Health Service Commissioner : fourth report for Session 1976-77 : annual report for 1976-77.

Annual Report of the Health Service Commissioner 1976-77

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HEALTH SERVICE COMMISSIONER

Fourth Report for Session 1976-77

Annual Report for 1976-77

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Introduction

1. In accordance with Section 37(4) of the National Health Service Reorganisation Act 1973 and Section 48(4) of the National Health Service (Scotland) Act 1972 I submit my report on the performance of my duties as Health Service Commissioner for the year 1 April 1976 to 31 March 1977. I continued to hold the three appointments of Health Service Commissioner for England, for Scotland and for Wales, and as in previous years I am submitting a single report to the three Secretaries of State. There was in fact no significant difference in the pattern and nature of complaints between England, Scotland and Wales which would require separate reports.

2. I have submitted during the year under review to the three Secretaries of State, three further reports* each covering a period of four months, to which I attached as Appendices the full, but anonymised, texts of all individual reports of investigations completed during the periods involved.

3. It is an important feature of the Health Service Commissioner's Office that the public have direct access to him. The only prior condition laid down in the Act is that the person with a complaint should first make it to the Health Authority. If the Authority's reply is not satisfactory, then the complainant has direct access to me.

4. The requirement that complaints should first be put to the Authority is obviously sensible, since many of them can be satisfactorily and more quickly settled at that stage. But the complainant's ability, if he is not then satisfied, to bring his complaint without further ado to me gives my jurisdiction a directness and immediacy which I welcome.

5. It means that if people are to make use of my services they must know that I exist. During the past year my senior staff and I have taken every opportunity offering, by national and local television and radio, in press reports and articles, and by addressing conferences of interested bodies, to make the services we can offer more widely known. I am glad to say that the number of invitations to speak to professional and consumer bodies shows a rising level of interest. But I recognise that we must continue and intensify our efforts to make known to the public the services that I can offer. The publication, for the first time, of the full texts of all reports which I issue, every four months, has attracted considerable attention in professional and consumer journals and certain cases, of particular interest, have been widely reported in the national press.

6. Whether for this or other reasons the number of complaints I have received during the year has for the first time since the Office was opened in 1973 shown a significant increase to 582, the rate of increase being particularly marked in the

* First Report of the Health Service Commissioner, Session 1976/77—HC 21.
Second Report of the Health Service Commissioner, Session 1976/77—HC 160.
Third Report of the Health Service Commissioner, Session 1976/77—HC 321.

two last quarters. The detailed statistics are given in a later section. In relation to the total number of contacts between patients and the National Health Service hospitals, whether as inpatients, outpatients or casualties, this number is so small as to make any interpretation impossible. But it is encouraging to see an increased public demand.

7. I have to say, however, that while the number of complaints I received has risen, the proportion which was within my jurisdiction and which I could investigate has remained static. 60% of those I had to turn away fell into three categories of roughly equal size—first, those which had not yet been put to the Authority (those, I hope, would either be settled or come back to me); second, those where I considered the complaint concerned the exercise of clinical judgment; and third, complaints against family practitioners or service committees of Family Practitioner Committees. The question of my jurisdiction in matters affecting the exercise of clinical judgment is, as I reported in my last year's report, being reviewed by the Select Committee on the Parliamentary Commissioner for Administration and this review is still under way.

8. During the year I issued 120 results reports of investigations into individual complaints. In 67 cases I found the complaint justified in whole or in part. The nature of the complaints naturally varied widely as did the points which I thought it necessary to criticise as a result of my investigation. But there is one underlying consideration which seems to me to be present in most if not all the cases. That is the problem of communication. Without getting into the area of communication as an act of clinical judgment, which is outside my jurisdiction, I believe that the value of explaining to people what is happening, what arrangements are being made for them, cannot be overestimated. I think it could do a great deal to satisfy the worries and misgivings of people who in the end find that they must bring their complaint to me.

9. I am afraid it is inevitable that not all my reports proved satisfactory either to the complainant or to the Health Authority. But I can assure the public that my investigations are most thorough. Hitherto they have included personal interviews with all people closely concerned with the complaint. Whether or not it will prove either desirable or possible to continue this practice if the number of complaints continues to increase is a matter which I shall keep under review.

10. I have had a few letters from doctors questioning the value of investigations into complaints which appear to be trivial. They have pointed out that my investigations take time of medical and nursing staff which could otherwise be employed on ministering to the sick. In replying to these letters I have made the point that it seems to me that confidence in the National Health Service is of paramount importance and that this confidence will be increased if people with genuine grievances know that they will be fully and impartially investigated. Grievances which to people working inside the Service may not seem of great importance are to the patient himself or his near relatives a matter of considerable importance. On the other hand, I have assured the doctors that where complaints turn out to be totally unreasonable, I have not hesitated in my reports to say so.

Statistics

11. The following figures of complaints denote the workload upon my office during the 12 months ended 31 March 1977:

	England	*Scotland*	*Wales*	*Total*
(*a*) Complaints received 1 April 1976–31 March 1977	483	56	43	582 (504)
(*b*) Complaints brought forward from 1975/76 on 1 April 1976	93	2	10	105 (106)
Total (*a* + *b*) examined in the year ...	576	58	53	687 (610)
Complaints rejected during the year April 1976–March 1977 as outside jurisdiction	342	38	33	413 (360)
Discontinued complaints	12	1	—	13 (17)
Results reports issued during the year April 1976–March 1977*	102	8	10	120 (128)
Complaints carried forward to 1977/78 on 1 April 1977	119	11	10	140 (105)

* Two related complaints were reported upon in a single results report.
( ) Denotes figures for 1975/76.

At the end of each year a number of complaints, as shown above, are still being examined; some will subsequently be rejected, others accepted for investigation, and investigations on others are continuing. In order to obtain an appreciation of what happened to the new complaints received in the year under review, it is necessary to analyse these end of year balances. When this is done the position for 1976/77 was that of the 582 new complaints received, 423 in fact were rejected; some 72% of the total received.

12. It is important to know for what particular main reason such a large proportion of received complaints have to be rejected because of limitations imposed upon me by the National Health Service Reorganisation Act 1973. A breakdown of these 423 rejections is given below.

	England	*Scotland*	*Wales*	*Total*
Body complained of outside jurisdiction ...	21	7	2	30
Complaint against FP, dentist etc. ...	70	7	6	83
Clinical judgment	73	6	12	91
Legal remedy available	25	—	—	25
Personnel matter	26	3	1	30
Out of time	24	1	—	25
No hardship/injustice sustained by complainant	5	2	1	8
Authority not given a chance to answer ...	69	12	4	85
Right of appeal to tribunal	8	1	1	10
No failure/maladministration	9	—	1	10
Complaint from local authority/public body	4	—	1	5
Contractual or other commercial arrangements	1	—	1	2
Discretion	15	1	3	19
	350	40	33	423

It will readily be seen that the three main causes for rejection of complaints were that they related to the exercise of clinical judgment (21%), that there was no prior reference to the authorities concerned (20%) and that they concerned services provided under contract by Family Practitioner Committees or action taken by the latter under National Health Service (Service Committees and Tribunal) Regulations 1974 (20%).

13. The number of new complaints (i.e. excluding those in hand from the previous year) increased from 504 in 1975/76 (England 418, Scotland 43 and Wales 43) to 582 (England 483, Scotland 56 and Wales 43) in the year under review.

14. During the period covered by this report i.e. 1 April 1976–31 March 1977 I issued to complainants 120 individual results reports of my completed investigations with copies to the authorities concerned. Of these, in 67 cases I decided that the complaints were justified; in 52 cases unjustified and in one case I reached no conclusion due to the lapse of time. Points of general interest arise from these results reports and I comment on a selection of them in later sections.

Jurisdiction

15. My jurisdiction was extended by the provisions of the Health Services Act 1976. The purpose of the Act was to set up a Health Services Board for England with a Welsh Committee and a Scottish Committee. The functions of the Board relate to the use of National Health Service facilities by private patients and to the control of hospital building outside the National Health Service. The Board and its Scottish and Welsh Committees are subject to examination by the Health Service Commissioners, who have powers to investigate complaints and publish reports. The procedures governing these complaints are the same as those which apply to my main jurisdiction except that the requirement in my main jurisdiction to report to the Secretaries of State is not extended to my jurisdiction under this Act. I am required annually to lay before each House of Parliament a general report of my activities under the Act. I may also from time to time lay such other reports as I think fit including special reports where hardship or injustice has not been and will not be remedied.

16. Part III of the Act came into force on 23 January 1977 and I have to report that between that date and 31 March 1977 I received no complaints under this extended jurisdiction.

Payment of hospital charges by private patients

17. Section 34(7) of the National Health Service Reorganisation Act 1973 allows me to exercise my own discretion in determining whether to undertake an investigation. In the exercise of this discretion I have decided that I will not normally start an investigation in a case where the complaint has been made by or on behalf of a private patient if his hospital account is outstanding. It would be undesirable if dissatisfied patients by referring a complaint to me thought they could postpone the payment of an account, which, before entering hospital as a private patient, they undertook in writing to pay. If as a result of an investigation which I carry out I decide that the complainant has sustained injustice or hardship as a result of an alleged failure in a service by a Health Authority, then I may recommend a remedy and would not hesitate to do so in an appropriate case.

Dental treatment

18. I am precluded by Section 34(5) of the National Health Service Reorganisation Act 1973 from investigating any action by a dental practitioner in connection with the services he provides under contract with a Family Practitioner Committee, but my investigation of the way in which a Family Practitioner Committee dealt with a complaint, which in the event I did not criticise, revealed an unsatisfactory situation.*

* Case W. 350/75-76 on pages 78–81 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

19. Dentists, unlike doctors, do not have lists of National Health Service patients. A patient can go for treatment to any dentist and each course of treatment is considered to be a separate contract. Many members of the public are unaware, as had been this complainant, that the onus is on them to ask the dentist to treat them under the National Health Service. A patient who may have been attending a dentist for treatment under the National Health Service for many years has to make it clear each time he attends for examination or a course of treatment that it is still his wish to be so treated otherwise he may be treated as a private patient and charged accordingly. Although the Department issues a leaflet which explains this there is no means of ensuring that it is seen by every patient. I was critical of what I regard as being an unsatisfactory system and in my report I said that, if it had the status of a Departmental rule, I should describe it as a bad rule. It was however a matter for negotiation between the Department and the dental profession and I expressed the hope that they would renew their discussions about ways of avoiding misunderstandings which otherwise must inevitably arise, and which can make patients unwittingly liable for payment for private dental care.

Investigations

20. In previous years I included in my Annual Report summarised texts of some individual completed investigations. Since all my reports are now published, this is no longer necessary. Instead I now go on to discuss a number of subjects of general interest arising out of my last year's work and illustrate them by reference to cases which I investigated.

Admission to hospital

21. In his Annual Report for 1974/75* my predecessor referred to the number of complaints he had received about the length of time patients had to wait for admission to hospital where the demand for treatment was greater than could be met from available resources.

22. When a patient is refused admission to hospital, he may be admitted to a private nursing home. I reported on one such case† jointly as Parliamentary Commissioner for Administration and as Health Service Commissioner for England. A woman aged 64 was considered by her family practitioner to be in need of a hospital bed as a medical emergency. After he had telephoned the medical registrars at the two local hospitals, and had been told that there was no suitable bed available, she had gone into a private nursing home. A consultant physician on the hospital staff who treated the patient in the nursing home told me that had the family doctor sought a consultant's advice a bed would probably have been found somewhere in the hospital. Her son sought a refund of the charges but this was refused on the grounds that the patient had agreed to go into the nursing home. But her son said that she had been too ill to give true consent, and that the only alternative would have been to stay at home where she would almost certainly have died.

23. My investigation showed that there was continuing difficulty in providing enough beds for emergency admissions in this district, due to the high proportion

* First Report of the Health Service Commissioner, Session 1974/75, paragraphs 21 and 22—HC 407.

† W. 111/75-76 on pages 4–7 of the Third Report of the Health Service Commissioner, Session 1976/77—HC 321.

of elderly residents. Such patients required active medical treatment and nursing care in an acute ward on admission but later often needed long term care in a geriatric ward. Because there were insufficient geriatric beds they had to remain in acute medical beds.

24. I accepted that the district had special problems but I considered that the Area Health Authority had a duty to provide accommodation when a patient from one of their districts needed immediate admission to hospital as an emergency. I considered that the Authority's failure to provide a hospital bed in this case amounted to a failure in a service they had a duty to provide, for which I criticised them. The Authority told me their decision not to make an *ex gratia* payment (which the Department had asked the Authority to consider making in this case) had been influenced by the view that there were other cases of a similar nature so that, if they approved one, they would have to approve them all. I do not accept this argument. Each case should in my opinion be judged on its own merits and it seemed to me that there were significant differences between this patient's case and the others cited. Accordingly I also criticised the Authority for the way they had arrived at their decision, and I invited them to give further consideration to making an *ex gratia* payment. They decided to uphold their original decision.

25. The Member put several Parliamentary Questions to the Secretary of State arising from this case. He asked if the Secretary of State would give a direction that an *ex gratia* payment should be made. The Secretary of State replied that to do so would be inconsistent with my role and would derogate seriously from the management responsibilities of Health Authorities; but he confirmed that he would expect a Health Authority to provide accommodation for the admission of a patient to hospital where a responsible hospital doctor considered he should be admitted immediately as an emergency.

26. I came to a different conclusion in a case* involving a woman taken ill while staying in a hotel on holiday. In this case the hospital consultant took the view that her condition was not such that she required admission to hospital immediately. Had she been in her own home she could have been nursed there, but she could not remain in the hotel. There was no room for her in the local hospital's geriatric ward (for which there was a waiting list) so she went into a private nursing home. Later there was a dispute about the payment of the nursing home's charges. My investigation showed that the consultant, and the family practitioner who called him in, discussed what was best for the patient in all the circumstances and decided she should go into the nursing home. I was satisfied that everyone had been concerned to do what was best for the patient and what they thought she herself would have wanted had she been able to express an opinion. Although I found no reason to criticise the action taken in this case, I put on record my general view that, where a patient who is unable to express an opinion herself and has no friends or relatives able to do so on her behalf needs to be admitted, either on urgent medical or (as in this case) a combination of medical and social grounds, admission should normally be to a National Health Service bed rather than to a private bed.

* W. 75/76-77 on pages 138–140 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

27. Another complaint* involved the refusal of a hospital to readmit a patient who had been discharged to her daughter's home. Her condition was such that both the family and a doctor from the local emergency service thought she should go back into hospital. However, the emergency service doctor discussed the patient's care with a hospital doctor, (not a consultant), who said there was no further medical treatment which could be given, and the emergency service doctor did not press for readmission. Instead he advised the family to speak to the patient's own family doctor at the first opportunity. They did this and the patient was in fact readmitted without difficulty three days' later at the request of the family doctor who had come to the conclusion that a new clinical condition had arisen which could not be adequately treated at home. I concluded that the hospital doctor's decision not to readmit her at the request of the emergency service doctor was properly taken in the exercise of his clinical judgment, based on his own recent knowledge of the patient and his discussion with the emergency service doctor who had just seen her.

Consent

28. During the year I have received several complaints based on the contention that a valid consent to treatment had not first been obtained. My approach to this subject is that, since no one is bound to submit himself to treatment, any treatment requires either express or implied consent. Where emergency measures are taken to save life or where a patient is detained in hospital under one of the Sections of the Mental Health Act 1959, the question of consent does not arise in the same way, but before the administration of anaesthesia, surgery, ECT, trials of a new drug or participation in clinical research consent is certainly necessary. Failure to obtain it in such cases amounts in my view to maladministration.

29. I criticised the failure to obtain the consent of a patient in a case involving the sterilisation of a young woman who had been admitted for termination of pregnancy.† Three years later (having meanwhile become married) the young woman visited her family practitioner thinking she might be pregnant and learned for the first time that she had been sterilised. She disputed the suggestion that she had been unable to give consent herself pointing out that she had been 23 years old at the time and in full-time employment. The consultant had agreed to carry out the termination after receiving a psychiatrist's report that the woman had suffered from epilepsy and immature personality. After examining the patient and hearing her mother's views the consultant had concluded that she was not able to decide for herself whether or not she would benefit from being sterilised and her father gave consent.

30. After I had considered the evidence and received professional advice I concluded that the consultant could not reasonably argue that the sterilisation was essential for the young woman's health, but must have had wider considerations in mind. Accordingly, since the consultant's decision did not arise solely out of the exercise of clinical judgment it was open to me to comment on it. Although I accepted that the patient's history, as recorded in her medical notes, raised reasonable doubts about her ability to understand the nature and consequences

* W. 14/76-77 on pages 104–108 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

† W. 236/75-76 on pages 23–30 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

of sterilisation, I considered that the consultant had been wrong to carry this out without her consent.

31. Another complaint* concerned vaccination of a 12 year old girl. A vaccination session had been arranged at her school, and her mother had originally given her consent. She changed her mind later however because her daughter was due to go on a trip to France the following week and she was concerned that she would not be able to see if there was any reaction. The girl attended the vaccination session in order to have the effects assessed of tests done the preceding week. Her mother said her daughter had been overwhelmed by the doctor, who had told her there would be no reaction while she was abroad, at which her daughter had reluctantly allowed herself to be vaccinated. There was some uncertainty about what the doctor was told, but I had no doubt that the girl herself told the doctor that her mother did not want her to be vaccinated. However, it is not unusual for doctors to receive such comments from children who do not want to be vaccinated. I could understand why the doctor (who had the mother's written consent) went ahead after explaining the position to the girl; although with hindsight I thought it might have been wiser for the doctor to have checked the girl's story with the teacher, who was aware that the mother had withdrawn her consent.

32. In another case† a patient gave her consent to an operation believing she had been given an assurance that it would be carried out by a particular consultant, whereas it was in fact performed by a registrar. However, the evidence of three doctors who had been concerned with her care, and the consent to operation form which she had signed, convinced me that no such assurance had been given and I did not uphold this complaint.

Detention in mental illness hospitals

33. During the year I reported on two investigations into complaints made about compulsory admission to, and detention in, hospitals under Part IV of the Mental Health Act 1959. The compulsory detention of a person in a psychiatric hospital is, in my opinion, a matter of grave importance and the Act sets out various conditions attaching to such detention which are clearly intended by Parliament to safeguard the individual from being wrongfully deprived of his or her liberty. I was disturbed to find that the Health Authorities concerned in the complaints had failed to comply with one or more of the statutory requirements.

34. In one of the cases I investigated, a woman was‡ compulsorily admitted to hospital under Section 29 of the Act which permits an application for admission for observation to be made in the case of urgent necessity by a close relative of the patient or by a mental welfare officer, with one medical recommendation. An order under Section 29 is valid only for 72 hours from the time of admission unless a second medical recommendation is received by the managers of the hospital within that period, when the patient may be detained, under Section 25 of the Act, for up to 28 days from the time of admission. I found however that the second recommendation had been received eight hours outside the statutory time

* W. 393/75-76 on pages 26–30 of the Third Report of the Health Service Commissioner, Session 1976/77—HC 321.

† W. 363/75-76 on pages 85–87 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

‡ W. 379/75-76 on pages 92–95 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

limit of 72 hours and had not been signed by the responsible officer on behalf of the hospital managers. I concluded that the woman's detention after the first 72 hours was technically illegal but I was satisfied that this was due to an oversight and it was quite clear from my enquiries that the doctor who made the second recommendation considered the woman needed to remain in hospital. I suggested that the Health Authority should take whatever steps were necessary to ensure that the forms were properly completed in the future.

35. In two other related cases* I investigated I found more serious administrative shortcomings and failures to comply with the statutory requirements. A woman was compulsorily admitted to a hospital under Section 25 of the Mental Health Act 1959 and was unhappy there. The consultant decided to make an order under Section 47 of the Act, discharging her from detention so that she could attend for treatment as an informal (i.e. voluntary) patient at a private nursing home, but he did not notify her of her change of status. As a result of investigations into another complaint by my predecessor the Department of Health and Social Security issued a circular to Health Authorities recommending that patients whose discharge had been authorised should be told of this in writing.† For some reason which I have been unable to establish a copy of this circular was not sent to this hospital and the staff had therefore not seen it.

36. The woman went to the private nursing home on 15 September 1975 as an informal patient and left the next day. That night the police received a message from the woman's husband which they took to mean that a certified patient had absconded and she was apprehended on 17 September. And, acting on incorrect information given to the police and a social worker by a member of the staff at the first hospital that the woman had left the private nursing home before a Section 29 order could be made (which, I have established, they had no intention of making), the social worker and a police surgeon authorised the woman's compulsory detention under Section 29; and she was admitted to another mental hospital.

37. The next day the consultant at that hospital decided to transfer the woman back to her original hospital and to make an order for discharge so that she could go as an informal patient. The woman denied that the consultant told her of his intentions and I criticised him for not making the written order required by Section 47(1) of the Act. The first hospital admitted the woman as an informal patient but later in the day learnt that she had been admitted to the other hospital compulsorily under Section 29 of the Act and they recognised that, because 72 hours had not elapsed, the order was still in force. The other hospital, when asked for the papers to be transferred, did not have an order of discharge and were not aware of the consultant's intentions; and the documentation for her transfer was completed as a formal patient.

38. On receipt of the papers the senior registrar at the hospital where the patient had been readmitted decided to sign a second medical recommendation which converted the Section 29 order to a Section 25 order. Section 28(2) of the Act says that, where practicable, one of the doctors signing the medical recommendations for a Section 25 order should have been previously acquainted with the patient;

* W. 329/75-76 and W. 414/75-76 on pages 58–68 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

† Paragraph 29(c) of the First Report of the Health Service Commissioner, Session 1974–75—HC 407.

but I found that neither the police surgeon who had signed the original Section 29 order nor the senior registrar had seen the woman before. At the time when the second medical recommendation had been signed, 24 hours of the Section 29 order remained unexpired, and I considered that it would have been practicable for one of the several doctors who had examined the woman when she had been originally detained at the hospital to have seen her and, if he thought it appropriate, to have signed the recommendation.

39. Section 25(4) of the Mental Health Act 1959 provides that a patient may be detained for a period not exceeding 28 days beginning with the day of admission. The sector administrator had written to the woman and given the date of the end of the period of her compulsory detention but I found that it was one day later than was correct and her departure from hospital was therefore delayed by this error.

40. I concluded that the staff at both hospitals had, by their mistakes, caused the woman to be detained for 29 days after the consultant at the first hospital had originally discharged her and I considered that the two Health Authorities concerned should together make a substantial *ex gratia* payment to compensate her for the distress and suffering she has been caused.

Ambulance services

41. During the year I reported on several investigations into complaints made to me about the failure to provide transport, or long delays in providing transport, for patients between home and hospital, and my enquiries brought to light some deficiencies in the procedures for ordering ambulances and in the organisation of the service. I also found that some patients were justifiably aggrieved that they had not been kept informed about when the ambulance would be likely to come.

42. In one case* I found there was confusion about how to call an ambulance, at a time when the ambulance service was still recovering from the after-effects of a strike. A man had been receiving treatment at a hospital for coronary heart disease as both an inpatient and an outpatient for many years. His wife became worried about him and called in the family doctor who told her to get in touch with the hospital. She telephoned the registrar there who said he was willing to see her husband but, because of disruption to the ambulance service, he advised her to arrange transport by minicab. She said she could not afford to do this, and the registrar told her to telephone for an ambulance. She contacted the hospital transport department who said that an ambulance had to be ordered by a hospital doctor or the family doctor. My enquiries revealed, however, that it was usual for a member of the public to be told either to use the 999 emergency service or to get in touch with the family doctor. The family doctor in this case could not remember telling the man's wife to ring the hospital but he confirmed that, if the husband had been in need of immediate treatment, he would have ordered an ambulance. Because of the time which had passed since the events complained of, I was unable to establish precisely what had happened and could not reach any conclusion.

43. In another case† I criticised the Health Authority because they had no arrangements to tell patients who were waiting for an ambulance to take them

* W. 306/75-76 on pages 85–87 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

† W. 67/75-76 on pages 4–9 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

home, the reason for, or the length of, any likely delay. The complainant's elderly mother received treatment in the Accident and Emergency Department of a hospital and was told she could return home but, in the event, she had to wait nearly two hours for an ambulance. My enquiries revealed that an ambulance was ordered at 12.22 pm but, I was told, the ambulance service frequently found difficulty in providing transport for non-urgent cases between 12 noon and 2 pm when vehicles were engaged on taking outpatients home, and the crews needed a meal-break before starting to take patients to hospital for afternoon treatments. The complainant's mother went home by the first available ambulance at 2.20 pm. I considered that it took far too long to provide transport and I was glad to record that, as a result of my investigation, the hospital and ambulance service introduced a procedure which they hoped would reduce delays and keep patients or their relatives informed of the length of time they were likely to have to wait for an ambulance.

44. In another case* I was critical of a failure by an ambulance station officer and the control centre to follow instructions that all requests for ambulances should be numbered and classified according to their urgency and that the times of receipt of calls and passing of instructions to ambulances should be recorded. This failure meant that no one in authority was aware of the length of time the complainant's wife had been waiting for transport to take her to hospital. She was a stretcher case and had expected an ambulance to call for her shortly after 9 am, but it did not arrive until 12.35 pm. Her distress at the delay was aggravated by the fact that the house was only 50 yards from the hospital and 200 yards from the ambulance station. On enquiry I found that the family doctor who had arranged for the complainant's wife to be admitted to hospital had not classified the request as urgent. The control centre passed a message on to one vehicle but, when it was on its way to pick up the patient, it had to be diverted to an emergency call; the control centre then allocated the request to another ambulance which eventually collected the complainant's wife having, in the meantime, been delayed by being directed to pick up a casualty. I considered there was a totally unnecessary delay in sending an ambulance due mainly to failure to comply with the ambulance service instructions. And I suggested that even though the doctor's request was not urgent, the control centre should have instructed the station officer and the driver of a vehicle used for sitting patients which was idle for 46 minutes during the morning to collect the complainant's wife in one of two multi-purpose unmanned vehicles parked at the station.

45. I was critical in another case† of the absence of written instructions on the procedure for ordering ambulances from the control centre. The complainant's wife telephoned the consultant psychiatrist at a psychiatric day centre where she had received periodic treatment for a number of years and asked for transport to take her there two days later, on a Thursday, and she had expected that arrangements would be made. But transport was not provided, nor was she advised of this. And, on the day when she expected to attend the centre, she took her own life. I found that the consultant had written a note to his secretary about the patient and on the evidence it was clear that he wished the complainant's wife to attend on Thursday if transport could be arranged at such short notice. The note was

* W. 345/75-76 on pages 95–98 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

† WW. 31/75-76 on pages 125–127 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

not marked urgent and when the secretary received and dealt with it on the Wednesday, believing in common with other medical secretaries that the ambulance service required 48 hours' notice of all non-urgent requests, she decided to make the transport arrangements for the following Monday. My investigation revealed that the ambulance service did not insist on receiving 48 hours' notice and in practice they accepted non-urgent requests for transport provided they were received the day before; and I was assured that transport could have been arranged on the Thursday. I was critical of the fact that no written instructions had been issued about the ordering of ambulances and that, in this case, nobody told the complainant's wife that she would not be attending the centre on the Thursday.

46. In two cases I reported on I decided after investigation that the complaints were not justified. In one case* a family doctor visited the complainant's son who was ill and decided to order an ambulance to take him to hospital. But before it arrived, 32 minutes later, the son had died. When the doctor telephoned the ambulance control room, he classified the case as urgent—which meant that the patient should be delivered to the hospital within one hour. I found no evidence of misunderstandings within the ambulance service and my examination of the vehicle timings led me to believe that, but for the son's completely unexpected death, the ambulance would have arrived at the hospital within one hour.

47. In the other case† a woman, on holiday, injured her leg in a fall and received treatment at the Accident and Emergency Department of a hospital. She complained to me that the hospital had said it was not possible to arrange transport to take her to her home 40 miles away but they offered to take her by ambulance to the pick-up point for the coach to take her to her home-town and would arrange for the coach to be met by another ambulance to take her home. This was not acceptable to her and she returned home by taxi. The decision whether or not the woman, or any other patient, needed to be provided with special transport is one for the doctor treating her. I had no doubt that such decisions stemmed from the clinical judgment of the doctors concerned. In the woman's case, it was the opinion of the casualty officer and also of the accident department sister, that her condition did not warrant the provision of transport to take her home.

Handling of complaints

48. When a member of the public makes a complaint to a Health Authority he is entitled to expect that the Authority will deal with it properly themselves. In my Annual Report for 1975/76‡ I criticised the shallowness of the investigations of some complaints by the appropriate authorities and the inadequacy of some of the replies which had been sent to complainants. I have also found this during the year under review: of the investigations I reported on I found that in 57 of them there were shortcomings in the way the complaints had been handled by the Health Authorities. In several cases§ I not only criticised the length of time the Authority had taken to deal with the substantive complaint, but also their failure

* W. 311/75-76 on pages 55–58 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

† W. 264/76-77 on pages 109–111 of the Third Report of the Health Service Commissioner, Session 1976/77—HC 321.

‡ Paragraph 16 of the First Report of the Health Service Commissioner, Session 1975/76—HC 528.

§ W. 195/75-76, W. 232/75-76, WW. 32/75-76 on pages 20–24, 50–56, 128–129 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

to take evidence from some of the staff directly involved and to include in their reply all the relevant evidence they had obtained.

49. One example of this* concerned a complaint about inadequate nursing care. Not only did I find the Authority's reply to have been too long delayed, factually inaccurate, misleading in its implications and containing technical terms and abbreviations which no lay person could be expected to understand, but I found, too, that its tone left much to be desired.

50. When a complaint relates mainly but not exclusively to medical matters, I do not think the Authority should simply pass the letter on to one of the medical staff and leave it to him to resolve the complaint. One such complaint† concerned a patient's attendances for examinations at a special centre some distance from his home, the consultant's alleged failure to keep appointments, and a breakdown in transport arrangements. In accordance with the Authority's normal procedure the consultant was invited to comment on the complaint; and when he offered to reply to the complainant himself the Authority agreed. It appeared to the consultant that the complainant (who was not the patient) was seeking to interfere in matters which were not his concern and this feeling was reflected in the consultant's reply.

51. However, I should also say that some of my investigations have shown that the Authority have carried out their enquiries properly and have sent a very adequate reply to the complainant. For example, in a case‡ where it was alleged amongst other things that a patient had been assaulted by a member of the nursing staff, I was able to commend the Authority concerned for conducting a thorough investigation into a very serious complaint. But I nevertheless take the view that in a significant proportion of the cases investigated by me the standard of investigations and reply by the Health Authority fell some way short of what the complainant could have expected.

Closures or changes of use of health buildings

52. I have received a number of complaints about proposals for closures or changes of use of health buildings. I am at present carrying out three such investigations which are not yet completed, but in a number of other cases I have had either to refer them back to the complainant or reject them as being outside my jurisdiction. Some had not been previously put by the complainant to the Authority concerned. Others sent to me, by Community Health Councils acting on their own behalf, had to be rejected since under Section 35(1) I may not accept complaints from such bodies which are financed by public funds. Section 35(2) however provides for aggrieved persons, who are unable to act for themselves, to be represented by a suitable body and I accept complaints from Community Health Councils acting in this capacity provided the complaint has first been put to the Authority concerned.

53. I have also noticed that the procedures, outlined by the Department of Health and Social Security in their circular HSC (IS) 207, which Health Authorities should follow in relation to closures and changes of use are not always known

* W. 78/76-77 on pages 140–144 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

† W. 261/75-76 on pages 61–62 of the First Report of the Health Service Commissioner, Session 1976/77—HC 21.

‡ W. 308/75-76 on pages 46–49 of the Second Report of the Health Service Commissioner, Session 1976/77—HC 160.

by complainants with the result that I have been approached before the end of the period given for local consultation initiated by the Health Authority concerned.

54. I have also been asked to veto a Health Authority's decision to close a unit, but this is not within my powers. It is not for me to question a discretionary decision of a Health Authority when this has been properly taken, but I can and do investigate complaints of alleged maladministration leading to the Health Authority's decision. In such cases, I insist that the complaint must come from or on behalf of a personally aggrieved individual, that the Health Authority concerned is adequately acquainted with the grievance, and that the period given for adequate local consultation has been allowed to elapse.

Relationship with other Commissioners

55. I have carried out three investigations in my dual capacity as Parliamentary Commissioner for Administration and Health Service Commissioner and I issued single reports* for each. I have also jointly investigated a case† in my own dual capacity and in conjunction with the Commissioner for Local Administration. The procedures involved in this tripartite investigation were complex and I am glad to acknowledge the co-operation I received from the Commissioner of Local Administration.

Office staffing

56. On 31 December 1976, Mr John Scarlett, CBE, MA, retired after a distinguished career in the public service. During the last three-and-a-half years he was Secretary to the Health Service Commissioners and Deputy to my predecessor, Sir Alan Marre, and to myself. He played a major role in the establishment of the office and its recognition and acceptance by Health Authorities is greatly due to his personal contribution.

57. On 1 January 1977 he was succeeded by Mr Geoffrey Weston, CBE, FHA, on secondment from North West Thames Regional Health Authority where he had held the post of Regional Administrator.

58. There has been a considerable turnover of staff at the end of their periods of secondment and I am very glad to pay tribute to their dedication and efforts, during the three-and-a-half years of the office's existence, in establishing the quality and thoroughness of investigations undertaken.

I. V. PUGH,

Health Service Commissioner.

May 1977.

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* W. 339/75-76 on page 68 of the Second Report of the Health Service Commissioner—HC 160.
W. 111/75-76 on page 4 of the Third Report of the Health Service Commissioner—HC 321.
W. 193/76-77 on page 97 of the Third Report of the Health Service Commissioner—HC 321.
† W. 129/76-77 on page 64 of the Third Report of the Health Service Commissioner—HC 321.

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