A consumer review of the work of the Health Service Commissioner

In June 1999 AIMS was informed that the Cabinet Office was undertaking a Review of the Public Sector Ombudsmen in England and we were invited to submit our views. The following is a copy of the AIMS submission.

1. We shall comment only on the work of the Health Service Commissioner as we have little experience of the work of other Ombudsmen.

1.2 However, we are receiving a number of alarming complaints about the behaviour of social service departments in child abuse allegation cases and these usually also involve complaints about the quality of medical care. It is possible that in future we shall be asking for more investigations combining health and social services, but the complexity of one side of the investigation is already difficult for our clients to handle. We should point out that whereas Community Health Councils and some other agencies help many members of the public with health service complaints, advice and support to deal with social service complaints is much harder to find.

2. What is AIMS?

2.1 The Association for Improvements in the Maternity Services (AIMS) is a voluntary pressure group which was founded in 1960. We operate a free help line and deal with enquiries and complaints about maternity care throughout the United Kingdom. Our complaints work involves prolonged support of many distressed clients. We therefore obtain good feedback on how far our clients achieve their aims and the many difficulties they encounter. At any one time we are dealing with around 80 serious complaints about maternity care in the UK. Although our work concentrates on maternity care it also includes paediatrics, psychiatry, general practice and gynaecology.

2.2 We have considerable experience in the way different GP practices and Health Trusts respond to complaints, and the effects of different complaints procedures. We refer clients to Community Health Councils, the NHS complaints procedure, litigation, and professional disciplinary bodies such as the General Medical Council (GMC) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and, of course, the Health Service Commissioner.

2.3 We read the Health Service Commissioner's reports carefully. We have to. Since we are advising very distressed or bereaved clients, we need to know what kind of complaints have a reasonable chance of succeeding (e.g. complaints about Trust's handling of the complaint have a high success rate, complaints about doctors' or midwives' behaviour a much lower one). We also have to know our Ombudsman, since each holder of the office has had a different approach and the percentage of complaints upheld varies by over 100%.

2.4 The content and style of the reports in fact tell us a great deal about how each Ombudsman perceived maladministration, injustice or quality of care. Case reports provide ripe material for ethical or philosophical analysis.

2.5 We also read the reports of the Select Committee to which the Ombudsman reports and sometimes attend their meetings.

3. The value of the Ombudsman's reports

3.1 The reports of the Health Service Ombudsmen over the years provide invaluable historical data on the NHS. They show the types of complaint which are prevalent in particular periods and also attitudes towards them. For example, complaints about care of the elderly in hospital were so common under the reign of Sir Cecil Clothier that he suggested relatives should be warned that when elderly people went into hospital they would deteriorate. The reports also provide valuable teaching material for administrators and professionals in health care. We frequently quote them ourselves in lectures to administrators, midwives and doctors.

4. Health Service Commissioner Staff

4.1 In our experience, the HSC's staff always responds helpfully and courteously to requests for information.

4.2 We receive reports from complainants that they are always courteously and sympathetically treated by investigating officers sent by the Ombudsman. It has been helpful to give such an assurance to our clients, many of whom are fragile.

4.3 From some recent cases seen by ourselves and others, we suspect that staff turnover or expansion may have led to inexperienced HSC employees making judgments on cases with insufficient understanding or experience.

5. What complainants seek from the Ombudsman

5.1 People do not appeal to the HSC unless they believe that they have a just cause and that they have been in some way mistreated. They are invariably anxious that information from their case will be used to improve care for others. They also seek validation of their complaint and an apology. They do not know that a successful

complaint could result in senior officials of a Trust being questioned again by a House of Commons Select Committee and how powerful the effect of that can be.

5.2 The HSC publishes statistics individual complaints found justified by the Commissioner. May we point out that as there are usually a number of individual grievances per case, a finding that some aspects are justified does not necessarily result in a satisfied complainant. Sometimes the Ombudsman upholds the least important aspects of the complaint and rejects the core issues. There are no statistics on how many complainants have all their grievances upheld.

6. Queries about Ombudsman investigations

6.1 A number of complainants have expressed concern to us that staff questioned in the course of the investigation are anonymous in the copy of the final report. In some published reports the Ombudsman has listed people interviewed e.g. the house officer, the ward sister etc. In others it might say "members of the medical, nursing and administrative staff". They query whether those who gave evidence on particular incidents were indeed those present and on duty at the time. They sometimes have cause to doubt this. We have been involved with a case where there was an internal hospital enquiry in which a nurse who gave evidence in support of a colleague was in fact subsequently shown not to have been on duty at the time. We can understand our clients' concern.

6.2 Often a representative of the Medical Defence Union or the Medical Protection Society is present if a doctor is questioned by an investigator from the Ombudsman's office. If they feel doctors are being unfairly treated, defence organizations make strong representations - for example the Medical Protection Society tried to get the HSC to criticise doctors only if facts were proved "beyond reasonable doubt" (Health Service Commissioner's Annual Report 1990-91). Fortunately the Ombudsman, William Reid, did not accept this and said he used the test of what would be seen as fair and reasonable, and said Parliament and the public would expect nothing less.

6.3 We have little confidence in an Ombudsman who, throughout a report, refers to midwives as "nurses". HSC investigators do not necessarily check that staff have the qualifications they claim and this has caused problems (see para 21.1).

7. Methods of investigation

7.1 There was a case in 1980/81 where the HSC, Sir Cecil Clothier, actually held a formal enquiry with evidence on oath and parties being legally represented because of conflicting evidence (Robinson J, 1988). This was the only occasion we know of where the complainant, the patient's widow, actually heard the evidence given to the Ombudsman by others. It was enormously comforting to her, and she felt that justice had at last been done, but it is a process denied to all other Ombudsman complainants (Case No. W.309/893-4).

7.2 We have seen other cases where there is a clash of evidence and such an approach is justified. We think this method should be used more often.

8. Checking Draft Reports

8.1 A copy of the Commissioner's draft report is sent to the Trust for checking of "facts" before it is finalised. This means that the Trust cannot afterwards quibble about them if their officials are called before the Select Committee. (Though in one case a Trust tried to do just that). There are two problems with this. One, not surprisingly, is that Trusts try to challenge conclusions and judgments as well as facts, and we know of two cases where that happened. We do not know how often it happens, and what success they may have, but we think the Ombudsman should be asked how often he changes reports and on what grounds. The second problem is that a similar courtesy is not offered to the complainant. We recall one case where a complainant did criticise wrong facts in a report, but it was too late for alteration - he only got the final version.

9. Who says "Sorry"?

9.1 One problem which we have run into is complainants' dissatisfaction with apologies they receive from a Trust via the Ombudsman: "The Trust has asked me to express their apologies to the complainant". A number of complainants tell us that they are not satisfied. They want an apology from the Trust itself, signed by the person who sent them all those dishonest or pusillanimous replies. Successive Health Service Commissioners have told us that this procedure is used because they can at least ensure that an apology of some kind does reach the complainant. (Occasionally people refused to apologise even though the Ombudsman has said that such an apology should be sent). We do not think that the Ombudsman's policy in this matter is justified by his argument. After so much distress, expense, and hard work our complainants expect and should receive, wherever possible, an apology directly from officials of the offending organisation. If they are unwilling to provide it perhaps the Select Committee might want to know why.

10. The need for investigation

10.1 A most valuable aspect of the Ombudsman's work is that he* sends an investigator into the hospital to question staff and to study all the relevant documents. In many cases this is the first time a proper investigation has taken place or relevant witnesses had been questioned. A glaring defect in the way complaints have been and are investigated in the NHS is the failure to do primary investigation. The missing element is Hercule Poirot, and that is exactly what the Ombudsman sometimes provides. For example, in one case the HSC's report included a diagram of a unit where a baby had died in Peterborough, proving that

continuous observation was very difficult and the Select Committee were also shown photographs of the unit (Select Committee on Public Administration Minutes of Evidence 6 December 1989) In a more recent case, a woman who proved to have breast cancer, was told by Bradford Hospital Trust that the 19 week wait for her mammogram was caused by a shortage of resources. In fact the Ombudsman's investigator found that her appointment had wrongly been placed on the non-urgent slot - and the Trust knew it (Case E. 2095/97-98). Only an outside investigation gave the complainant a chance of finding out that the Trust had lied. Unfortunately, the number of cases handled in this manner, has now declined (see paras 16.2, 16.3 and 18.1).

11. Briefer reports and less investigation by the Ombudsman

11.1 We were disappointed when the length of case reports was reduced a few years ago, since often the devil was in the detail. The reduction was happily accepted by the House of Commons Select Committee. Doubtless busy MPs have more than enough to read. However, this was a major loss so far as we were concerned, and it is a loss of educational material for the NHS.

11.2 Also in recent years the Ombudsman has reduced the number of grievances investigated per case (Annual Report 1991-92) aiming to give "investigations a sharper focus by leaving aside matters which are incidental or peripheral to the main substance of the complaint". We have our doubts about this. Firstly failure to answer or settle certain problems in our experience often leaves complainants unable to recover emotionally, secondly what seems minor to the Ombudsman may be very important to a patient or relative, and thirdly investigation of "subsidiary" issues often reveals important defects in management or attitudes. It would be interesting to go through some of the

* So far the Ombudsman has always been male.

multi-strand investigations of the past and try to find any aspects which should have been omitted. We have not come across any.

12. Ombudsman landmarks

12.1 We greatly welcomed the innovation by William Reid to publish names of Trusts or areas where complaints had been investigated. Up to that time we only had access to such information for the limited number of cases pursued by the Select Committee.

12.2 Some Ombudsmen cases have provided important landmark decisions from the consumer point of view. A decision which established an important principle for us was the patient's right to know the names of medical/nursing/midwifery staff who had treated him or her (unless there was very good reason otherwise). This enables us to check whether the personnel concerned are properly qualified or registered; sometimes we find that they are not. By being able to quote this Ombudsman case

(E. 288/93-94 and E.439/93-94) to recalcitrant hospitals we have been able to expedite access to such information.

12.3 Another example was judgments of two Ombudsmen that correspondence about a complaint should not usually be kept in a patient's clinical records. This was most welcome since our clients fear that making a complaint could adversely affect their future care. However, their proviso that doctors could make a clinical judgment that part of the complaints correspondence needed to be retained in the medical records (W.181/84-85, W.452/90-91) has resulted in incomplete protection of patients against future discrimination. We believe that complainants should be able to make the decision as to what, if anything, is included. We have to advise our complainants that it is possible for correspondence about their complaints to be retained in their, or their relatives' records, if the doctor thinks it necessary. In one case this included a letter from the consultant in which he referred to the complainant as "this peculiar and difficult woman" and "she is a waste of time and health service funds."

12.4 The Commissioner's continued references to disappearance of medical records and poor quality of medical records have been a helpful reminder to administrators and clinicians, particularly as this is such a common problem in our case work.

13. The price of making a complaint

13.1 Those who are not experienced in working with and supporting complainants may feel that since the Ombudsman's service is free there is no cost and little risk to those who ask for investigation. As experienced workers in the field we know that this is not true: there is a financial and emotional price to pay.

a. Costs of photocopying, postage and telephoning can be substantial for people on low incomes or living on benefit, and they often mention this.

b. Further work on the case is time consuming and demanding and even our clients with professional jobs (including doctors) are surprised at how much time and effort it takes, and how emotionally draining it is.

c. Prolonging the complaint keeps the injury or bereavement at the forefront of the mind and may inhibit emotional resolution. However, this has to be balanced with the need to get answers in order to achieve resolution. We spend a great deal of time helping people to make the right decisions for them and in order to do so need to advise them about possible chances of success, depending upon which avenue they pursue.

d. If the complaint is rejected by the Ombudsman not only may there be a greater sense of grievance but the complainant himself runs the risk of counter allegations by the hospital staff, to which he or she has not had a chance to respond, being found justified and published by the Ombudsman e.g. in one report the

Ombudsman said that "the histrionic" behaviour of the complainant's fiance had contributed to the failure of the hospital meeting.

e. As experienced complaints workers, we are well aware that any complaint about quality of care is likely to provoke counter-allegations about the personality or behaviour of the complainant, her friends or relatives, and this becomes a smokescreen to taint investigation of the complaint. Our impressions were validated by recent research which showed that doctors typically undermine complainants' competence by casting doubt on their accounts, and that they often attribute the complaint to the personality of the complainant - they are seen as malcontents, moaners, vindictive, mentally ill, etc. (Allsop J, 1999). The problem for the complainant is that he or she may never be told of the counter allegations, or have a chance to refute them but they are likely to affect response to the complaint, including that of the Ombudsman. These hidden allegations always have more power in an informal, non-tribunal system where the complainant has no opportunity to hear evidence given by others

14. Which Ombudsman?

14.1 The public thinks of "The Ombudsman" as an official who provides impartial judgments. Only those of us who have monitored the work of a series of Health Service Commissioners over the years are aware of how much the underlying ethos of various holders of the office can differ and the variation in the percentage of complaints which they find justified.

14.2 A number of Ombudsmen have commented in their annual reports on their correspondence from dissatisfied complainants. We know that some Ombudsmen cause more dissatisfaction than others.

14.3 Towards the end of Sir Cecil Clothier's term of office we had become so concerned at the low success rate for complainants and the ethical basis of his judgments that we were no longer recommending to clients that they should go to the Ombudsman. In 1980-81 the number of grievances found justified fell to 31.5%. As there are usually a number of grievances in each complaint, we have to remember that although the Ombudsman may find one part justified, it may be the least important one from the complainant's point of view.

14.4 The figures merely confirmed what consumer groups were finding from experience. Instead of trying the Ombudsman we turned more to suggesting legal action where appropriate. Sir Cecil Clothier's reports played no small part in increasing consumer support for legal action against the NHS. We had nowhere else to go.

14.5 We were also concerned at the quality of investigation. In one case which had gone to the Ombudsman at our suggestion there had been problems when the mother wanted the baby's father and a woman companion with her at the birth (Casse W, 198/79-80). Sir Cecil Clothier repeated and endorsed criticisms of the

companion made by the doctor they had complained about. We felt there was a major injustice in this case. Only the mother and the staff were interviewed by the Ombudsman's officer: neither the baby's father nor the birth companion, who were witnesses and participants in the events, who were both criticised, were interviewed at all. Two articles about the case appeared in the AIMS Journal (Ducharme E, 1979 and Saunders L, 1980) and another was published in the magazine Spare Rib.

14.6 In another maternity case (W.1327/78-9) where a number of nurse observers suddenly appeared to observe a delivery (the mother described them as being "like a sea of vultures" crowding around her in the small delivery room), Clothier wrote: "I am satisfied there were a number of nurses around the bed at the birth ... but there is no evidence that they were in the way nor that the complainant made any objection previously or at the time to them being there. The birth took place in a teaching hospital and I think their presence was in the circumstances perfectly justifiable .... The complainant was to a large extent the author of her own misfortunes. She was a difficult patient, readily prepared to find fault." We found this an astonishing judgment, particularly in view of Department of Health guidance about the need for consent to presence of medical students. The Ombudsman was so unaware of women's needs during birth, we gave up. We were not prepared to submit our already distressed and traumatised complainants to additional risk of being criticised.

14.7 A year after Clothier's successor Mr Anthony Barrowclough was appointed and we after had studied his first annual report we asked for a meeting with him which was attended by the Chair of AIMS, Beverley Beech, Jean Robinson former Chair of the Patients' Association and Mr Arnold Simanowitz, of Action for Victims of Medical Accidents. We pointed out that the success rate for complainants had fallen so low under his predecessor that we were unhappy about advising our already distressed clients to undergo yet another stressful procedure. At the end of the meeting we asked for his response and he replied "I hear what you say". We noted an increase in success rates for complainants in the following years' statistics.

14.8 Sir William Reid, who succeeded him, was in our view, and that of other consumer organisations we work with, an excellent Ombudsman and we recommended him without reservation to our complainants. This does not mean to say that we always were happy about his judgments, or necessarily agreed with them, but we had overall confidence in the quality of his work and the fairness of his decisions.

14.9 The current Ombudsman, Mr Michael Buckley, had a hard act to follow but his second annual report (1997-8) caused grave disquiet among consumer organisations and led to the first complaints from consumer groups about a Health Service Ombudsman. The National Consumers Council, Association of Community Health Councils and the Consumers Association also protested, as well as ourselves.

15. Fewer investigations and vanishing statistics

15.1 The 1997-8 Annual Report was eagerly looked forward to, because it would give the first details on how the Ombudsman was using his new powers - to investigate clinical complaints and to deal with complaints about GPs, dentists and pharmacists. We were particularly anxious to see the success rate for complaints in these groups compared with other types of complaint. We were therefore astonished when the Ombudsman's 1997-8 report - the first covering this area - not only failed to publish this information, but also discontinued the detailed annual statistics previously published which showed how many cases were found justified for each type of complaint.

15.2 A meeting between the HSC and a number of consumer groups followed. We were told that the basis on which some complaints were analysed was being re-considered. We awaited the next report with interest but unfortunately continuity of statistical data was lost.

15.3 Unfortunately the Commissioner had succumbed to the all-too-common current trend of publishing a glossier, fancier, multi-colour report containing far less information than the old black and white version. The fact that names of offending Trusts had now been omitted was seen as an ominous sign by some consumer groups. Moreover the number of investigations carried out was half that of the previous year (270 compared with 551). Only 120 investigations were completed compared with 238 the year before. The position is even worse than it appears on the surface since, by our calculation, only 87 of the 120 investigations are of the kind which the Ombudsman would have investigated before his powers were extended, so it is this figure which should be compared with previous years' totals. And 30 of that 87 were criticisms of convenors' or panels' actions, not primary investigations of maladministration and care in the NHS. That leaves a mere 57 true "investigations" of the old kind.

15.4 The number of grievances per report has continued to fall, although the number of complaints received was the highest ever. As the Commissioner was now allowed to investigate new areas of complaint the number investigated should have risen. Only 4% of complaints had been accepted for investigation - the lowest ever. The percentage of complaints upheld - 78% - was the highest ever, but it amounted to only 210 grievances, far lower than the 382 of the year before. The length of time each investigation took had been reduced from 56 weeks to 45 - but at a totally unacceptable price from the consumer point of view.

16. Efficiency v. justice

16.1 Included in this report were two new ways of dealing with complaints, the implications of which have not been discussed but which give us cause for concern. There are now so many such complaints about Trusts' mistakes in following the new

complaints procedure that the Ombudsman's staff do not investigate them all but contact the Trust to point out that correct procedure is not being followed and suggest they might like to look at it again.

16.2 One hundred and eighty-three complaints were "rejected following agreement by the NHS body to take further action" and 155 were "rejected with advice to the NHS body". This means that in 338 cases Trusts were found at fault, but there was no investigation, no finding, and no indication to the complainant as to what wrong had been done. Most of these apparently concern operation of the new NHS complaints procedure. Of course in many ways it is useful to complainants if a quick call or note from the Commissioner's office makes officials realise that they are not doing it right.

16.3 This has the laudable aim of speeding things up for the complainant, but it has other disadvantages:

a Sometimes it is done merely with a telephone call, not even a letter. Such communication should always be in writing.

b. Trusts who are failing in their obligations are not formally investigated or publicised.

c. Complainants do not have the benefit of a formal report or finding that the Trust was at fault and have no copy of the Ombudsman's letter to the Trust.

d. The widespread number of these complaints indicate serious faults with the NHS complaints procedure itself. By sweeping them under the carpet, the Ombudsman is reducing investigation and pressure for change.

e. The private nature of these acts precludes the Select Committee from detailed examination.

16.4 We have recently had an example of the second category. One of our clients was one of those whose complaint was "rejected with advice to the •NHS body." In other words no investigation has been done, the complainant does not have the satisfaction of knowing that at least part has been found officially justified, but nevertheless the Trust has been advised that in some way it could have done better, but the complainant has been given no details. Our client made a number of allegations about quality of maternity care which suggest other mothers may be at risk. The local convenor, after multiple and serious errors in procedure, (more serious than others which have appeared in Ombudsman reports) refused her an independent panel. The Ombudsman's staff appear not to have understood the clinical issues. Our client is now in limbo. This kind of Ombudsman response is neither fish, fowl, nor good red herring. We were so concerned at the details of this case that we suggested she went to her MP.

16.5 The issue for many of our clients is not money but accountabilty. (Many who eventually turn to legal action and get out-of-court settlements, would gladly exchange the money for their day in court). If identification of misdemeanours is fudged even by the Ombudsman, accountability is lost. Clients are unlikely to feel that justice has been done.

17. New statistics still inadequate

17.1 The latest figures for 1998-9 show the number of cases investigated has fallen yet further to 248 and the number of investigations completed is only 119. (Back in 1974-5 the Ombudsman issued 128 reports, and he only received 493 complaints compared with the 2,869 received now). The number of grievances per report continues to fall, to 2.1 - the lowest ever. Ten years ago the Ombudsman did nearly four times as much work - investigated 556 cases, with 4 grievances per report. This year only 153 grievances were upheld. In a year when the Ombudsman received 3,320 complaints, 2,146 of which came within his remit, the outcome for complainants is so poor that it hardly seems worth the price of the postage stamp. These are not betting odds.

17.2 Following protests from consumer groups about his 1997-8 statistics, the Commissioner explained that he was re-organizing categories for analysis. With any reorganization of this kind, continuity is lost, but we awaited developments with interest. At least we have some more data in 1998-9 than the desert year of 1997-8. Unfortunately his new table deprives us of important information we used to get. We no longer have crucial data on how many cases were upheld or not upheld in each category.

17.3 The statistics we had hoped for on clinical judgment have not appeared; there is an overall category "all aspects of clinical treatment". Moreover they are not subdivided into care by doctors, nurses or midwives - and this is important. We really need to know if complaints against one group are more likely to be upheld than complaints against another. We cannot tell if complaints-handling by hospitals is more or less likely to be criticised than complaints-handling by GPs, for example:

For maternity care (our special interest) although 2 of 4 complaints were upheld, we cannot tell if they were those on clinical care or those on complaints-handling or records. Yet we very much need to know, when advising our clients, what percentage of complaints about clinical care in maternity care are upheld.

Complaints about attitude of staff - a category we watch with particular care - is now subsumed into complaints about privacy, dignity and confidentiality, which are all quite different, so we have no means of analysing those. It is all highly unsatisfactory.

17.4 We attach a copy of the letter which we sent to the HSC and to the House of Commons Select Committee on Public Administration, Appendix I.

18. Ombudsman - reduction in quality of Ombudsman's service

18.1 So far as we are concerned the quality of the Ombudsman's service has deteriorated. We had looked forward to his new powers to look at both clinical judgment and actions of general practitioners. We had not thought that investigation of other cases would be reduced. But this is what has happened. There has also been another change. The new NHS complaints procedure which began in 1966 has caused many complaints - often about convenors refusing complainants' requests to have an independent panel. Therefore many Ombudsman investigations have merely looked at whether the convenor, or the panel, did or did not follow the rules. There is no primary investigation of the original cause of the complaint, so cruelty, maladministration and dishonesty are safe from the Ombudsman's criticism. Only the convenors - amateur recruits - are in the firing line, not the people who actually provide or administer health care.

19. Legal action

19.1 The Health Service Commissioner does not investigate complaints which could lead to litigation or are likely to do so. Unfortunately this means that many important matters likely to come within his remit are excluded. Clinical negligence often occurs in a context of sloppy or bad administration or care. The most serious cases are settled out of court and do not see the light of day. Even if a case is heard in court, many serious aspects of a complaint are not relevant to the legal issues and are never aired, leaving complainants frustrated and other patients at risk. We would like the Ombudsman to be able to investigate these other issues, since many of them could be separated from the legal case.

20. Time Limits

20.1 The Ombudsman has a time limit of one year from when the complainant learned of the matters which are the subject of complaint. This is a major problem and may lead to the most serious complaints being excluded. Although we are assured that allowance will be made for justifiable delays, many complaints are rejected because they are beyond the time limit. We work in an area where clients are often overwhelmed by bereavement, have post traumatic stress disorder from birth experiences, or are coping with physical injuries from childbirth or the burden of a handicapped child. This often causes long delay before the complaint is even set in motion. However, we also find that during the whole procedure clients often have to take an emotional "rest" before they are capable of proceeding to the next stage, which means that the process can be slow even in those complaints where they get efficient responses from the Trust. A further common cause of delay is gaining access to medical records under the Access to Health Records Act and the Data Protection Act. These allow a 40 day delay before records are supplied but many hospitals and GPs do not comply with the statutory period.

20.2 In many cases we cannot escape the impression that Trusts, or doctors, are deliberately dilatory so that the complaint will be outside the Ombudsman's time limit. Sometimes they succeed. We think the one year time limit is too short and there is insufficient flexibility exercised.

21. Clinical Complaints

21.1 We welcomed the extension of the Commissioner's activity to cover both clinical complaints and the actions of general practitioners. Over the years we had noticed a considerable variation in the extent to which individual Ombudsmen were prepared to approach the border of what was and was not clinical judgment. In one case, rejected by the Ombudsman (Clothier) because it was within the realm of "clinical judgment" by a nurse, the nurse in question proved on investigation later to be only an enrolled nurse who was not, in fact, qualified to exercise clinical judgment. This provoked a strong rebuke to him by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

21.2 If clinical complaints could be properly and fairly investigated by the Ombudsman this could reduce the need for people to turn to litigation. There are also areas of medical or nursing malpractice where litigation is virtually never used e.g. poor quality care of the elderly. Nobody sues for the untimely death of an elderly granny because there is no financial loss from her demise - indeed one's inheritance may be acquired sooner. Nevertheless, in view of the frequency of such complaints and the fact that medical mishaps are more likely to occur in care of the elderly, this is an important area of investigation if care is to be improved.

21.3 We were anxious that the names of medical advisers used by the Commissioner should be provided. (The names of medical advisers to NHS Independent Complaints Panels are available to complainants). From extensive experience we are only too well aware that with some doctors one could almost predict the comments they will make on a particular topic e.g. obstetricians and complaints about unnecessary intervention in labour. We believe that opinions of this kind should be signed. Unfortunately, the Commissioner has refused to do this.

21.4 The first detailed cases published do not increase our confidence. Care which many people would regard as unacceptable is simply judged "sub-optimal". One case, concerned the care of an elderly woman (E.1705/96-97) with bowel problems, who was discharged undiagnosed from hospital and died within two weeks from cancer. A doctor we spoke to was deeply shocked at the medical assessor's report but the Ombudsman had simply accepted it. It is not just the medical standards but the ethical standards in this case which cause us concern.

21.5 Some of the complaints could well have been referred to the GMC or UKCC to see if those responsible were fit to practise. If they reached Professional Conduct Committee the complainant and witnesses would have been publicly questioned and

we would recommend that route rather than an Ombudsman investigation as more likely to satisfy complainants.

21.6 In a maternity care case in which a complainant has referred to us we were most concerned that the two anonymous experts used to give an opinion by the Commissioner were an obstetrician and a nurse. The complaint largely concerned clinical care by midwives. We were surprised to find that the Ombudsman's investigator thought a nurse, who does not have the relevant training or experience, was thought fit to give an opinion in a midwifery case. We should point out that obstetricians are unlikely to know the relevant midwifery literature or practice either.

21.7 One development which is causing us concern is that doctors appear to be taking over what were "non-clinical" aspects of investigation formerly done only by lay investigators and the Ombudsmen. There are frequent allegations that doctors, nurses or midwives have been rude to patients. Usually these are denied. After the event it is often impossible to prove who said what, so most are unproven (we have previously corresponded with the HSC pointing out that they should not be rejected as unfounded when a fairer judgment would be unproven one way or the other). Now these allegations appear to form part of the clinical investigation and clinical assessors' reports when they are no more qualified to judge these than anyone else. We suspect (and there is research supporting us) that doctors are less likely to find a fellow professional at fault than lay investigators are. Invariably they seem to report that they do not believe the doctor would have behaved like that - and the Ombudsman may accept that finding.

21.8 Of course, these are early days for the Commissioner's venture into a new field. We shall watch future developments with interest.

22. The role of the House of Commons Select Committee on Public Administration

22.1 The Committee is where the buck stops. It is the point where officials of erring Trusts, and even doctors, have to answer publicly to elected representatives of the taxpayer. Before the Ombudsman began to publish names in his reports, it was the only way we could find out the names of some of those Trusts. We know of one case where a bereaved family attended one such meeting and felt that at last they had got justice.

22.2 The Committee has seen it as their job to support the Ombudsman, by adding their weight to his criticism of offending Trusts. They have not seen it as their job to monitor the Ombudsman himself, despite very different performances from different holders of the office. When there was a fall in the number of complaints found justified, one MP thought it was a good thing, and presumed it was because NHS standards had risen.

22.3 The most discussed aspect - raised by the Commissioner himself - has been the length of time it takes to investigate cases. The only costs mentioned (but not discussed) have been on one occasion the direct salary costs per case investigated (over £5,000) but no one has asked questions about overall cost, although the British Ombudsman is expensive compared with others in Europe. It is unusual for an Annual Report not to contain any cost information and we think it should be included.

22.4 We think it would be helpful if the Committee were provided with specialist briefings on medical and nursing issues. This would help them to focus questions and deal with some of the witnesses who try to pull the wool over their eyes. We remember one case on pressure sores where obviously they did not know about standard risk assessments and procedures, and could have asked more pertinent questions if they had been briefed.

22.5 A recurring theme for many years has been the question of discipline of NHS staff - especially consultants. Over and over again frustrated MPs on the Committee have asked what happened to those who made serious mistakes, and the answer was usually nothing - they had been promoted, moved elsewhere or, at worst, had been "counselled". Personnel matters are, of course, outside the Ombudsman's remit, but MPs were truly reflecting the views of many complainants when they support the complainant who was indignant that she could not even be told what, if any, disciplinary action had been taken against a nurse who had made serious mistakes. Trust officials have often given evidence on the virtual impossibility of disciplining consultants. Since the Committee has continually raised this problem, it is ironic that the new complaints procedure removed complainants from any contact or influence on the disciplinary process, and took away their right to know what action, if any, had been taken. This is a most unwelcome development for the health service consumer whose powers of redress are already so few.

22.6 As is all too obvious from the Committee's proceedings, those who have erred have very often moved on to employment elsewhere - often to a higher and better paid position. This has frequently been a source of frustration for Committee members who have asked what penalties have been imposed on those who have been found incompetent. We think it would help if the Ombudsman had the power to question former employees of a particular Trust (particularly if they are still employed in the NHS) and the Select Committee should also be able to do this. It is true that the Trust has corporate responsibility for the actions of its employees, but those who have been incompetent in one area of health care can still cause death or injury when they move elsewhere.

23. Obtaining consumer views

23.1 The current HSC is now obtaining feedback from users of his service. This is a welcome and much overdue step. There is now a substantial amount of qualitative

research on treatment of health care complaints and we feel this important subject merits independent academic study. If outside researchers are used, confidentiality could be preserved by having initial letters sent by the HSC office so that researchers have no contact with complainants until they have agreed to take part.

24. No protection for private health care patients

24.1 For all the imperfections of the NHS complaints procedure and the Ombudsman's office, they do at least provide somet avenue of complaint for aggrieved patients. However,there is no protection for patients in private health care who have no statutory complaints procedure and no independent investigation - a state of affairs which we deplore.

Beverley A Lawrence Beech - AIMS
Jean Robinson - AIMS

16th July, 1999

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Note:
Further copies of this paper and copies of an earlier occasional paper: *Procedures related to adverse clinical incidents and outcomes in medical care* are available from the Publications Secretary, Mandy Hawke, 2 Bacon Lane, Hayling Island, Hants, PO11 ODN, Price £2.50 each (incl. p & p).

APPENDIX 1

21 Iver Lane, Iver, Buckinghamshire, SLO 9LH

OCCASIONAL PAPER

A CONSUMER REVIEW OF THE WORK OF THE HEALTH SERVICE COMMISSIONER

Tel: 01753-652781. Fax: 01753-654142
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3rd July, 1998

Mr Michael Buckley
Health Service Commissioner
Millbank Tower
Millbank, SW1P 4QP

Dear Mr Buckley

We have read your Annual Report for 1998 with interest. There are a number of issues which concern us.

1. The report, whilst a glossier production than in previous years and in larger print, contains far less information than earlier reports (35 pages of large print compared with last year's 97 pages of smaller print).

2. Despite the large print and new layout, information is not easier to find or absorb than earlier reports. In some ways it is more confusing.

3. Trusts investigated are not named in the annual report. Consumer groups greatly welcomed the introduction by your predecessor, Sir William Reid, of the naming of Trusts. We regard their omission in this report as a retrograde step, and this suggests less openness in the Ombudsman's office. We realise that Trusts are named in the separately published reports of investigations completed, but fewer people will see these.

4. Our major concern in the dramatic fall in number of cases investigated - a mere 270, compared with 551 last year, and the lowest number in the ten-year table provided. This small number is particularly worrying in the context of a rising number of complaints - the highest recorded, and also when one takes into account the fact that this report was the first in which your office was covering two entirely new categories of work - clinical complaints and complaints against GPs, and there has also been a large number of complaints about failures in the operation of the new complaints procedure. One would expect, therefore, that the number of cases investigated would rise. Since your office has included a number of new GP cases, it would seem that the fall in volume of earlier "standard" work is even greater than the worrying figures suggest.

5. Although the percentage of complaints upheld - 78% is the highest ever, this is small comfort to consumers since the number upheld was the second lowest in the last ten years 210 last year compared with 382 last year and 338 the year before. In the last 10 years the only year where a smaller number was upheld (177) was 1989-90.

6. Our second major concern is the omission of analyses by service area, subject and profession, which have previously been provided. These tables have in the past provided information which we regard as essential to understand what the Ombudsman is doing, to advise our clients, and to look for areas of particular concern. It seems ironic to us that the very official who is charged with investigating complaints about the Code of Openness in the NHS, is now failing to provide essential statistics on his work. We regard the Ombudsman's reports as important historical documents.

7. You refer to your policy of asking the NHS body concerned to take immediate action where there are shortcomings in complaints procedure. Whilst this may be helpful to many complainants, you are not providing us with an adequate analysis of what those complaints consist of, whether you follow up what action if any is taken as a result, and whether the complainant is satisfied. The frequency of failures in the new complaints procedure, and what the problems are, is a question of great public interest. It seems to us that the size and complexity of the problems with the complaints procedure are being concealed, and it is important that the data should be available.

INVESTIGATIONS COMPLETED October 1997 - March 1999.

8. We understand that a serious confidentiality problem has occurred in connection with your last report on investigations completed. This concerned a complaint about care during labour and a neonatal death. Because the place of birth, date of birth and date of death were given in your summary, the bereaved parents were easily traceable by the press, and were under pressure as a result. Fortunately, much of this pressure was diverted by the local Community Health Council. We would like your assurance that such an event could not occur again.

9. We note the names of Trusts investigated are given in short epitomes, but sometimes they are not given in the longer accounts. We would prefer that they appeared in both.

10. We are delighted that the Commissioner now has power to investigate actions of GPs, and also GP's removing patients from their lists. AIMS has many cases where women and their families are removed because they want a home birth.

11. We greatly welcome the inclusion of reports by medical advisers to the Commissioner in the GP complaints. This enables us to judge both the quality and approach of the GP advisers, and will also enable GPs to understand the standards by which they are likely to be judged. (You will also recall that we were - and are - critical of the refusal of your office to publish the names of medical advisers). We look forward to the publication of similar information on hospital complaints.

12. The provision of this information enables us to raise a query about the appendix to E.184496/7 (p100) where two GP advisers looked at a complaint about a GP's failure to admit a patient to hospital quickly enough and also that the GP's manner in a home visit caused unnecessary distress. It was, of course, appropriate for the specialist advisers to comment on the medical need, or otherwise, for admission and whether practice arrangements were efficient. However, your medical advisers also concluded that the GP's manner "did not cause unnecessary distress". We do not see why a medical assessor's opinion here is any more relevant, and should carry any more weight, than anyone else's.

13. This complaint is typical of many hosptial complaints which were investigated by the Ombudsman before clinical judgement was within his remit and did not need a clinical opinion. In a number of these cases Ombudsman reports have concluded that it is impossible to come to a conclusion after the event about a doctor, nurse, or midwife's manner and that no finding is made. The medical assessors in this case, who had not met the parties, concluded that the GP's manner had not caused distress and recommended that the Ombudsman should not uphold that part of the complaint. This causes us concern, and we hope it does not act as a precedent.

14. We were most interested to read the brief report on Case E.117596/907 which shows the difficulties we had predicted when a GP fund holder has the right to sit on a panel, even though the practice may be the subject of a complaint. We think it is a great pity that this complaint was given such a brief and short report, and we hope very much that the Select Committee will call representatives of Salford Community Health Care Trust before them.

15. We have a general complaint that even the longer accounts provided in your reports on investigations completed are less detailed than those in earlier Ombudsman reports, which we always found clear, easily understandable, very educational and excellent teaching material.

16. Whereas once we relied on the Ombudsman to send staff in to do a primary investigation in a hospital in cases of serious complaints which had not been dealt with properly, what we now get is a series of reports on whether the convenor or panel or chief executive did or did not follow the rules of the new complaints procedure - a procedure which you know well is continually criticised by consumer groups. The bereaved or distressed complainant may (if one of the lucky few) get a report from you criticising the convenor. But the nub of the complaint is hardly touched by you or your officials and the sad complainant does not get what he or she would once have had - a true re-investigation by your office. Indeed, your accounts of such investigations of this kind that you have done, give very inadequate material on what the real complaint was. It is therefore, unlikely to bring comfort or satisfaction to complainants.

17. Admittedly, much of this difficulty is caused by the complaints procedure itself. But one gets the impression from your reports that once convenors and trust panels

have settled down to follow the rules properly, problems will cease and you will have little to do. What is going to happen is a growth of cynicism and despair - and we see far too much of that already.

18. Frank Dobson has criticised lawyers for taking medical negligence cases against the NHS. On current trends in the Ombudsman's office, both on numbers of cases investigated and pattern of work chosen, we can only say that lawyers will be busier than ever.

Yours sincerely

Beverley A Lawrence Beech
Hon Chair

Jean Robinson
Hon Research Officer

Copy: Clerk to the Select Committee on Administration