complaints quickly and thoroughly, and to monitor the effectiveness of improvements made to the storage arrangements for patients' records.

17.Case No. E.539/95-96 - Breach of confidentiality

Matters Considered

*Disclosure of personal information about a patient*

Body complained against

The Riverside Mental Health NHS Trust, London

Summary of case

In January 1995 a woman, who had a history of mental illness, and who lived in a housing association hostel, consulted a psychotherapist. The psychotherapist referred her to a consultant psychiatrist. The woman complained that the psychotherapist and the consultant psychiatrist breached her right to confidentiality by passing on, without her permission, personal information about her to a residential support worker at the hostel.

Findings

I recognised that difficult considerations apply to patients whom doctors consider to be at risk of harming themselves or others. It seemed to me that any decision on whether to disclose information about such patients, with or without their consent, must rest on a careful analysis of the individual case and ultimately on the clinical judgment of the doctor concerned. Recent Department of Health guidance has emphasised the need to balance patient confidentiality against the need, where appropriate, to share information with others. Against that background I found that while technically the psychotherapist breached the woman's right to confidentiality he did so in the interests of the patient and of the other residents and staff at the hostel. I did not therefore uphold the complaint against him. I found that the consultant psychiatrist's action in contacting the support worker without the woman's consent was taken in the exercise of his clinical judgment. At the time in question that was a matter outside my jurisdiction, so I could make no finding on that part of the complaint.

18.Case No. E.682/95-96 - Inadequate admission and discharge arrangements and unsatisfactory handling of a complaint

Matters considered

*Failure to check and record a patient's property on admission -inadequate discharge arrangements - handling of complaint*

Body complained against

Wirral Hospital NHS Trust

Summary of case

A woman complained that when her mother was admitted to Arrowe Park Hospital on 27 May 1995 no record was made of her hearing aid, which was subsequently lost. In addition, the arrangements for her mother's discharge were inadequate. On 14 June the woman wrote to the patient services manager to complain about the attitude of a senior house officer. The patient services manager replied on 22 June but the woman was dissatisfied with the reply and wrote to the director of operations /chief nurse on 27 June. In that letter she also complained about the loss of her mother's hearing aid and the discharge arrangements. The woman remained dissatisfied with the response to her complaint.

Findings

I found that adequate steps had been taken to check and record the patient's belongings and I did not uphold that complaint. I found that staff failed to follow the Trust's discharge policy in several respects - some records were not completed as fully as they should have been, some entries were unsigned and undated and staff failed to tell the woman that her mother was still wearing a drainage bag and that a district nurse would be visiting. Finally, the handling of the complaint was unsatisfactory in that the Trust's complaints procedure was not followed properly and staff were not adequately prepared for meetings. The final reply was not from the chief executive and did not contain any information about action taken as a result of the woman's complaint.

Remedy

The Trust apologised and agreed to remind all nursing staff to follow fully the requirements of the discharge policy and to ensure that staff were aware of and followed the complaints procedure.

19.Case No. E.723/95-96 - Failure to give information about a planned operation

Matters Considered

*Inadequate information about waiting time for an operation*

Body complained against

Swindon and Marlborough NHS Trust

Summary of case

A woman, who attended a hospital in May 1995 and was told that she would be operated upon in about one month, had to wait over a year for surgery. During that year she was not informed of the reasons for the continuing delay or the maximum length of time she would have to wait.

Findings

The estimate that there would be a one month wait was reasonable at the time. Due to a change in circumstances at the hospital, that wait was extended greatly. I upheld the complaint and criticised the Trust for failing to react to the change by informing waiting patients, and for expecting them to find out this information for themselves. They did not give the woman her Patient's Charter right to receive detailed information on local health services, including waiting times. I also criticised the failure to give her other information she requested about the operation.

Remedy

The Trust apologised and agreed to give a guaranteed date by which a patient will be admitted for treatment if it is not possible to give a date for the operation, and to give as much information as possible about the reasons for delays.

20.Case No. E.758/95-96 - Consideration of request for extra-contractual referral

Matters considered

*Delay in deciding whether to fund an ECR request- unacceptable arrangements proposed for assessment of patient.*

Body complained against

Herefordshire Health Authority

Summary of case

In April 1994 a woman's general practitioner referred her to an allergy clinic in Yorkshire, but Herefordshire Health Authority refused to authorise funding for the referral. The woman was referred to a local consultant physician who was unable to help her. After a request from the woman's general practitioner to reconsider their rejection of the referral to the clinic, the Authority decided to seek a second expert opinion and in March 1995 they told the woman that they wanted her to undergo an assessment by an independent consultant in Southampton, who had particular expertise in allergy treatments.

The woman complained that the Authority acted unreasonably in expecting her to travel to Southampton for assessment and that the Authority delayed in coming to a decision about the funding of the extra-contractual referral.

Findings

Department of Health guidance states that appropriate clinical advice should be sought by health authorities when they are considering ECRs. I found that the Authority acted properly in seeking to refer the woman to the consultant in Southampton for assessment. I found that the delay in deciding it was necessary for a referral to the consultant in Southampton was unsatisfactory, and I upheld the woman's complaint of dilatoriness to that limited extent; the Authority were not at fault for other delays.

Remedy

Herefordshire Health Authority apologised to the woman, and agreed to amend their policy on ECRs to include guidelines on timescales for handling requests and a clearly stated appeals procedure.

21.Case No. E.788/95-96 - Refusal of Accident and Emergency staff to contact police

Matters Considered

*Refusal of staff to contact police - unsatisfactory handling of complaint*

Body complained against

Richmond Twickenham and Roehampton Healthcare NHS Trust

Summary of case

In September 1994 a man who had been injured in an assault attended the A and E department at Queen Mary's University Hospital, London. He complained that the nurses in the A and E department refused to help him contact the police. He also complained that the Trust subsequently refused to concede that he should have been helped to contact the police and that they refused to name the nurses about whom he wished to complain. The nurses who dealt with the man recalled that he was significantly under the influence of alcohol and unco-operative when he arrived at the A and E department. They did not remember him asking them to contact the police.

Findings

I had no reason to doubt the evidence given by the staff. I was not persuaded that the man asked for help in contacting the police and therefore I did not uphold that aspect of the complaint. I dismissed his other complaint.

22.Case No. E.803/95-96 - Care of a patient in Accident and Emergency department and unsatisfactory handling of a complaint

Matters considered

*Delay in A and E - inadequate nursing care - handling of complaint*

Body complained against

Redbridge Health Care NHS Trust, Essex

Summary of case

In February 1995 a woman was taken by ambulance to the A and E department of King George Hospital, Essex. Although a doctor decided that she should be admitted to a ward the woman remained on a trolley in the A and E department where she later suffered a cardiac arrest and died. The woman's daughter complained to me about her mother's care in the A and E department and about the Trust's unsatisfactory handling of her complaint.

Findings

I found that the woman had been waiting for nearly ten hours in the A and E department when she suffered a cardiac arrest. Part of the delay was because she was not seen by a doctor as promptly as required by her assessment of priority on arrival; for the remainder of the time she was waiting for a bed to become available in a ward. Because the decision to admit her was not timed in the records, I could not say exactly how long the woman waited for a bed, but it was clearly longer than the Trust's own standard of 90 minutes. The care she received during that time was inadequate: nursing observations were not carried out and there was no call bell to attract the attention of staff. The number and skills of staff were inadequate. I found that the Trust's handling of the complaint was inadequate, both in the initial investigation and when the matter was reviewed by other managers. I found it appalling that, having identified shortcomings and told the woman's daughter that remedial action would be taken, senior management did not make sure that the action was taken promptly. I upheld both complaints and I drew this case to the attention of the purchasing Health Authority.

Remedy

The Trust agreed to review their systems for monitoring of performance in the A and E department and to make sure that staff skills and numbers were adequate. The Trust also agreed to make sure that all outstanding action arising from the complaint was taken urgently and that their arrangements for handling complaints avoided the serious shortcomings which I had identified.

23.Case No. E.936/95-96 - Failure to act on a complaint

Matter considered

*Failure to act on a complaint.*

Body complained against

Addenbrooke's NHS Trust, Cambridge

Summary of case

A woman attended an outpatient appointment at Addenbrooke's NHS Trust low vision clinic in May 1994. She was told that she would be referred to a consultant at a second hospital. In December 1994 she contacted the second hospital and was told there was no record of her referral. She complained to the Trust, but was dissatisfied with the explanation that she received and the failure to address her request for a meeting.

Findings

I found that the Trust's initial investigation of the woman's complaint was wholly inadequate. It failed to establish that the referral was not made because a member of the Trust's staff forgot to make the necessary arrangements. I also found that the woman's request for a meeting had been ignored. I noted that in two previous investigations I had

occasion to criticise the way that the Trust dealt with complaints. I could not place much reliance on an assurance I had received from the Trust following an earlier investigation that a robust system was in place for monitoring complaints.

Remedy

The Trust apologised for their shortcomings and agreed that the Trust Board and chief executive would undertake monitoring of the effectiveness of the complaints handling procedure.

24.Case No. E.1348/95-96- Funding of an extra-contractual referral (ECR)

Matters considered

*Refusal to continue ECR funding of a patient's treatment*

Body complained against

Croydon Health Authority

Summary of case

A man had been receiving cardiac care from a consultant at Maidstone Hospital for some years. On 23 August 1995 Croydon Health Authority, who had been funding that treatment, wrote to tell him that they would no longer fund that treatment as an ECR, and that he could see the same consultant at Guy's Hospital, where they had a contract. The man considered that travelling to Guy's would have been difficult for him because the pollution in London aggravated his asthma. The Authority offered the alternative of a referral to another consultant at a hospital nearer to the man's home, but he found that unacceptable and he complained to me.

Findings

The Authority's ECR policy, which came into effect in April 1995, listed some circumstances in which ECRs would be authorised, including the continuation of treatment for which a patient was already receiving care from a non-contracted provider. That was the man's situation, and I found that the Authority had failed to follow their own policy. I upheld the complaint.

Remedy

The Authority agreed to fund the man's cardiac care at Maidstone Hospital, and apologised to him. They agreed to review all other cases since April 1995 in which an ECR had been refused and the patient had expressed dissatisfaction about the alternative referral offered by the Authority. They undertook to deal with all ECR requests in accordance with their existing policy until such time as it was amended. They agreed also to ensure that the ECR appeal procedure was followed correctly in all cases.

25.Case No. E.441/96-97 - Convener's decision not to convene an independent review

Matters considered

*The procedure followed by a convener in deciding not to convene an independent review of a couple's complaint*

Body complained about

Lifespan Healthcare NHS Trust, Cambridge

Summary of case

A couple sought an independent review, under the NHS complaints procedures introduced on 1 April 1996, of their grievances about the care and treatment of their children, who were patients at the Croft Children's Unit, which is managed by the Trust. Their request was considered by the Trust's convener. In June 1996 the convener told the couple that their request for an independent review had been refused.

Findings

I found that the convener did not comply with the NHS Executive guidance for the handling of complaints in the NHS. The convener misdirected herself by telling the couple that a conflict of evidence between them and staff at the unit could not be resolved by her further investigation. She also applied an inappropriate test of proof on the couple's accusations, which was a matter for an independent panel to consider. The convener followed the national guidance in taking independent clinical advice in coming to her decision, but did not tell the complainants

Remedy

The Trust apologised and agreed to review the convener's decision in the light of the procedures laid down in the national guidance, and to consider whether there was scope for further efforts at local resolution. They agreed to tell complainants in future when clinical advice has been obtained by a convener in coming to the decision whether to convene an independent review.

26.Case No. E.443/96-97 - Refusal of a request for an independent review

Matters considered

*The procedure followed by a convener in deciding not to convene an independent review of a woman's complaint*

Body complained about

Dewsbury Health Care NHS Trust

Summary of case

A woman sought an independent review under the NHS complaints procedures introduced on 1 April 1996 of her grievances about the lack of availability of suitable therapeutic counselling. Her request was considered by the Trust's convener. In May 1996 the convener told the woman that her request for an independent review had been refused.

Findings

I found that the convener did not comply with the NHS Executive guidance on handling complaints. The convener failed to: set out clearly the reasons for her decision; take appropriate clinical advice from someone not previously involved in the complaint; and tell the woman of her right to complain to me.

Remedy

The Trust apologised and agreed to review the convener's decision following the requirements of the complaints procedures, and to make sure that in future the national guidance was put into practice.

27.Case No. E.541/96-97 Convener's decision not to convene an independent review

Matters considered

*The procedure followed by a convener in deciding not to convene an independent review of a woman's complaint.*

Body complained against

The Royal National Orthopaedic Hospital NHS Trust

Summary of case

A woman sought an independent review, under the NHS complaints procedures introduced on 1 April 1996, of her grievances about misdiagnosis of her condition, lengthy waiting times and a lack of communication. Her request was considered by the Trust's convener. In June 1996 the convener told her that her request for an independent review had been refused.

Findings

I found that the convener did not comply with the NHS Executive guidance for the handling of complaints in the NHS by failing to take appropriate clinical advice in coming to her decision. The convener believed that the clinical complaint had been made too long after the events complained about, and therefore exceeded the time limit for complaints to be investigated. That was not her role, and in any event the Trust's customer care manager had already agreed that the Trust would look into the complaint. I did not uphold a complaint that the convener did not advise the woman of her right to appeal to me.

Remedy

The Trust apologised and agreed to review the convener's decision not to grant an independent review in the light of the procedures laid down in the national guidance. They agreed to tell complainants in future when clinical advice had been obtained by a convener in coming to the decision whether to grant an independent review.

28.Case No. W.26/95-96 - Communication with relatives

Matters considered

*Lack of information given about patient's diagnosis - monitoring of food intake.*

Body complained against

Gwynedd Hospitals NHS Trust, Bangor

Summary of case

In January 1994 a woman, who had been experiencing difficulties in swallowing, attended Ysbyty Gwynedd as an outpatient. In late June she was diagnosed as having cancer of the oesophagus. After several stays in hospital she was finally admitted as an emergency on 21 August. Her husband learned by chance about the diagnosis of cancer only by chance a few days before the woman died on 13 September. He complained about not being told earlier and also that his wife's food intake had not been monitored resulting in her receiving inadequate nourishment.

Findings

The biopsy which confirmed the woman's cancer was done on 27 June. The results were reported on 30 June and noted in her medical records on 5 July. Doctors and nurses were well aware of the diagnosis but did not convey that to the woman's husband until a nurse referred to it in September. Each assumed that others had passed on the information, although there was no written record of that being done. I found that there was inadequate communication between doctors and nurses; and between both doctors and nurses and the woman's husband. I strongly criticised those failures in communication, as a result of which the husband was told of her diagnosis in an inappropriate way and two months later than he should have been. I upheld the complaint. The woman's food intake was mentioned frequently in the nursing documentation, and she was referred to the dietetic service. I found that that was in accord with what her consultant considered appropriate for someone in her condition. I did not uphold that complaint but I considered that her husband might have understood better why her food intake was not monitored in the way he expected if he had been made aware of her diagnosis and prognosis at an earlier stage.

Remedy

In the light of the complaint the Trust amended an audit checklist to make sure that details of interviews with patients and relatives were recorded. They also issued policy guidance on 'breaking bad news effectively'.