NHS WALES

Complaints in the NHS

Training for Lay Members of Independent Reviews and Panels

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INTRODUCTION

The NHS complaints procedure introduced in Wales in April 2003 gives an important role to lay members. To carry out this role lay members need to have the knowledge and skills to make the system effective. Lay members need to meet the agreed standards and be held accountable for their performance.

This training programme identifies the knowledge and skills that lay members need to do their work. It has been developed for lay members based on the three road shows held in March 2003 in Carmarthen, St Asaph and Cardiff attended by many lay members and complaints staff, and a survey on training needs identified by Welsh lay members in October 2003. Nearly 80% of lay members replied to the questionnaire and there was a high degree of consensus about the key aspects needed in the training package and these are reflected in the modules. A reference network of representative lay members commented on draft modules.

The training programme is primarily for potential and existing members to use in their own time and assess their own progress. The training programme covers four modules and has a separate section with case studies to which you will need to refer as you go through the programme. Each module builds on the one before.

1. The foundation module

This covers background information and skills that everyone who is a lay member will need before sitting on a panel.

It also includes the “lay member complaints competency model” on which the training programme is based, as well as a guide to organising your continuing development as a lay member.

2. Panel members

This module looks at the skills and knowledge that you need to sit as a panel member.

3. Reviewing the complaint – the roles of Reviewer and Lay Adviser

This module looks at the skills and knowledge that you need to consider a request for an independent review whether as a Reviewer or Lay Adviser.

4. Chairing the panel

This module looks at the skills and knowledge that you need to chair a panel.
HOW TO USE THE TRAINING PROGRAMME

The programme is for potential and existing lay members to use in their own time and assess their own progress. Each module builds on the one before. You need to successfully complete the Foundation Module (Module 1), before moving on to Module 2 on being a panel member.

In the modules you will find suggested activities which ask you to take time out from reading in order to write down your thoughts about the subject being discussed, or to answer questions that you can compare with the comments that are given at the end of each module. This is to give you the chance to think about the subject matter and relate it to your own experiences or expectations.

The modules provide all the information you need to complete them, however there are signposts at the end of each module to other resources and information that you can find, particularly via the internet.

Before you start

Before you start you will need to obtain and read about the NHS Complaints Procedure in Wales. Complaints in the NHS: a Guide to Handling Complaints in Wales was published by the Welsh Assembly Government in April 2003. As well as the hard-copy ring binder format, the Guidance can be downloaded from the internet: www.wales.nhs.uk/documents/nhs-complaints-guide.pdf In this training programme, it is simply called the Guidance.

You should also be familiar with the leaflet for the public about the complaints process, Complaints in the NHS: a Guide to handling complaints in Wales. This explains what people using the NHS in Wales can expect from the complaints procedure.

Everything in this training programme relates to the new Guidance. You will be referred to sections relevant to each part of the module and you need to know what it contains and how it can help you. This will make it easy to refer to the sections when you need them.

As you work your way through the modules

All lay members need to understand the context in which complaints about health care arise and understand how the NHS Complaints Procedures work. You will be asked to have a development plan which is explained at the end of Module 1.

A good way to get a feel for what actually happens at an Independent Review Panel is to observe one. If you have been appointed as a lay member but have not sat on a panel as yet, you may ask to be an observer provided the
chair and the parties agree. The Independent Review Secretariat (IRS) will help you arrange this on request.

The Independent Review Secretariat Manager provides support to lay members to help you develop the knowledge and skills you need. There will be arrangements for mentoring, where an experienced lay member can advise and support a new member. Further information on this will be available from the IRS.

It is important to understand the relationship of lay members to the IRS. You are appointed to your role as a lay member by the Welsh Assembly Government. It is the IRS which appoints you as a lay member to a particular case. It is therefore to the IRS that lay members are accountable for the efficient performance of their roles in relation to a particular case.

If you would like more information about the role of the IRS, contact:

The Manager
Independent Review Secretariat - All Wales
PO Box 2, Bronllys
Brecon, LD3 0XR

Tel: 01874 712536
MODULE 1 – THE FOUNDATION

- This is the foundation module on which the other modules in the training programme build.
- It covers background information that every lay member will need before sitting on a panel or undertaking other roles.
- It applies to all lay members, regardless of their level of experience and what other roles in the complaints process they may undertake.
- Completing this module successfully is a pre-requisite of progressing on to the other modules in this training programme. There is a certificate at the end of this module which you should complete and send to the IRS Manager.

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AIMS OF THE FOUNDATION MODULE

By the end of this module you will:

1. Understand how the NHS in Wales works
2. Be familiar with standards that patients and the public expect
3. Be familiar the NHS complaints procedure in Wales, and
4. Understand the role of lay members in the complaints procedure.

Experienced lay members may find that they know much of this information already. However, some details have changed. So please take the time to work through the questions at the end of each section before you move on.
1. **THE NHS IN WALES - MAPPING THE LANDSCAPE**

As a lay member will need to be familiar with how the NHS really works in Wales, not just in theory. You may need to assess whether the treatment and care provided, and where it was provided, was acceptable.

You can find information on national and local services from:

- **NHS Wales Directory** [www.wales.nhs.uk/directory.cfm](http://www.wales.nhs.uk/directory.cfm)

- **NHS Planning and Commissioning Guidance** (Welsh Health Circular 2003/63, June 2003) contains excellent maps of NHS areas and descriptions of how NHS Trusts, Local Health Boards and Health Commission Wales (Specialist Services) should be working collaboratively to commission and deliver the range of primary, secondary and specialist services. [www.wales.gov.uk/subihealth/content/keypubs/pdf/whc63-nhs-plan-comm-e.pdf](http://www.wales.gov.uk/subihealth/content/keypubs/pdf/whc63-nhs-plan-comm-e.pdf)

- Community Health Councils (CHCs) can provide invaluable local knowledge about the local NHS and users’ experiences of it. They produce a range of reports and surveys that are freely available. Association of Welsh CHCs, [www.patienthelp.wales.nhs.uk](http://www.patienthelp.wales.nhs.uk)

Refer to information about the NHS and then complete Activity 1 below.

### Activity 1: The landscape of the NHS in Wales

Find out about the landscape of the NHS in your part of Wales, including the following:

1. What are the boundaries of the local health board?

2. Who are the commissioners of the local NHS services?

3. Who provides local NHS services in this area?
   a. NHS Trusts - which ones and where?
   b. FHS practitioners - how many local GPs, dentists, pharmacists, ophthalmic practitioners?
   c. Jointly commissioned services between NHS and social care?
   d. Non-NHS providers - what services and where?

4. What local patient and user representatives and advocacy services are there in the area?

5. What is the role of the National Assembly of Wales in health and social care?
If you feel you understand:

- How NHS services are commissioned and funded
- How NHS and private healthcare services are provided
- The independent contractor status of Family Health Service (FHS) practitioners
- How health and social care services are meant to work together
- The role of the Welsh Assembly in health and social care

Then move on to the next section.
2. PATIENTS’ EXPECTATIONS AND STANDARDS

Complaints arise because patients or their carers feel that the services they receive were inadequate or of a poor standard. As a member of a complaints panel you will need to understand some of the reasons why people complain, what they hope to achieve. You will also need to consider what are reasonable standards that patients should expect and whether or not the NHS has met them.

Patients’ experiences and expectations

There is a lot of research about patients’ views and their experiences of services and the reasons that people make complaints. The Commission for Health Improvement believes from its extensive inspections of local services and talking with users that what people want is:

- Treatment that is effective and delivers good outcomes
- Services that are quick and easy to use
- Services that are well organised
- To be treated with dignity and respect
- To be treated in places that are safe, clean and comfortable.

There are reports on local services from a patient’s perspective. Your Community Health Council may have produced reports about patient and public views on services and on the issues most important to patients. ([www.patienthelp.wales.nhs.uk](http://www.patienthelp.wales.nhs.uk))

Why people complain

Many people may experience problems in health care, but only a few complain. Often people report that they initially make a complaint because they think it important that what happened to them does not happen to others. Sometimes their distress and anger increases because they feel that their concerns are met with a defensive or off-hand manner and, as a result, the complaint can escalate. This is why it is so important to deal with problems as they arise through early and effective local resolution.

In trying to resolve a complaint it is important to try to find out and understand what the complainant hopes to achieve. Does the complainant want:

- To get an explanation and further information?
- To get recognition that they have had a problem and deserve to receive an apology?
- To improve services for other people?
- To get compensation?
- To get the complained against practitioner disciplined or sacked?
The NHS complaints procedure can give people more information and an explanation, an apology and should improve services as a result of a timely and well-conducted investigation and recommendations. However, it cannot recommend or award compensation or get a person sacked or disciplined. These are covered by separate procedures. If the complainant raises any of these issues, you may need to explain that compensation, discipline and also legal remedies are outside the scope of the independent review process.

Read through the complaint letter excerpts in Activity 2 (on the next page) and then consider how you think that Mrs X would expect staff in the hospital to respond to her complaint. Note that this is not a request for independent review but an initial letter of complaint. An appropriate response at local level might prevent her taking the complaint further to an independent review with the additional statements and clinical advice that would entail. In this activity you are simply being asked to consider what a satisfactory local response to Mrs X should be.
Activity 2: Understanding why people complain

Mrs X was referred by her GP to a Consultant Surgeon about a lump in her breast. She was admitted to hospital for surgery. She had expected to return home that day. The consent form was for surgery and chemotherapy but she consented only to the former and made this clear at the time.

After surgery, she was told that further tests were required and that she should telephone the hospital for the results of the biopsy. She also had drains in the wound and was unable to go home that day. No counselling was available because the breast counsellor was on holiday.

When she attended for the test results, she was told that cancerous cells were found in the lump that had been removed; chemotherapy and radiotherapy were proposed. She complained to the hospital trust.

Here are excerpts from her letter of complaint.

“(the consultant) said: ‘at your age it’s unlikely to be anything serious. If you were ten years older we would be ringing alarm bells...have it taken out, that’s the best thing...’

I was given no information about what the operation would involve, or that it could possibly be cancer, nor what would happen if it was...when I was booked in, I asked the doctor if I could go home that day and he said, ‘yes, I expect so, if you feel OK....’

When asked to sign the consent form, I questioned the chemotherapy and the nurse said this was just in case they found anything ‘dodgy’. This really upset me and I refused to sign for it.

Mr Y the surgeon gave me the results in a room where a secretary was typing; she stayed there while I was being told that there were some cancerous cells in the lump...

I was very upset and embarrassed to be in such a state whilst people came in and out to use the photocopier etc. There were files marked ‘deceased’ in this office, hardly the place to break the news that someone has cancer!

I don’t want other women to go through what I have endured through insensitivity and poor communication.”

Here are some questions to consider:

- What do you think Mrs X wants to happen by making her complaint?
- From her perspective, what seem to be the most important issues?

There are some comments on these questions at the end of the module.
Standards for services

Our satisfaction and dissatisfaction with services often depends on what standard of service we had expected. Sometimes these expectations are reasonable and sometimes they are unreasonable.

When you become involved with a complaint, you need to consider if the service was below a standard that the patient and carer had a right to expect. Some of these standards are set down by registration and regulatory bodies such as the General Medical Council and others by the Welsh Assembly Government.

Professional standards for medical practice

General Medical Council, *Good Medical Practice* 2001, outlines what is expected of doctors by their statutory body in order to main registration and the right to practise. This is the basis for the revalidation process that all doctors will be undergoing every five years. The publication is available on this website [www.gmc-uk.org](http://www.gmc-uk.org) and copies can be requested from the Public and Patient Involvement Branch of the Welsh Assembly.

Other professions have followed the overall standards that cover what is expected of professionals including good clinical care and keeping up to date, relationships with patients including complaints, consent, confidentiality and communication.

National Service Frameworks for Wales

One way in which the Welsh Assembly improves and monitors standards and quality across health care sectors within Wales is through National Service Frameworks (NSFs). These:

- set national standards and define service models for a service or care group
- put in place programmes to support implementation
- establish performance measures against which progress within agreed timescales would be measured.

NSFs have been introduced to address variations in standards of care and to achieve a greater consistency in the availability and quality of services by putting in place mechanisms which enable best care to be provided to everyone. You can read more about NSFs at [www.wales.nhs.uk/sites/cfm](http://www.wales.nhs.uk/sites/cfm) or you can find out more about the Welsh Assembly’s 10-year plan for health services in Wales in *Improving Health in Wales – A plan for the NHS with its partners* (at [www.wales.gov.uk/healthplanonline](http://www.wales.gov.uk/healthplanonline) or contact Health and Well-being Strategy and Planning Team (HSPT) at the Welsh Assembly on 029 2080 1032).
Understanding attitudes to complaints

We all bring our personal values to any tasks we undertake. As a lay member you also bring your own experience and knowledge to the role, whether from your understanding of health services in Wales, your experiences as a user or carer or of working with the public, in particular in dealing with people who have a grievance, a complaint or are distressed.

Your experience and skills help you to contribute a fresh perspective and to understand the complex issues involved in many complaints. By the time a complaint has escalated to an Independent Review, people and processes have often become very intertwined. Often the original cause for the complaint has become obscured by subsequent complaints about the way the complaint was handled, leading to frustration and anger. These may be about delays, alleged breaches of confidentiality, lack of responsiveness, etc. People with mental health problems and those caring for them, in particular, may feel that their complaints are not being taken seriously.

An essential part of the role of a lay member is to be fair to both parties and take an objective view of the events that gave rise to the complaint. As a lay member you will have to be impartial. Activity 3 below may help you understand whether you personally are more likely to empathise with the complainant or the professionals involved in a complaint.

Activity 3: What do you think about complaints and people who complain?

On the next page are some statements about complaints and people who make them. Read through all of the statements first.

Then go through them one by one again. Using the box to the left of the statement, rank each one on a scale of 1-12:

1 - is the statement you most strongly agree with
12 - is the statement you most strongly disagree with

There are no right or wrong answers so say what you really think!
<table>
<thead>
<tr>
<th>Rank</th>
<th>Statements</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>NHS users should be encouraged to complain if they aren’t happy because we don’t complain enough in this country</td>
</tr>
<tr>
<td>2</td>
<td>These days people seem too ready to complain about the smallest things</td>
</tr>
<tr>
<td>3</td>
<td>People who complain make me feel negative about the NHS</td>
</tr>
<tr>
<td>4</td>
<td>A complaint is an emotion wrapped up in a bureaucratic process</td>
</tr>
<tr>
<td>5</td>
<td>NHS patients shouldn’t complain because it’s a free service</td>
</tr>
<tr>
<td>6</td>
<td>We can learn from complaints if we take the time to understand why people are raising particular issues</td>
</tr>
<tr>
<td>7</td>
<td>Most people who complain are trying to put the blame on someone else and not face up to their own guilt</td>
</tr>
<tr>
<td>8</td>
<td>Patients aren’t health professionals, so we shouldn’t take their complaints too seriously</td>
</tr>
<tr>
<td>9</td>
<td>Most people don’t know what they want when they complain</td>
</tr>
<tr>
<td>10</td>
<td>Some patients can never be satisfied so it’s best to ignore them</td>
</tr>
<tr>
<td>11</td>
<td>We don’t often hear from people who really have something to complain about</td>
</tr>
<tr>
<td>12</td>
<td>The complaints procedure should resolve things for the individual and improve the service, not focus on the formal procedures</td>
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- What statements did you rank 1, 2, 3 and 4 - the ones you most strongly agreed with?
- What statements did you rank 9, 10, 11, and 12 - the ones you most strongly disagreed with?

There are no right or wrong answers, but as a lay member you will be working as a team with others with different views. From your answers can you identify:

- Your general assumptions about people who complain?
- Your feelings for people who are complained against?
- What the most important purpose of the complaints procedure is? Helping individuals or improving services?
- Whether you think complaints are triggered by one-off isolated incidents or indicative of wider problems?

Keep these statements and any views you have on your choices in a convenient place. Refer to them as you work through these training modules. Revisit them from time to time to see if your views have changed. If they have changed, make a note of what that change was and why it happened.
If you feel you understand the following:

- Some of the reasons why people make complaints
- What remedies there are for patients who have experienced difficulties
- How to find out about standards for care that the NHS aims to achieve
- What you think about complaints and people who complain

Then move on to the next section.
3. NHS COMPLAINTS PROCEDURES

“The complaints system should be proactive in encouraging people to voice their concerns and be seen as part of the wider arrangements for involving patients and the public in monitoring services.”

“Introduction to complaints”, Welsh Assembly Government website on Patient and Public Involvement [www.wales.nhs.uk/ ppi](http://www.wales.nhs.uk/ ppi)

Complaints received in Wales

Information on complaints to the NHS in Wales is produced annually. The most recent report to September 2003 breaks complaints down by NHS body, subject and service area. The most recent report can be accessed at [www.wales.gov.uk/keypubstatisticsforwalesheadline/content/health/2003/hdw200309301-e.htm](http://www.wales.gov.uk/keypubstatisticsforwalesheadline/content/health/2003/hdw200309301-e.htm)

This showed that in 2001-2002:

- There were 5,475 complaints - down 6% on the previous year.
- 1 in 3 complaints related to clinical treatment.
- More than half of the complaints related to medical/surgical staff.
- Nurses, midwives and health visitors accounted for 16% of all complaints.
- Complaints about hospital & community services were down 10%.
- Complaints about family health services were up 2%.
- Complaints about dentists rose by 15% (having fallen by 20% the previous year).
- 64% of complaints were concluded within the 4-week target - up from 60% in the previous year.
- Requests for Independent Reviews in hospital and community health services totalled 119, and panels were set up on 14.
- Requests for IR from family health services totalled 69, of which 16 panels took place, only 6 being concluded within target timescales.

**Principles for complaints handling**

Most complaints can be resolved at the point when they arise (this is called "local resolution"). A few complainants take their complaint further because they have not been given the answers they sought, or the complaint was badly handled. With more sensitive handling the complaint might have been resolved.

If the complaint has escalated, poor complaints handling often becomes part of the issues complained about. As a lay member you need to understand what it is reasonable to expect in terms of complaints handling in local resolution. Improving outcomes through better local resolution of complaints was a key objective of the Welsh Assembly in introducing the new complaints procedure in 2003. Training modules for front line staff about handling
complaints and comments are at Section 5 of the Guidance (see Activity 4 below).

Principles for good complaints handling at every stage include the following:

- **Access**: procedures should be well publicised and easy for complainants to use, reducing barriers of class, disabilities, race, language and literacy. Complainants are encouraged to contact their Community Health Council at an early stage for advice and support.

- **Patient centred and responsive** - aiming to satisfy complainants by offering a range of ways of trying to resolve the complaint – meetings, conciliation / mediation, independent “second opinions” where possible.

- **Thorough and timely**: Complaints will be dealt with promptly and unnecessary delays avoided.

- **Fair and impartial**: complaints procedures should be fair to both complainant and staff complained against.

- **Open and transparent** - the process is explained clearly and carried out so that all parties understand what is happening and why.

- **Improving service quality**: Recommendations from complaints investigations and panels should be followed up by NHS bodies. Information from complaints, respecting confidentiality, should be shared and incorporated in the clinical governance framework for organisations and practitioners.

**Health Service Ombudsman’s role**

The Health Service Ombudsman is the final stage of the complaints process where complainants are dissatisfied with Independent Review (either because a Panel is refused or because they are not satisfied with the conduct of the Panel). Practitioners and their staff can also complain to the Ombudsman about how they have been treated by the complaints process, including by a panel (See Guidance paragraphs 2.81-2.85 on the Ombudsman’s role).

**Activity 4: Handling complaints when they first arise**

Read Part 1 of the Guidance “Managing Complaints” which outlines what Local Health Boards and Trusts should do when handling NHS complaints and the options for local resolution.

Look at the handouts in Part 5 of the Guidance, “Training on Complaints” which will help you appreciate what can be achieved at the local resolution stage of a complaint.

Look again at the complaint by Mrs X in Activity 2 and consider:
If you were handling Mrs X's complaint at local level, how would you go about communicating with her after you first receive her letter?

What do you think the Trust and its staff can do to resolve Mrs X’s complaint to her satisfaction?

There are some comments on these questions at the end of the module.

Activity 5: Understanding Independent Reviews


Then complete the following activity. Even if you are an experienced member of complaints panels, you will need to look afresh at the Guidance. There are many changes in it from the 1996 guidance.

1. On a separate sheet, make a list of your expectations of being a lay member based on the key points identified in the Guidance.
   - Your role as a lay person
   - The skills you will need
   - What complainants will expect of you
   - What the complained against will expect of you

2. If you are an experienced lay member, extend the list above by also identifying what things have changed in your role in the new system compared to the previous one.

Keep your list handy so that you can refer to it as you work through the next module (Module 2) on being a panel member. You may want to amend your list of expectations on the basis of learning more about the role.

If you feel you understand:

- Why complaints are important for the NHS
- What are the principles for good complaints handling
- What can be done to resolve a complaint locally
- The role of Independent review panels
- What’s new in the Guidance about Independent Reviews

Then move on to the next section.
4. ROLE OF LAY PEOPLE

As a lay member you will be involved in complaints that have not been resolved locally and which will be among the most complex and distressing cases. Your actions will have an impact on the lives of complainants and individuals who are complained against.

You have been appointed as a lay person because you are independent and can cast a fresh eye at a complaint and help both sides to understand better what has happened and what has gone wrong. To make sure that lay members are seen by the public as independent, current or retired NHS staff, members of any of the clinical professions or board members of NHS bodies will not normally be appointed as lay members. Lay people who are no longer board members of NHS bodies may be appointed, provided they do not become involved in the area of their former responsibility.

The role description for lay members is given below.

**Job summary:** To take roles as lay members in the NHS Complaints Procedure in Wales, including to take part in the Panel, comment on draft versions of the report and agree the final report of the Panel.

**Accountability:** To the Welsh Assembly Government and the Independent Review Secretariat

**Key duties**

With other lay members, to
- Undertake as full and thorough a review of each request as is possible
- Consider all information in a fair and unbiased way
- Ensure the outcome of each review is explained fully and openly to all parties
- Contribute fully to any panel proceedings as necessary
- Work within the terms of the guidance at all times

**Personal characteristics**
- Independent and able to act without bias
- Committed to public service values of accountability, probity, confidentiality, openness and equality of opportunity
- Sensitive to views of patients, carers and individuals complained against
- Committed to attend training and continued personal development
- Able to travel where necessary to attend panel hearings.

**Essential skills**
- Listening and questioning skills
- Able to analyse complex data
- Able to make balanced judgment and reach conclusions
- Able to work in a team and collaborate with others.
Public duties of lay members

Being a lay person in the NHS complaints procedure is an important public service. You are dealing with issues that have an impact on the lives of other people. It is essential that you meet the highest standards for public services.

The Nolan Committee's Seven Principles of Public Life aims to ensure high standards and make it clear how potential conflicting interests are to be raised and dealt with. In your public duties you will need to ensure that you meet these standards.

**Selflessness:** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

**Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

**Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

**Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

**Openness:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

**Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership:** Holders of public office should promote and support these principles by leadership and example.

Accountability is a key element in the job description of lay members. Lay members are accountable to the Welsh Assembly Government for their performance as a lay member and to the Independent Review Secretariat for carrying out those roles in respect of individual cases to which they are appointed. In performing your role you will be expected to meet standards which will be described in later modules. Clarity is essential about what constitutes this relationship. Remember that accountability is a two-way
street, you cannot be accountable for things to someone or some agency, without a reciprocal accountability to you. As the system of lay members in the NHS complaints system in Wales develops and matures, the accountability relationships will take on more substance.

Activity 6: Your role as an independent lay person and public service

A. Read the role description for lay members of complaints panels. Then consider how carrying out this role reflects the Nolan Principles.

B. Below are some questions to consider about what “being accountable” as a lay member in the complaints process in Wales means.

Not all of them have an obvious answer. Keep your answers or questions relating to the topics below in a place where you can revisit them from time to time as your experience as a lay member grows and as the Welsh Assembly Government develops its links and relationships with lay members as a group.

- **Accountability’s meaning for lay members** - “what am I accountable for?”; “To whom am I accountable?”; “Does this kind of accountability have parallels in anything else that I do?”

- **Showing I am accountable for carrying out my role** - “how and when do I need to show evidence, and what kind of evidence, that I am carrying out my role effectively?”

- **Responsibilities of individuals and panels** - “am I accountable to the parties in a complaint? If so, for what? Is the panel itself accountable to the parties in any distinct way?”; “are lay members accountable to each other? If so, for what?”

- **The Welsh Assembly’s expectations of lay members** - “what standards does the Welsh Assembly Government expect us to follow?” “Is being accountable to the Assembly the same as being accountable to the public?”

- **Performance review** - “How will my performance and the performance of panels of which I am a member be measured?” “Will I be told by the Independent Review Secretariat if my performance needs to be improved and helped to improve it?”

- **Reward and continuation (reappointment as a lay member)** - “How is accountability linked with the system of rewarding lay members and decisions about reappointment?”
5. CONTINUING YOUR DEVELOPMENT AS A LAY MEMBER

Part of your accountability to the Welsh Assembly Government as a lay member in the complaints process is keeping a personal development plan. This is simply a tool to help you keep track of things you have accomplished and learned as a lay member. Your development plan:

- Provides tangible evidence that you are keeping abreast of developments in the wider health world.
- Allows you to identify your own learning objectives and the indicators that will show you are achieving them.
- Helps you to acquire the competencies and experience needed to take on the Reviewer, Adviser or Panel Chair roles.

Development plans are common in many parts of the health world. Their adoption by lay members in Wales is a recognition of the importance of the role of lay members in the NHS complaints procedure in Wales. You can keep this development plan on a computer or make up a simple file (like a loose leaf binder) to keep documents and your notes. The important thing is to keep the plan up to date, to revisit it regularly and to reflect on its relevance to your growing experience.

Your development plan is also a place to be self-critical or to identify wider issues that could be addressed by all lay members, by the Independent Review Secretariat or by the Welsh Assembly Government in the overall complaints system in Wales.

Suggested items to include in your development plan are listed in the box below. However, your development plan can include anything you think is relevant to your learning and development in the complaints process. As a rule of thumb, if you think it should be included, put it in and describe why it is relevant. (For example: someone who mainly chairs panels might serve as a panel member from time to time and this would provide an opportunity for a different perspective on panel dynamics and reflection on his or her personal chairing style - all that counts as a learning experience).
Activity 7: Your development plan

1. Reflect on what you have learnt about your role and responsibilities as a lay member.
   - Which elements of the role do you feel most comfortable with?
   - Which elements do you think you will find the hardest?
   - Are there areas where you would like further information or help?

2. Look at the list of items below and start to build up your development plan.

Items to include in your development plan

- Personal details to identify whose plan it is
- A summary of your complaints experience up to the time your development plan begins (e.g. how many years in complaints work, what roles you have undertaken most often etc)
- Dates covered by the plan - generally 12 month periods
- Training courses attended relating to complaints work
- Conferences attended that are relevant to your role
- Any writing or speaking you have done on the basis of your complaints role
- Any appraisals you have had, formal and informal
- Any mentoring or “shadowing” you have received or provided to other lay members
- Notes of memorable events/cases and people (all anonymised) you have experienced in the course of your complaints work, indicating any lessons you or others learned from these and how it may have changed your practice as a lay member
- Reading lists - things you have read and intend to read that will advance your competency in complaints work
- Any audit projects or other research into complaints activity you have been involved in
- Your personal intentions as a lay member - where do you want to get to?
- Objectives you need to achieve in order to meet your intentions
- Indicators of your progress, e.g. “I will know I am moving towards realising my intention when …”

If you feel you understand the following:

- Why lay members are involved in the complaints procedure
- The role that lay members have and changes from 2003
- The standards of public life that you are expected to meet
- How you are accountable to the Welsh Assembly Government and the Independent Review Secretariat

YOU HAVE COMPLETED THE FOUNDATION MODULE.

CONGRATULATIONS!
Before you move on to Module 2 for Panel Members, take time to look at:

- The suggestions for further information and reading
- Notes on self assessment questions
- The lay member complaints competency model

and

- Complete and return the certificate of completion: Module 1
FURTHER INFORMATION AND READING

About the NHS

www.wales.gov.uk/subihealth/content/keypubs/pdf/whc63-nhs-plan-comm-e.pdf

Commission for Health Inspection (CHI) Clinical Governance Reviews on Welsh NHS bodies www.chi.nhs.uk and search for “Wales”

www.chi.nhs.uk/eng/about/publications/getting_better/getting_better_txt.pdf

Ombudsman annual reports on cases investigated in Wales.
www.ombudsman.org.uk

NHS in England, see: *Guide to the NHS for Members and Officers of Local Scrutiny Committees*, November 2003. Prepared for England, this Guide can be used with care by lay members in Wales needing to know about the English NHS, e.g. when dealing with cross-border complaints. Section 7, is a useful “A-Z of the NHS”
www.doh.gov.uk/involvingpatients/nhsguide_scrutinycommittees.pdf

Experience of being a complainant

**The Complaints Journey** website www.icaslearning.com contains online complaints training modules prepared in late 2002 for use with English Independent Complaints Advocacy Services. There are some useful discussions and checklists that can be used in the context of the new Welsh complaints procedures. These modules contain a number of case studies (click on “module map” to find them) that are helpful for giving a feel about the personal dimension to complaints.

Standards and professional practice

**Freedom to practise: dispelling the myths** (November 2003) focuses on the patient journey in emergency care and outlines what patients can expect from the roles nurses and allied health professionals including paramedics are allowed and able to do within their Codes of Practice.
www.doh.gov.uk/emergencycare/freedomtopractice.pdf
Patient and Public Involvement In Wales

Community Health Councils in Wales: Association of Welsh CHCs, Tel 029 2023 5558  www.patienthelp.wales.nhs.uk

Signposts – a practical guide to public and patient involvement in Wales (October 2001)

Signposts Two - putting patient and public involvement into practice in Wales (September 2003)
Contact the Public and Patient Involvement Branch at the Welsh Assembly for copies, www.wales.nhs.uk/peri
NOTES ON SELF ASSESSMENT QUESTIONS

This is a list of some of the questions you were asked earlier in the module about Activities 2 and 4. Below each question are some comments reflecting the approach the authors of the module took to the question. Use these to compare with your response. Remember, there are no “right” answers.

Activity 2: Understanding why people complain

What do you think Mrs X wants to happen by making her complaint?

Comment: she wants her embarrassment and distress to be acknowledged in a meaningful way by the Trust. She wants to be told that she matters as an individual not as just another cancer patient. She does not want the Trust to explain at length that her problems arose because they have to do things in a particular way. And she wants changes in procedures so that others to be spared the same experience she had.

From her perspective, what seem to be the most important issues in her experience of unsatisfactory service from health professionals?

Comment: not being treated as an individual but as a part of the Trust’s processing of patients. Her cancer was unique, no matter how many hundreds of other cases the consultants had seen and discussed with patients. They didn’t acknowledge this in the way they dealt with her.

Activity 4: Handling complaints when they first arise

If you were handling Mrs X’s complaint at local level, how would you go about communicating with her after you first receive her letter?

Comment: You want to avoid appearing defensive and to acknowledge that her experiences were genuine and that she was right to make a complaint. The Trust can review its procedures as a result. A phone call may be the best way to acknowledge this, perhaps offering her a meeting with managers in the unit.

What do you think the Trust and its staff can do to resolve Mrs X’s complaint to her satisfaction?

Comment: Mrs X is not complaining about the clinical care as such and in addition to the acknowledgement of her distress and right to complain, she would like to see changes in information given, procedures for consent, privacy for interviews and protocols for breaking bad news and arrangements for counselling when the counsellor is away. Evidence that these areas will be addressed is what she wants. Of course, if Mrs X is not satisfied by the Trust’s response, then she can request an independent review by identifying the issues about which she remains dissatisfied. A lay reviewer will then consider Mrs X’s request and decide how to proceed.
Complaints panel literacy: skills and stages

- Identifying & obtaining relevant information
- Handling information, volume and complexity
- Appraising quality and reliability of evidence
- Making decisions on balance of probabilities
- Interacting effectively with others involved with the panel
- Organising and communicating views effectively
- Synthesising new knowledge/advancing lay member complaints practice

Novice advanced beginner competent proficient

Entry technical, communications and people skills

Interchangeable Roles: Expert Lay members, Lay Member Complaints Competency Model
The Lay Member Complaints Competency Model is the result of analysing the lay roles in the complaints process in Wales. It is a blueprint for how the four training modules were constructed. It shows relationships between those just commencing their roles as lay members (novice) and those lay members practising at higher levels reflecting greater knowledge, skills, understanding and experience (advanced beginner, competent, proficient). Advancement from novice to advanced beginner should be swift, reflecting opportunities for practical learning as lay members. Progress to higher stages of competence are proportional: more time will be needed to move to competent and then to proficient reflecting their greater breadth and depth.

Appointment as a lay member assumes possession of entry-level technical skills (e.g. using information technology), communications skills (e.g. oral, written, non-verbal) and people skills (e.g. creative listening, respecting dignity, handling emotion and aggression). These are generic and can be gained in a variety of ways through prior experience.

Each of the seven “pillars” of the competency model refers to related elements of knowledge, skills and understanding which are addressed in later modules. When applied together through a lay role in the complaints process, these enable the individual to work at one of the levels in the far right hand column (novice to proficient). Acquiring higher level skills and using them in more complex and demanding situations moves the lay member’s overall competency further up the column. Expertise at higher levels is only acquired through practice, experience and assessment. It cannot be acquired through knowledge alone. Continuing lay member development, as outlined below, is a key mechanism in acquiring greater expertise.

The diagram is provided to assist each individual to plot where they are now in relation to each of the seven competencies and, more importantly, to estimate where they would like to progress to as a result of gaining more experience of being a lay member in the complaints process. It is not an exact science, simply a graphical approach to concepts which may be difficult to grasp in words alone. It is also not a competition. Everyone will have their own understanding of where they are starting from and where they want to get to in terms of competencies.

High level “complaints literacy” and panel role proficiency can be developed over time by all lay members. Performance at the competent and proficient stages should imply interchangeability with at least one other role, e.g. between the panel member and reviewer/lay adviser role, or between the panel member and panel chair role. Occasionally there may also be interchangeability for some individuals between reviewer and panel chair roles. Lay members who are able to operate at this level will be acknowledged experts, able to work across all lay complaints roles. A hallmark of the “expert role” is the ability to solve complex problems with vision and an intuitive grasp of issues and principles and to provide leadership to advance the lay role in the complaints process itself.
CERTIFICATION OF COMPLETION: MODULE 1

When you have completed this module, please provide the following information and submit this form to:

The Manager
Independent Review Secretariat - All Wales
PO Box 2, Bronllys
Brecon, LD3 0XR

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I certify that I completed this module on (date)______________

The amount of time taken to complete the module was approximately ______

As a result of undertaking this module, I have identified the following issue(s) which I would like to discuss with the Independent Review Secretariat:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

As part of my development plan as a lay member, I intend to take the following actions to continue my learning:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Signed)______________________  Date______________

You should make a copy of this form and keep it with your development plan.
MODULE 2 – PANEL MEMBERS

- This module is for those who have successfully completed the Foundation Module.

- All lay members must be competent to carry out the role of an Independent Panel Member.

- It is good practice for individuals who also carry out reviewer, adviser and panel chair roles to serve from time to time as panel members. The reviewer will automatically serve as a panel member any time s/he decides to hold a panel.

- Completing this module successfully is a pre-requisite of progressing on to the other modules for Reviewers and Chairs. There is a certificate at the end of this module which you should complete and send to the Independent Review Secretariat.

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3. Appraising evidence and agreeing findings 42

4. Deliberating as a panel 44

5. Agreeing the panel report 48

Notes on self assessment questions 50

Certificate of completion: Module 2
AIMS OF MODULE 2

By the end of the module you will know how to:

1. Prepare for a panel
2. Question and listen to parties and witnesses
3. Consider the evidence and agree findings of fact
4. Deliberate as a panel
5. Agree the report and make recommendations

You will do this by working through an anonymised case study and answering a series of self-assessment questions about the case, which you can compare with comments at the end of the module.
INTRODUCTION

This module is for everyone who sits on an independent review panel. You will have completed Module 1 (the Foundation Module) and be familiar with Part 2 of the Guidance on Independent Reviews. Review the Guidance now if you need to. Keep your copy handy while you are working through the case study as you will be asked to review and consider how to apply sections of it relating to particular aspects of the case.

You can use this module in several ways:

- If you are just starting as a panel member, it is an essential part of developing your competency for the role
- If you are already experienced as a lay member in the complaints process, it can be an exercise in self-validation of your knowledge and skills
- Once you are sitting on panels regularly, the module can be used for periodic reference and review.

The Independent Review Secretariat

The Independent Review Secretariat provides administrative support for the Panel, appointing members, paying their expenses, arranging the panel venues and sending out the papers to panel members and parties.

Administrative support for meetings will vary from panel to panel depending on local resources. This is discussed further in Module 4 for Panel Chairs.

The Panel members

Each panel has three lay members, including the Chair, appointed by the Secretariat. Normally the Reviewer and the Lay Adviser will be members of the Panel. The Chair will generally be the Lay Adviser who advised the Reviewer on the case, unless s/he does not wish to chair (in which case the Reviewer will chair). The Reviewer will draft the terms of reference with the Chair and send them to the complainant for comments. The Reviewer and Chair will also decide what witnesses to call and what documents or reports they want before the panel convenes.

The third Panel Member may feel at a disadvantage, as the other two members of the panel will already be familiar with the case. However, as the third panel member your role is important in casting a fresh eye on the complaint and ways of resolving it.

The Chair as the panel’s leader should make sure that you are fully briefed about the complaint before starting any interviews so that you are able to play an equal part as a member of the team. Once the panel is underway, its conduct is in the hands of Chair who is charged to act fairly to all parties.
How to use the case study

This module uses Case Study 1 in the separate collection of case studies. It is a dental complaint based on a real, anonymised case. It gives a relatively simple illustration of the panel member’s role and the functioning of the panel members as a team.

The topics covered in this module reflect the key tasks in the panel member’s role (see table below). Here is a suggestion for using the case study in the context of those key tasks:

1. First, read through Section 1 of the module about preparing for the panel.

2. Then read through Case Study 1 Documents A and B, perhaps more than once.

3. Next, work through each of the tasks in turn in Sections 3-5, referring back to the case study as needed.

4. Complete the self-assessment questions in each section as you work through it.

5. After that, read Case Study 1 Documents C and D containing the panel's full report. When you have finished reading these, review any of the answers you have given to the self-assessment questions and consider if you want to change anything.

6. At the end of the module, compare your responses to the questions with the comments given for each question. These comments reflect what really happened during the hearing, but that does not mean that things could not have been done just as well in a different way.

Assessing your progress

This is something you will want to do for yourself. There are three groups of self-assessment questions. These are not a test. They are a means for you to gauge your own understanding of the content of the module. At the end of the module there are some points that you may want to consider and you can compare these with your answers. There are no right or wrong answers, which is why the collective input and deliberation of the panel members is so important to achieving a good result.
<table>
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<th>Major elements</th>
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| Prepare for panel | ▪ Rationale for panel  
▪ IR Secretariat support staff  
▪ Role and relationships of panel members  
▪ Good practice in panel conduct  
▪ Knowing what happened at local resolution |
| Question and listen to parties and witnesses | ▪ Role of clinical advice  
▪ Consent, confidentiality and patient records  
▪ Role and conduct of supporters of the parties  
▪ Interviewing parties and witnesses  
▪ Dealing with emotion, distress or aggression |
| Appraise evidence | ▪ Adhering to terms of reference  
▪ Assessing oral and written evidence  
▪ Role of assessor(s) in the panel  
▪ Determining reasonable expectations |
| Deliberate as a panel | ▪ Decision-making on balance of probabilities and dissenting views  
▪ Standards for expectations of practitioners and services  
▪ Facts and recommendations  
▪ Panel boundaries and alternatives |
| Agree the report and make recommendations | ▪ Commenting on drafts  
▪ Signing off final written report  
▪ Assessor(s) written report  
▪ Post-panel security of documents and communications |
1. PREPARATION FOR THE PANEL

You are to be a panel member at a hearing for this complaint (Case Study 1). When you are a member of a panel hearing a complaint you will receive the papers from the Independent Review Secretariat well before the date set for the hearing.

In the dental complaint case that you are going to hear, Mr JB made a complaint to the Local Health Board containing allegations regarding the standard of teeth extraction performed on his father, Mr AB, by a dentist, Dr C, on 20 August 2003 and the lack of aftercare from the practice which had caused his father considerable distress.

The reason for holding the Panel

The Reviewer has decided to set up a Panel on the complaint that we are going to examine in this Module (Case Study 1), having taken account of the views of the Lay Adviser. The Reviewer may decide to set up a panel in cases where:

- Further attempts at local resolution are unlikely to lead to an outcome which will satisfy the complainant; and
- There is reason to believe that the underlying causes which led to the complaint have not yet been fully exposed; or
- The response of the organisation, family health services practitioner or non-NHS provider to the complaint appears to be unreasonable.

If the complaint is about clinical issues, the Reviewer will ask for clinical advice. Almost all complaints involve clinical issues. Clinical advice helps the Reviewer decide whether to hold a panel or not. It provides a fresh view on the issues and comment on whether the complained against has reasonably answered all the points of a clinical nature in the complainant’s initial letter of complaint. A copy of his or her comments is included in the complaints file for the panel and the papers for the parties.

In Case Study 1, the Reviewer and the Lay Adviser agreed that local resolution had gone as far as possible, though it had not been carried out very satisfactorily. They agreed that a panel had a reasonable chance of getting at the facts in the widely differing interpretations of events made by the complainant and the practitioner.

Reading the papers

It is essential that all panel members are familiar with all the papers for the panel before it meets. Before the panel begins you will need to consider the areas where there is uncertainty and where you will need to form a conclusion. This is the way to identify areas for the investigation and the questions that need to be asked. List in advance the questions you want to ask so that they can be co-ordinated with other panel members’ questions.
It may be that you identify areas where witnesses might be asked to give a statement or be interviewed or additional documentary evidence could be sought. Suggest this to the Chair, who can, where necessary, ask the Secretariat to arrange for additional information or for witnesses to attend the panel.

Activity 1

Read through Case 1 Study Documents 1-A and 1-B, perhaps more than once.

What questions would you like to ask the complainant and the complained against? Make a note of these and go back to them after you have finished the module and read the panel’s final report. Would you want to make any changes to your questions based on the information examined by the panel?

Medical terms and further information

You will encounter many clinical and technical terms in patient records and advisers’ reports. An up to date paperback medical dictionary, such as the Oxford Concise Medical Dictionary, is a helpful basic reference.

The Guardian newspaper website http://society.guardian.co.uk/glossary/ maintains a glossary of hundreds of phrases used in the public and voluntary sectors of health and social care, with links to websites where you can find more information. It also includes advice on how to write clear and concise public documents that will be easily understood by everyone.

The National Electronic Library for Health also has access to medical databases and other health information. www.nelh.nhs.uk/

Consent, confidentiality and patient records

Usually the complainant is the patient, but in Case Study 1 an elderly father has given authority to his son to make the complaint on his behalf.

For panels to undertake their work they may need to access relevant parts of a complainant’s medical record. Under data protection legislation, you should only have the relevant sections of the records. There are important restrictions on those who receive personal information about patients both in their discussions with others and how you make sure that no one else can see the information. Panel members need to have a secure place in which to keep case papers, including those received electronically, especially if they are working from home.
- Read Guidance section 4.2 on Handling information and Data protection.
- Review Guidance paragraphs 1.15-1.20 and form 3.2 and consider the implications for the panel when the patient is not the complainant.

If you feel that you have understood:

- The rationale for holding panels
- The importance of patient confidentiality
- Relationships between lay panel members

Then move on to the next section.
2. QUESTIONING AND LISTENING

At the panel hearing in addition to the panel, there will be one or more Clinical Assessors to advise the panel. The complainant and complained against as well as anyone invented to attend to give evidence will also normally bring someone with them to support them while they are interviewed or during the hearing.

As a member of the panel you will need to consider the evidence and written advice before and during the panel. To do this, you and other panel members will need to consider:

- The purpose of the panel investigation
- What specific shortcomings there were in local resolution
- How the clinical advice assists in understanding the evidence
- Consent, confidentiality and patient records
- Any written statements from witnesses or other interested parties

Clinical assessors

At the panel a clinical assessor will comment on clinical aspects of the complaint to help the panel come to a conclusion on clinical aspects of the complaint. A Dental Assessor who has the patient’s records will advise this panel. The panel will have copies of relevant parts of the patient’s health records and originals will be available at the panel.

Members will meet with the clinical assessor before they interview the parties. This is important to identify the important issues to explore and decide who will ask which questions.

- Read Guidance paragraphs 2.46-2.52 on the role of clinical assessors.

Supporters of the parties and witnesses

However welcoming you are as a panel and however much you try and put the parties at their ease, coming to a panel is a daunting and stressful experience for the complainant and complained against.

It is important that both parties are able to bring someone to assist them and give them support. CHCs in Wales have traditionally provided a support service to complainants throughout the stages of the complaints process. This is now called “independent complaints advocacy services”. There are also specialist advocacy services available in some parts of the country. Specialist advocacy may be more appropriate for complainants with mental health issues or learning difficulties or for young people.
Staff or professionals complained against are often accompanied by someone from their defence organisation, a trade union, or a professional colleague or friend. The Chair will determine the standards of conduct of all supporters in the panel.

- Read *Guidance* paragraphs 1.44-1.49 and 2.64-2.65; for further information on advocacy services see *Guidance* Section 4.6

How the panel works

The chair and panel members can decide how to conduct the proceedings. Panels may work in different ways, taking into account what the complainant wants.

Sometimes it may be best to:

- hold separate meetings with the complainant and the complained against, or
- bring the complainant and the complained against together at the same meeting to hear the evidence given by others, or
- hold smaller meetings involving one member of the Panel. No clinical issues should be discussed without the Clinical Assessor.

The decision on how the Panel proceeds should reflect what the complainant wants. Sometimes the complainant wants to hear directly from the complained against. Some people feel that it is easier to judge the strength of the evidence if the parties are giving it in front of each other. Sometimes complainants do not want to meet the complained against and feel that this would be too distressing. Interviewed individually, people may feel that they can talk confidentially and get you on their side in a way they would not do in front to the other party. This can sometimes become a "mixed blessing" if other issues start being raised. Panel members need to be aware of the need to stick to the terms of reference when interviewing all parties, regardless of whether they are together or separate.

- Read *Guidance* paragraphs 2.60-2.65

**Interviewing parties and witnesses**

Whatever way you decide to conduct the panel, you will need to listen carefully and ask questions. Before the panel meets the parties, all the panel members including the assessor(s) should discuss the issues that need to be clarified and decide who should ask these questions. The chair will guide this pre-meeting. It is often the case that lay members lead in the questioning of
the complainant and non-clinical parties and the assessor(s) lead in questioning the practitioner complained against. Whichever way is adopted, it is important to maintain a team approach to questioning so that nothing is overlooked. Asking the same question in different ways by different people can be very revealing.

There is no formal cross-examination in the panel and you must not be confrontational in your approach to any of the parties or witnesses. Active listening by all panel members is equally important so that the deliberation, which follows the interviews, is fully informed by everyone’s views. “Active listening” techniques were developed for conflict resolution and mediation, but can be applied in many other situations. When using them, listeners (the panel members and assessors) are:

- focusing their attention on the subject who is speaking (the party making their presentation) and appreciating the feelings behind the words
- reviewing (in advance) what they already know about the person speaking
- avoiding distractions as much as possible
- acknowledging emotional states (e.g. “I appreciate that I’m asking you to talk about an experience that was distressing for your father” etc)
- setting aside their own opinions until they have heard what the party has to say
- being aware of non-verbal aspects of communication (listening with your eyes and other senses) and how your own body positioning may be perceived by the party speaking (leaning forward, good eye contact, acknowledging what is being said, etc)

**Dealing with emotion, distress or aggression**

Sometimes the complainant, or more rarely a person complained against, may become upset or angry. As a panel you will need to help the Chair to defuse the situation. It is helpful to remember that an emotion which has not been addressed is often what is driving the complaint forward. As the complainant sees it, the panel process can seem overly bureaucratic or even a diversion from the “real issue”. Addressing the emotion rather than doggedly concentrating on completing the complaints process may be the way to diffuse tensions and make any progress, but it will require skilful handling in a panel setting.

- Read *Guidance* Handout 7, page 199 which gives advice on handling difficult situations.
Good practice in panel conduct

These “hall-marks of successful complaints handling” are adapted from the Health Service Ombudsman’s *Annual Report 2000-2001*. Independent reviews are likely to lead to more satisfactory conclusions when:

- All the parties have a clear and common understanding of the terms of reference for the review, and address them
- The panel meeting is not conducted in a way that encourages an adversarial approach on anyone’s part
- Sound judgments are made about flexibility in the way the Panel works
- Careful consideration and planning means that all who have relevant information are interviewed or asked to contribute what they know
- The conclusions members reach are based on the evidence they have heard, or read and the recommendations are based, in turn, on those conclusions
- Reports are well structured and reflect the panel’s considerations in full
- There is a clear understanding that the lay chair will write the report and about the responsibility for circulating it and producing the final version of the report
- Steps are taken to be fair, and to be seen to be fair, to all parties.

Activity 2: Self-assessment questions about the case

On the basis of what you have read about this case so far, consider the following questions and make a note of your answers. At the end of the module you can compare your views with other comments.

1. Why do you think the Reviewer decided to set up a panel?
2. What do you think that Mr JB hopes to achieve from the Panel?
3. Do you think Dr C’s handling of the complaint was adequate?
4. Was there anything Dr C could have said in his reply to the initial letter of complaint that might have satisfied the complainant Mr JB? If so, what should have been included and why?
5. Are there any points Mr JB makes in the letter of complaint that Dr C does not answer?
6. Are there any conflicts in the evidence between the events described by Mr JB and Dr C?
7. Are there any witnesses or other people who have not made a statement who might be able to throw light on what happened?
8. Who can you show the papers to and discuss the case with?
If you feel that you have understood:

- The role and responsibilities of:
  - The Chair
  - Members
  - Clinical Assessors
  - Supporters of the complainant/complained against

- How a panel hearing should be conducted

Then move on to the next section.
3. APPRAISING EVIDENCE AND AGREEING FINDINGS

Adhering to terms of reference

The questions “what is the evidence?” and “what are the facts?” are not always straightforward. It is easy to drift into new areas of enquiry during the proceedings which do not relate to the complaint. Sticking to the terms of reference as a guide to what the panel members and assessor(s) will ask questions about is essential. These have been agreed by the Reviewer, Chair and the complainant and shown to the complained against practitioner in advance. The Chair will usually remind each person interviewed about the terms of reference before they begin.

Information that emerges during the course of interviews that doesn’t pertain to the terms of reference should be identified by the chair so that everyone will be clear whether it is to be considered by the panel or not.

Read Guidance paragraph 2.63 for how new evidence should be handled

Assessing oral and written evidence

You should not make any pre-judgement about who is telling the ‘truth’ or who is mistaken before you have had an opportunity to see and hear all the parties, together with any witnesses and written statements.

Often the perceptions of the events described by the complainant and the practitioner or person complained against will be different. This does not mean that someone is lying. Both parties are often simply reporting the ‘truth’ as they see it and the facts as they recollect them.

By the time the case comes to the independent review panel, the parties will have told their version of events many times and each time it will have become more fixed as the ‘truth’, making a resolution of any misunderstandings much harder to achieve.

Determining reasonable expectations

The terms of reference talk about the panel determining whether the care provided was of a standard “which could reasonably be expected”.

“Reasonable” in this context has two meanings and panels should consider both of them:

- What is reasonable in terms of what professionals (in this case the dental assessor) should expect of other professionals (in this case Dr C)?, and
What is reasonable in terms of what members of the public and patients should expect from the care they and their families receive from NHS services (in this case Dr C)?

If there are variances in these two perspectives of what is “reasonable”, then the panel should highlight this in its report and comment on the differences from the standpoint of resolving the complaint.

Activity: More self-assessment questions about the case

On the basis of what you have read about this case so far, consider the following questions and make a note of your answers. At the end of the module you can compare your views with other comments.

9. In what circumstances do you think that it would be best to hold separate interviews?
10. Do you think the panel chair should have arranged for Mr AB, Mr JB and Dr C to be in the same room while they were interviewed? If yes, what do you think might have been gained by this?
11. What do you think should happen in the case of Mr AB and Dr C?
12. What questions do you want to ask Mr AB?
13. What questions would you like to ask Dr C?
14. What questions would you like to ask the dental assessor and what are the key points that the panel can learn from the assessor’s report?
15. Do you think there are any differences in “reasonableness” from the professional as opposed to the patient perceptive in this case? If so, what are they?

If you feel that you have understood:

- Why it is important to adhere to the terms of reference
- Your role in assessing evidence
- How ‘reasonable’ expectations are determined

Then move on to the next section.
4. DELIBERATING AS A PANEL

Having heard the evidence and questioned the witnesses, if any, and listened to what the assessor has to say, you will need to discuss as a panel what you believe really happened. Whose version of events do you feel is more likely to be accurate on the ‘balance of probability’? These are the ‘findings of fact’.

You will then need to consider, with advice from the assessor, whether the service or experiences of the patient or carer fell below what they had the right to expect.

Finally you will need to look at what lessons there are to be learnt for the service and for the NHS generally.

The panel chair will draft the report, but you need to make sure that you all agree what should be in the report before you leave the hearing and only sign it when you are satisfied with it.

In Case Study 1, you can find out how the Panel was conducted and the advice of the Dental Assessor as Documents 1-C and 1-D.

The balance of probabilities and dissenting views

As a panel you must judge the evidence and come to conclusions on the balance of probabilities. This is sometimes referred to as the “civil standard of proof” or "a preponderance of evidence".

In practice this standard means that that there must be enough evidence confirming that what is asserted in the complaint is “more likely than not” to be true. This is not the same standard of proof as used in the criminal law, generally “beyond reasonable doubt”, so panel members who may also be magistrates or legally qualified need to be mindful of this.

This standard of decision-making is widely used in administrative settings such as panels and tribunals. To use it well, panel members need to be inquisitorial and not adversarial in identifying, obtaining, and assessing the quality of evidence and take decisions accordingly.

The more complete the picture is, the better the decision on the facts of the case is likely to be. Experienced panel members will know that every piece in the jigsaw puzzle cannot be found in some cases, or there are competing versions of the same events that cannot be reconciled. But if all the crucial bits are complete, then the decision will be soundly based on the relevant facts. It is, therefore, possible to conclude many cases where there are some problems with the evidence, if the panel comes to a view that the issues made in the complaint were “more probable than not” to have happened as the complainant or complained against states.
Often you may find the judgement difficult and you may not be confident in the degree of probability and you will need to write the report and any recommendations to reflect the weakness or conflicting versions of the evidence.

Where there are any dissenting views amongst panel members, or where the panel dissents from the views of its clinical assessors, then this must be recorded in the notes of the panel. If the dissent is substantial, this must be recorded in the panel’s final report together with the reasons for it.

**Standards for expectations of practitioners and services**

There is information on what constitutes good standards of practice for health professionals and for health and care services generally, such as National Service Frameworks. More information about NSFs is given in the Foundation Module.

Panel Members and assessors need to be aware of these standards when deciding whether care provided was reasonable, both from a professional perspective (a view which the panel’s assessors will provide) and from a lay perspective, which panel members decide for themselves.

Panel members should take the time to read the Ombudsman’s annual report as this contains considerable information about what the Ombudsman considers to be reasonable expectations and standards from NHS bodies, practitioners and services generally.

**Professional standards - further information**

See *Guidance* Sections 4.6-4.7

**All doctors**

General Medical Council *Good Medical Practice*.  [www.gmc-uk.org](http://www.gmc-uk.org)
Copies are also available from the Public and Patient Involvement Branch of the Welsh Assembly.

Additional guidance for General Practitioners

RCGP/General Practitioner Committee March 2002 *Good Medical Practice for General Practitioners*  [www.rcgp.org.uk](http://www.rcgp.org.uk)
Copies are also available from the Public and Patient Involvement Branch of the Welsh Assembly.

**Other FHS practitioners**

See websites for:  
General Dental Council  [www.dgc-uk.org](http://www.dgc-uk.org)  
Royal Pharmaceutical Society  [www.rpsgb.org.uk](http://www.rpsgb.org.uk)  
General Optical Council  [www.optical.org](http://www.optical.org)
Nurses and midwives
See website for Nursing and Midwifery Council www.nmc-uk.org

Other Health Professionals
See website for the Health Professions Council www.hpc-uk.org

Findings of facts
The core of the panel’s output is its “findings of fact” relating to the terms of reference. These are listed together in the report, along with any comments the panel or assessor(s) wish to make about the strength or quality of the evidence supporting the facts.

Review Guidance paragraphs 2.70-2.72

Recommendations
The panel’s recommendations are for improvement in services and avoidance of future problems. The panel should make realistic recommendations that are within the capacity of a practitioner or NHS body to implement in terms of an action plan which can be monitored.

The Chair will guide the panel deliberations so that it does not stray over boundaries into areas that are not part of the complaints process. Panels cannot recommend disciplinary action against any individual or referral to a professional regulatory body. However, it is always possible for the Chair, with the panel’s agreement, to write separately to an NHS body identifying concerns that have emerged during the course of the panel’s investigation. NHS bodies then have the latitude to decide how to proceed independently of the panel’s report.

A panel cannot recommend compensation be paid to a complainant, though it is within a panel’s remit to suggest to an NHS body that it consider compensation as one means of redress. Lay members should note that the NHS litigation and redress scheme is currently being reviewed and may change in the future.

These are matters which require clear reasoning and judgement on behalf of the panel members and particularly from the Panel Chair.

Activity 4: Final self-assessment questions
16. How do you think that Dr C met the standards for good clinical practice?
17. How adequate do you think the complaints handling was by the practice and local health board?
18. Are there any recommendations that you would make:

- to rectify the situation for the patient?
- to the dental practice to improve the services they provide?
- to the Local Health Board?

If you feel that you have understood:

- What is meant by deciding on “the balance of probabilities”
- What the panel can and cannot recommend

Then move on to the next section
5. AGREEING THE PANEL REPORT

Commenting on the draft report

The panel chair will draft the report. However, each panel member will need to keep notes during the interviews. You should be aware that all notes form part of the formal complaint's file.

As a panel member you will receive a copy of the draft report (electronically if this has been arranged in advance) and you will need to comment on it within 7 days. Email is a convenient means to make your comments back to the Chair, provided you observe proper security.

The complainant, complained against and witnesses will also have a chance to comment on the sections of the draft report containing their evidence, but not the draft conclusions or the clinical assessor’s report.

Signing off final written report

The report is not complete and cannot be sent to anyone until it has been signed off by all the panel members. The Secretariat will produce and distribute the final report.

- Review Guidance paragraph 2.73 for distribution of the report

Assessor(s) written report

It is usual for the panel to state that they agree with their assessors’ written report and that it is attached as an appendix to the panel report. If possible, a combined report is preferred where there is more than one assessor from the same discipline. In complex cases, more than one assessor’s report may be needed, for instance where nursing and medical advisers were assisting the panel.

If the panel disagrees with the clinical assessors’ report, it will need to give the reasons for this in the report.

- Review Guidance paragraphs 2.66 and 2.74 for the clinical assessors’ reports

Security of documents and communications

You are required to have a lockable filing cabinet with the key kept in a secure place. Papers should never be left out so other people might read them. Your computer should have a password protected section on which you store
electronic complaints papers. Emails are potentially very vulnerable if others share your computer. They should be saved as documents and stored in the secure part of your computer with the other complaints papers.

At the end of the case you should return the papers, including your own notes and copies of e-mails to the Independent Review Secretariat for safe keeping. (For more details see Module 3, pg 77).

The Ombudsman has powers to require all papers, notes and copies of emails from Panel members to be made available when formally investigating a case.

- Review Guidance paragraphs 2.87-2.88 on security

Activity 5

Re-read the Panel Report (1-D) for the case study you have been working on. Note the format for the IR Panel report in the Guidance, section 3.14

While you are reading, think about your responses to the self-assessment questions. After you have read the panel’s report, you may want to amend some of your answers before looking at the comments about each question at the end of this module.

CONGRATULATIONS!

YOU HAVE NOW COMPLETED THIS MODULE

Postscript - your continuing learning and development

Working through this module may have helped you identify areas of further learning which you need to address. Make a note of those learning needs and prepare a plan now for how you will meet them as you gain more and varied experiences as a panel member. Keep this with your development plan (see the resources at the end of the Foundation Module) and refer to it to measure your progress.
NOTES ON SELF-ASSESSMENT QUESTIONS

This is a list of all the questions you were asked earlier in the module. Below each question are some comments reflecting the handling of the real case which you may wish to compare with your answer.

Activity 1

1. What questions would you like to ask the complainant and the complained against?

Comment: There are several areas where the facts are unclear: did Mr AB leave without being examined, what emergency cover was provided by the practice, why did Dr C take so long to reply to the case, why was conciliation unsuccessful?

Activity 2

2. Why do you think the Reviewer decided to set up a panel?

Comment: the Reviewer felt and the Lay Adviser concurred that the gulf between versions of events was so wide that only a panel had a chance of getting at the facts, or at least a probable version of them. The clinical advice confirmed this view. Also the repercussions of the event were very distressing for Mr AB and considerable for the NHS, involving two hospitals and the ambulance service.

3. What do you think that Mr JB hopes to achieve from the Panel?

Comment: Despite talk of “compensation”, Mr JB probably wants a written apology from the dentist and an assurance from the LHB that it will take steps to ensure that this sort of thing won’t happen to anyone else in future. He wants to do the best he can for his father and feels that if he does not succeed, he will be letting him down. This is a powerful emotion driving his complaint forward and the panel needs to appreciate this.

4. Do you think Dr C’s handling of the complaint was adequate?

Comment: No, quite the reverse. Dr C took a rather dismissive and even condescending tone in writing to Mr JB. This might not have been his intention, but it is how his response was perceived. He was also perceived as arrogant in the conciliation meeting, which seems to have done more harm than good. He was very late in replying to his September letter and never explained this.

5. Was there anything Dr C could have said in his reply to the initial letter of complaint that might have satisfied the complainant? If so, what should have been included and why?
Comment: He should have been more conciliatory and displayed more empathy, even if he did not agree with his version of event. Mr AB’s distress was real, even if it could have been prevented, and Dr C does not seem to have acknowledged that. It is likely that if he had taken advice from his dental defence body, they would have advised him how to write a more diplomatic letter which might have satisfied Mr JB and the panel might have been avoided.

6. Are there any points Mr JB makes in the letter of complaint that Dr C does not answer?

Comment: One important one is not addressed: Mr AB’s call to the surgery to speak to Dr C and the alleged advice to “keep biting down on the folded handkerchief” to stop the persistent bleeding. Dr C only responded to the initial complaint letter and did not take the opportunity to write any subsequent letters or to respond to the points made in the request for independent review in which he could have addressed these issues. This was a wasted opportunity, even if he thought they were not important enough to respond to.

7. Are there any conflicts in the evidence between the events described by Mr JB and Dr C?

Comment: Yes, key points of difference in the accounts of events include whether the local anaesthetic was effective; whether Mr AB asked for treatment to stop, whether the patient was checked before he went home; what the answerphone message said.

8. Are there any witnesses or other people who have not made a statement who might be able to throw light on what happened?

Comment: Yes, several. The dental nurse at the surgery is an obvious one. The warden at Mr AB’s sheltered accommodation is another. The panel might even have asked for a statement from Hospital A which saw Mr AB initially in casualty but could do nothing for him. In retrospect, the Chair acknowledged in the panel’s discussion that a statement from the dental nurse in particular would have been helpful and that he should have sought one.

9. Who can you show the papers to and discuss the case with?

Comment: Security and confidentiality must be tempered by common sense and an understanding of who has a “need to know”. This would include other members of the panel and the Secretariat. When emailing about the case, consider who might be able to see your message both while you are working on it and when it is received. If many people have access to your screen and certainly if you are using a terminal in a public place, it is best to use abbreviations for names and to include as little identifying patient information as possible.
Activity 3

10. In what circumstances do you think that it would be best to hold separate interviews?

Comment: this is a decision for the panel chair who should always take account of the views of the complainant. It is often a difficult decision to make. Separate interviews can be more productive where there is obvious animosity between the parties, as there appears to be in this case because the conciliation meeting seemed to go badly.

11. Do you think the panel chair should have arranged for Mr AB and his son and Dr C to be in the same room while they were interviewed? If yes, what do you think might have been gained by this?

Comment: the Chair thought about suggesting it, but decided not to because he considered that Mr JB would most certainly reject the idea because the conciliation meeting had not been productive. However for other complaints it can be very important to hear what is said and it can make it easier for the panel to assess what may have happened and how any the misunderstandings may have arisen.

12. What do you think should happen in the case of Mr AB and Dr C?

Comment: To defuse the emotion which is driving Mr JB and the unassuaged feelings of Mr AB, Dr C should write to both of them acknowledging that they have had an upsetting experience. He does not have to say he was responsible for that, but he needs to be aware that Mr JB believes his handling of the complaint was insulting to him and his father. He could say that his treatment was well-intentioned and that he regrets that it did not work out that way for Mr AB. This is not admitting any kind of legal liability. And he can say what his practice will do to reduce the chances of this happening again. He could conclude by saying he is pleased that Mr AB's new dentist is being successful in completing his treatment. The LHB can assist him in composing this letter. Dr C and his staff also need some training in how to operate a local complaints procedure at his surgery.

13. What questions do you want to ask Mr JB?

Comment: Though Mr AB and his son met the panel together, the son did all the talking in response to the panel’s and the assessor’s questions. His father said he agreed with the version of events he gave. The father appeared rather depressed by his experiences and was certainly physically frail, so the Chair decided that it would not be appropriate to direct questions independently to the son as this would imply that his son was not giving the complete picture.

14. What questions would you like to ask Dr C?

Comment: He should be asked whether he has ever received any complaints handling training and when; what his understanding is of the impact the
events have had on the patient and his family; what he thinks they are seeking by going through with the independent review; what the practice could do to avoid something like this happening again; would he have done anything differently in retrospect about responding to the complaint.

15. What questions would you like to ask the dental assessor and what are the key points that the panel can learn from the assessor’s report?

Comment: Was Mr AB’s diabetes a factor in the bleeding problems he experienced? If it was, what steps Dr C took or might have taken to avoid any post-extraction problems. The assessor’s report makes it clear that even when a practitioner’s clinical care is satisfactory, what happens afterwards can be poor if the patient’s experiences are not appropriate to their needs and expectations. This insight was very helpful to the panel in deciding the “reasonableness” questions in the terms of reference and making their recommendations.

16. Do you think there are any differences in “reasonableness” from the professional as opposed to the patient perspective in this case? If so, what are they?

Comment: Yes there are differences. The assessor found that the clinical treatment provided was of a standard that was appropriate and that Dr C provided what he would expect to be provided. However, from the patient perspective, reasonable expectations were not met and this made Mr AB’s experience of the care very unsatisfactory. Not being able to get help and advice when things went wrong was unreasonable, as Mr AB could have expected some emergency arrangements from the surgery and also that the first hospital he was taken to would have been able to deal with his continuing bleeding.

Activity 4

17. How do you think that Dr C met the standards for good clinical practice?

Comment: Technically his clinical care seems to have been satisfactory, but the post-care arrangements of the practice where Dr C worked (and which as a part-timer he probably had no control over) put vulnerable patients like Mr AB at risk if things went wrong. It is total care and the whole patient experience which are the measures of quality and in this case that quality was lower than it should have been.

18. How adequate do you think the complaints handling was by the practice and local health board?

Comment: Dr C’s local handling of the complaint was poor both in terms of when he responded and how he responded to the complaint. He seems to lack insight into the whole process. This was compounded by the LHB appearing to have just “gone through the motions” of the complaints.
procedure without making any positive efforts to help Dr C understand what was needed and to improve on his local resolution. The conciliation attempt also seems to have been a largely wasted opportunity and the LHB might want to consider the quality of its conciliation service and if it could have done anything differently at that stage, such as offering a meeting with its own primary care dental adviser.

19. Are there any recommendations that you would make?

- To rectify the situation for the patient?

Comment: Nothing can make up for the distress which Mr AB experienced, but a well-crafted letter of apology from Dr C as outlined in Question 11 could go a long way to drawing a line under the complaint and satisfying the son that Dr C was now aware of the impact these events had had on his father and himself. This is distinct from the quality of the clinical care that he provided.

- To the dental practice to improve the services they provide?

Comment: The practice where Dr C works should institute a simple contact number in emergencies, especially for frail patients like Mr AB, which can put them in contact with a qualified practitioner to give advice or make a home visit if required. Dr C is a part-timer and he may not have been included in any training the practice has received about complaints handling. If this is the case, it needs to be rectified so that he can be properly accountable.

- To the Local Health Board?

Comment: The LHB should audit the emergency cover arrangements for its dental practices at night and over weekends and benchmark an acceptable standard for improving those that are sub-standard. It should also ensure itself that its dental practices receive regular training and updating in good local complaints handling, especially regarding part-time or associate practitioners. The fact that the LHB lost the radiographs in this case also suggests that its systems are in need of attention.
CERTIFICATION OF COMPLETION: MODULE 2

When you have completed this module, please provide the following information and submit this form to:

The Manager
Independent Review Secretariat - All Wales
PO Box 2, Bronllys
Brecon, LD3 0XR

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I certify that I completed this module on (date)______________

The amount of time taken to complete the module was approximately ______

As a result of undertaking this module, I have identified the following issue(s) which I would like to discuss with the Independent Review Secretariat:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

As part of my development plan as a lay member, I intend to take the following actions to continue my learning:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

(Signed)______________________  Date______________

You should make a copy of this form and keep it with your development plan.
MODULE 3 – REVIEWING THE COMPLAINT

THE ROLES OF REVIEWER AND LAY ADVISER

- You should only undertake this module after you have successfully completed both the Foundation Module and the Panel Member Module.

- All lay members must be competent to carry out the role of an Independent Panel Member before they take on more complex roles as a Reviewer or Lay Adviser.

- It is good practice for individuals who also carry out reviewer, adviser and panel chair roles to serve from time to time as panel members. The reviewer will automatically serve as a panel member any time s/he decides to hold a panel.

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| Certificate of completion: Module 3 | |
AIMS OF MODULE 3

By the end of the module, whether as a Reviewer or Lay Adviser, you will know how to:

1. Assess Independent Review requests and documentation
2. Request and interpret clinical advice
3. Confer with a Lay Adviser/Reviewer
4. Consider appropriate actions, including whether or not to set up a panel.
5. If a panel is set up, determine the terms of reference
6. Communicate the Reviewer’s decision to the parties
7. Move from Reviewer to the role of panel member

You will do this by working through two anonymised case studies - one in which a panel is refused and one in which a panel is agreed - and answering a series of self-assessment questions about the case, which you can compare with comments in the section at the end of the module.
INTRODUCTION

Before you start

You will have completed Module 1 (the Foundation Module) and Module 2 (Panel Members) and be familiar with Part 2 of the Guidance on Independent Reviews.

Review the Guidance now if you need to, particularly 2.10-2.16; 2.25-2.40. Keep your copy handy while you are working through the case studies as you will be asked to review and consider how to apply sections of it relating to particular aspects of the cases.

This module is for Reviewers and Lay Advisers reviewing complaints received by the Independent Review Secretariat. We have included them together as they are both involved in the preliminary assessment of complaints. Lay Advisers need to understand the role of the Reviewer in order to be able to offer relevant advice and support to the Reviewer in making decisions.

You can use this module in several ways:

- If you are just starting as a Reviewer or Lay Adviser, it is an essential part of developing your competency for the role.
- If you are already experienced as a Reviewer or Lay Adviser in the complaints process, it can be an exercise in self-validation of your knowledge and skills.
- Once you are regularly handling requests for independent review, the module can be used for periodic reference and review.

There is a certificate at the end of this module which you should complete and send to the Independent Review Secretariat.

Points to keep in mind

- Everyone has the right to receive an independent review of his or her complaint.
- The Reviewer with the advice of a Lay Adviser will decide what action to take: whether to send the case back for further local resolution, to refer to another body, to recommend no further action or set up a panel. The complainant does not have a "right" to a panel.
- If the Reviewer decides against a panel, the letter to the complainant should be sufficiently comprehensive of how the Reviewer considered the case point by point and describe the reasons for his or her decisions and recommendations (if any) and include clinical advice where appropriate.
Where the case is sent back for local action, The Reviewer needs to suggest what further action s/he feels might be taken to help resolve the complaint.

**Key tasks for reviewer with lay adviser**

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<td><strong>Major elements</strong></td>
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<td>Assess Independent Review request and documentation</td>
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<td>Determining immediate referral back for Local Resolution or other action if indicated</td>
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<td>Request and interpret clinical advice</td>
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<td>Agreeing terms with complainant</td>
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<td>Identifying any further documentation or witnesses required for the Panel</td>
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<td>Communicate Reviewer’s decision to the parties</td>
<td>Writing to complainants</td>
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Become Panel Member

- Making transition from reviewer to panel member
- Liaising with the Panel Chair and third Panel Member

The Lay Adviser

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<td>Scrutinising proposed terms of reference</td>
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<td>Identifying papers and witnesses required for a panel</td>
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1. ASSESSING THE REQUEST

In order to go through this module, you will need to look at the case studies in the separate section at the end of the programme. We suggest that you start by looking at Case Study 2 for this module.

Afterwards, you may also like to consider again Case Study 1, which you looked at in the module for Panel Members, and see if you agree with the decisions of the Reviewer and Lay Adviser.

As the Reviewer you have received a complaint (Case Study 2) from the Independent Review Secretariat.

The Independent Review Secretariat has sent you the following letters:

2-A. The letter from the Community Health Council asking for an Independent Review
2-B. The letter from the Community Health Council on behalf of Mrs LP, sent to the BLANK NHS Trust
2-C. The reply that the Trust sent

Read all three letters. Copies of these letters are found in the volume of case studies.

Preliminary assessment and obtaining further information

You cannot review the complaint if you do not have all the necessary papers and information corresponding to these questions. If you need more information, you will need to ask the Independent Review Secretariat to obtain this, such as copies of health records or reports on the local complaints investigation.

If it is a clinical complaint if the complaint relates in whole or in part to the actions taken by one or more health professionals exercising clinical judgement, you will need to ask the Secretariat to nominate a Clinical Adviser and to obtain the health records.

If it is not, you may still wish to take independent advice from a non-clinical source, for instance about a service manager’s decision or behaviour, and this is something to discuss further with the Lay Adviser.

Identifying the key issues

Complaints letters can sometimes be hard to interpret and it is not always clear what the complainant wants or is hoping to achieve. The involvement of the Community Health Council at an early stage can assist the complainant to clarify and organise their arguments. CHCs in Wales have traditionally provided help with complaints and they now have an expanded complaints advocacy function. When complainants make use of this, it can benefit all
parties. Complaints are also complex and distressing. You need to try and step back and look at each complaint in a measured way.

It is helpful to make a list of the key points that the investigation would need to address, against which you can assess how well the complained against has answered them.

**Local resolution**

Part 1 of the Guidance “Managing Complaints” identifies what is expected of NHS Trusts, Local Health Boards and Family Health Services Practices in dealing with complaints locally. Review this now if you need to.

The Reviewer needs to consider if more could be done locally to resolve the complaint. However, you can only make suggestions to the body or person complained against. What action they take is up to them. In considering these options, you will need to ask yourself:

- Did the practitioner or body complained against deal with the complaint promptly? How long did the investigation take?
- Was the complaint thoroughly investigated? Did it address all the points raised in the complaint? **Note:** It is important to appreciate that this does not mean that the complainant has to be satisfied with the local investigation, just that there is evidence which satisfies the Reviewer and Lay Adviser that it was timely and comprehensive of the issues and the result was well communicated back to the complainant.
- Was the complainant offered a meeting or conciliation or second opinion?
- Is there anything that could be done locally to help resolve the complaint?
- Is there any evidence that the body complained against has taken any appropriate action to remedy the causes of complaint for the complainant?
- Is there any evidence that the body complained against has learnt any lessons or improved services, where appropriate? You may wish to look for evidence of action taken, not just intention.

**Disciplinary, patient safety and legal issues**

*See Guidance paragraphs 1.97-1.110*

Sometimes a complaints investigation reveals serious issues that need to be addressed by the NHS Trust Board or the Local Health Board. The complaints procedure is only concerned with resolving complaints and learning lessons for improving services. It is not for investigating disciplinary matters. However, the Reviewer and Lay Adviser will need to include the following in their consideration, remembering that notes of their discussions must be made and these become part of the formal complaint file:

1. Are there any disciplinary issues involved? If yes,
   - Is the body complained against or the LHB (in the case of FHS practitioners) taking disciplinary action?
- Can the complaints procedure be run alongside any disciplinary investigation? **Note:** Disciplinary action may be commenced at any point for in respect of NHS Trust staff. Action against a contracted FHS practitioner, however, must wait until the panel's report has been completed.
- Has the complainant been informed and what were their views?

2. Are there issues of patient safety that warrant the body complained against considering a referral to:
   - Professional regulatory bodies?
   - National Clinical Assessment Authority?
   - National Patient Safety Agency?
   - Police?

3. Is there evidence that there may be possible claims for redress or clinical negligence? If yes, has the body complained against considered offering compensation or referred the case to risk manager?

You cannot recommend compensation but you may suggest that the complained against body considers this, if you feel this is likely to help resolve the case.

**Activity 1: Reviewing the complaint**

Consider the following questions and make notes of your responses. You may want to reconsider them at the end of this Module.

1. Was the request for a Review received within 28 days of local resolution?

2. If not, are there good reasons for this delay?

3. Do you have the complainant’s written statement setting out the complaint and why the complainant is still dissatisfied?

4. If the complainant is not the patient, has consent been obtained?

5. Do you have all the paper work from Local Resolution? Is there any other information you need?

6. What are the key issues in this complaint? Look at the letters from the complainant or written on her behalf and list the key issues for the complainant that are identified.

7. How was the complaint handled at local resolution? (Document 2-C)

8. Is this a clinical complaint? Do you need clinical advice?
9. Are there any disciplinary issues, patient safety or other issues to take into account?

10. What do you think the complainant is hoping to achieve from the Review?

If you feel that you have understood:

- The information and advice you need to review the case
- What can be done in local resolution, including the time scales
- How to recognise disciplinary and safety issues, if any.

Then move on to the next section.
2. REQUESTING AND INTERPRETING CLINICAL ADVICE

Most complaints will involve clinical matters and you need to ask for clinical advice. (See Guidance paragraphs 2.17-2.21). This should be given to you within 10 working days of receiving the papers. The list of Clinical Advisers is held by the Independent Review Secretariat.

The Clinical Adviser’s role is to advise the Reviewer in writing whether the NHS body or practitioner complained against has reasonably answered all the points of a clinical nature in the complainant’s initial letter of complaint. It can be difficult for practising health professionals to draw the line between commenting on the way the clinical aspects of the complaint have been dealt with and commenting on the clinical care itself. The template in Section 3.12 of the Guidance is intended to assist clinical advisers to prepare relevant reports.

A copy of the clinical advice should normally be sent to the complainant. If the advice includes any inappropriate remarks or observations about the complainant or the complained against it should not be accepted until these are removed. You may want to anonymise the name of the Clinical Adviser, but if you want to include the name of the Clinical Adviser, you should ask him or her first. Clinical advice, including the name of the Clinical Adviser, must be made available if the complainant or anyone complained against asks for it under the Data Protection Act.

Activity 2: Understanding clinical advice

The clinical advice that the Reviewer received is given as Document 2-D. Read this and consider:

11. Are there any further actions that can be taken locally?
12. Are there any unresolved clinical issues?
13. Are you satisfied that this clinical advice is fair and adequate?
14. Is the clinical advice suitable to be shown to the complainant? (i.e. is there any thing in it that might upset the complainant?)

If you feel that you have understood:

- When to ask for clinical advice
- The role of the clinical adviser

Then move on to the next section
3. THE LAY ADVISER

When the Secretariat receives the report from the Clinical Adviser, the papers will also be sent to the Lay Adviser nominated for this case. The decision about further action is made by the Reviewer taking account of the advice of the Clinical Adviser and the Lay Adviser, but in the end the decisions to be taken rests with the Reviewer.

The role of the Lay Adviser is to advise the Reviewer on whether or not an Independent Review Panel should be held and, if not, other alternative action. This can normally be done over the phone.

You can use the template below to structure your discussion, whether you are the Reviewer or the Adviser to help make the decision.

Activity 3: Conferring with the lay adviser

You have read the case files and the clinical advice, now fill in the form below, imagining you are either a Reviewer or Lay Adviser.

Have you identified areas that you would like to discuss with the Adviser/Reviewer?

Template to prepare for discussion with Lay Adviser or Reviewer

CASE NO: __________

Lay Adviser/Reviewer: ________________________

Date of discussion: ___________________________

<table>
<thead>
<tr>
<th>Key issues in complaint/ IR request</th>
<th>Adviser's [Reviewer's] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>As identified by complainant’s statement of [date] the key issues are 1. 2. 3. etc</td>
<td></td>
</tr>
<tr>
<td>Clinical advice Are the responses Adequate/Not adequate</td>
<td>Adviser's [Reviewer's] Views</td>
</tr>
</tbody>
</table>

65
<table>
<thead>
<tr>
<th>Outstanding clinical issues:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 + quote what advice said</td>
<td>etc</td>
</tr>
<tr>
<td>2 + quote what advice said</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conciliation/ meeting offered</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered?</td>
<td></td>
</tr>
<tr>
<td>Accepted?</td>
<td></td>
</tr>
<tr>
<td>Outcome?</td>
<td></td>
</tr>
<tr>
<td>Other issues?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parties named in the complaint</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>List them</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witnesses/statements required</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>List them</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues included in complaint</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>List them + why included</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues excluded from complaint</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>List them + why excluded</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviewer’s “three tests”</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree to panel if:</td>
<td></td>
</tr>
<tr>
<td>1. Further attempts at local resolution are unlikely to lead to an outcome which will satisfy the complainant; <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td>2. There is reason to believe that the underlying causes which led to the complaint have not yet been fully exposed; <strong>or</strong></td>
<td></td>
</tr>
<tr>
<td>3. The response of the organisation, family health services practitioner or non-NHS provider to the complaint appears to be unreasonable.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision</th>
<th>Adviser’s [Reviewer’s] Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer whole/part back for LR + recommended actions</td>
<td></td>
</tr>
<tr>
<td>Identify parts + reasons for recommendations</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **Agree Panel**  
Proceed to draft terms of reference |  |
| **Refer to other bodies**  
Identify + rational |  |
| **No further action**  
Provide full reasons for taking “no further action” to the parties. Inform complainant of right to Ombudsman if they are not satisfied with this decision |  |

If you feel that you have understood:

- When to ask for lay advice
- The role of the lay adviser
- How to ensure that the discussion with the adviser is comprehensive

Then move on to the next section.
4. **THE DECISION**

After taking the advice of the Lay Adviser, the Reviewer needs to make a decision. There are four main courses of action you can take. You may want to make different decisions for each part of the complaint, provided that you can justify each decision.

1. **Refer the case or part of the case back to Local Resolution, recommending actions that might resolve the complaint**
   - Is there more that could be done at Local Resolution and can you be specific in recommending what further action should be taken?

2. **Decide to set up a panel**
   - How would an Independent Review Panel help resolve the outstanding issues in the complaint? What are they? How would this add value to what has been achieved already at local resolution?

3. **Refer the case to action by other bodies**
   - Is there any further action that can be taken to resolve the complaint or learn lessons outside of the NHS Complaints Procedure?

4. **Advise that no further action should be taken on the complaint and that the complainant can complain to the Ombudsman**
   - You may find the complaint distressing, but you must lay emotions aside and look at the facts and the evidence. Whatever you decide, you must give full reasons that you will be able to justify to the Ombudsman.

**Activity 4: Deciding what action to take**

A. Look at **Case Study 2** and decide what action to take on each of the key issues you identified and give your reasons on each.

B. Now look at the **Case Study 1** (from Module 2). In this case the Reviewer decided to hold a Panel. You might decide differently. Compare your reasoning with the Reviewer in this case by:
   a) Listing your reasons for holding a panel and
   b) Listing your reasons for why a panel should not be held.
Which is more persuasive? If you decided not to hold a panel in this case, consider what actions you might recommend to ensure that lessons are learnt in this complaint and make a list of these.

If you feel that you have understood:

- The options available to the Reviewer
- How to identify the reasons for your decisions

Then move on to the next section.
5. COMMUNICATING THE DECISION

With the advice of the Lay Adviser you have made a decision about what to do. Now the Reviewer has to inform the parties of the decision and the reasons for it. The parties to be informed include:

- The complainant
- The complained against
- Anyone mentioned in the complaint

The complainant has the right to go to the Ombudsman if they do not agree with your decision. In deciding whether to investigate the complaint, the Ombudsman will look at the letter you send to the complainant and decide whether this gives the reasons clearly and your decision is justified.

Writing letters to the parties

If you are not setting up a Panel, you need to take particular care how you word your reply to the complainant. They may have pinned their hopes on a Panel investigation and be disappointed and angered by your decision.

Here are some letter writing tips to bear in mind:

- Do not begin writing your response to the complainant until your review is complete
- Introduce yourself and explain your role
- If there has been a bereavement, offer condolences
- Always appreciate and respect the complainant’s position. Avoid being judgmental, appearing to trivialise the complaint, responding emotionally or favouring the practitioner or NHS body complained against
- Explain what you have done as part of your Review in order to make your decision
- Take each issue raised in the complaint in turn and explain any actions you recommend and reasons for your decision. Do not include any facts which cannot be substantiated if necessary and refer to clinical advice you have received
- Keep the response to a minimum without being discourteous, abrupt or disregarding any of the queries which have been raised
- Avoid jargon and complex language. Keep your vocabulary simple but not chatty and your sentences short but not stiff. The complainant’s letter will normally indicate the knowledge and understanding that the complainant has
- Set out the action that you propose to take following the complaint
- Finally - Tell the complainant that they have the right to complain to the Ombudsman if they are unhappy with your decision and remind them that the CHC may be able to help them

Letters to all parties from Reviewers must be on Independent Review Secretariat letterhead and signed by the Reviewer.
Setting up a panel

If you decide to set up a panel, you will need to draft the terms of reference with the Chair appointed to the Panel. However, any decisions about how the panel will be conducted, evidence that is required or witnesses to be called will be made with the Panel Chair and not the Reviewer. This is covered in Module 4.

Activity 5: Writing letters to the complainants

A. Imagining yourself as the Reviewer, draft a letter to Mrs LP, the complainant in Case Study 2.

When you have done that consider:

i) Whether your letter to the complainant covers:
   - the reasons for your decision
   - all aspects of the complaint
   - her right to complain to the Ombudsman

ii) Whether your letter to the complainant is clear, balanced and fair

iii) How you would reply to the Ombudsman if called upon to justify your response?

iv) Would it be useful to send a copy of the clinical adviser’s report?

B. Then read the letter from the Reviewer in this case to Mrs LP (Case study 2, Document 2-E).

i) How does it compare with the one you drafted?

ii) Does it cover all the points in the complaint?

iii) How would you describe the tone: is it sympathetic, patronising or defensive?

iv) How do you think the complainant would respond when she received it?
Activity 6: Good practice in reviewing complaints

Reviewers may want to include specific views or recommendations in letters to parties, but be unsure whether this is appropriate.

The following are real examples in letters written to parties by Reviewers. Consider each one in turn and then write down whether you agree or disagree that it is appropriate for this point to be included in a letter.

At the end of the module you can compare your views with those of the authors.

1. Referring the complaint back to the NHS Trust for further local resolution, the Reviewer asked that copies of minutes of further meetings that he advised the Trust to hold with the complainant be supplied to him, so that he could monitor how local resolution was progressing.

2. Rejecting the request for a panel, the Reviewer told the complainant and the GP complained against that she was including an (anonymised) copy of the clinical advice she had received because she felt it would reassure the complainant that the case had been considered objectively.

3. Agreeing the request for a panel, the Reviewer told the NHS Trust that was complained against that he was including an (anonymised) copy of the clinical advice because he said it expressed more clearly and in explicit clinical terminology than he could as a lay person why the Trust had failed to provide appropriate care to the complainant’s late relative and he hoped they would have their clinicians read and learn from it.

4. The Reviewer in his letters to both parties said that the panel proceedings would be tape recorded because the Chair did not want to take notes and that the transcripts would be available for the parties to comment on before the report was drafted.

5. The letter to the complainant turning down the request for a panel said that the complaint had been thoroughly investigated already and found to be largely without foundation or outside the remit of the NHS and that since the complainant continued to press for a panel, she was either being vexatious or was confused and might want to seek counselling help.

6. Replying to an NHS Trust’s request to see a copy of the clinical advice, the Reviewer refused and said that this would not be fair to the complainant as supplying the advice would give an advantage to the Trust in preparing their defence.

7. The Reviewer’s letter to the elderly patient’s relatives, who were bringing the complaint on her behalf, admitted that in its investigation the NHS Trust had intentionally breached patient confidentiality with third parties, particularly social services, but that this was justified in order to complete a
thorough investigation even though they remained dissatisfied with the results.

8. The Reviewer’s letter agreeing a panel sent to the husband making a complaint on behalf of his wife (who had given her signed consent for him to act on her behalf), said that the panel would have to interview them separately so they could be sure of the facts in the complaint.

9. The Reviewer’s letter to the GP complained against said that it was the doctor’s responsibility to make the two locum GPs who were also complained against attend the panel, even though one of them had left the UK.

10. Writing back to the NHS Trust to say a panel had been agreed, the Reviewer said the panel chair wanted to include in the panel papers the notes of two conciliation meetings previously held with the parties.

If you feel that you have understood:

- What needs to be included in letters to the parties
- How to write sensitively and justify your decision

Then move on to the next section.
6. TERMS OF REFERENCE

If you have decided to hold a Panel, you will need to draft the terms of reference. You need to discuss these with the person who will chair the Panel. Unless the person who advises the Reviewer states that they do not wish to chair, then that person will automatically become the Panel Chair.

See Guidance paragraphs 2.37-2.40 and Section 3.13

During the Panel hearing the Chair will adhere to the terms of reference. Sometimes new issues are raised during the interviews, but it may not be possible to look at these if they are not included in the terms of reference unless both parties agree. It is crucial before sending the draft terms of reference for the complainant’s agreement that you are confident that all areas that you would like to investigate are covered.

Once you are satisfied with the draft terms of reference, they should be sent to the complainant with a request for any comments in writing within two weeks. If the complaint is very detailed, it may be necessary to reassure the complainant in the accompanying letter that although the terms of reference do not specifically repeat each of their points, the terms are sufficiently comprehensive to allow the panel to consider each issue in their statement and that the Chair will ensure this happens.

If you, as a Reviewer, are not prepared to accept their amendments, you can ask the complainant whether or not they wish to go ahead with the Panel or would prefer to go directly to the Ombudsman. The complainant may complain to the Ombudsman about any issues that are excluded form the terms of reference.

Note that the person or body complained against does not need to agree the terms of reference but once they are agreed, you must send the terms of reference to the complained against without delay.

Activity 7: Drafting the terms of reference

Here is a template for discussing possible terms of reference with a Lay Adviser or Panel Chair

<table>
<thead>
<tr>
<th>Possible terms of reference</th>
<th>Chair’s views</th>
</tr>
</thead>
<tbody>
<tr>
<td>List each of the issues that you have identified as outstanding.</td>
<td></td>
</tr>
</tbody>
</table>
Before sending the draft terms of reference to the complainant, check the list you have made and ask the following questions:

- Do the terms of reference cover all aspects of the complaint which are to be investigated?
- Are the terms of reference realistic, clear and sufficiently broad? This can be difficult where the complaint is very detailed.
- If there are parts of the complaint which are not covered in the terms of reference, are the reasons for this justifiable and are these matters addressed in the letter to the complainant?

**Finally**
Read the notes you made in activity 1 and reflect on the responses you made. Do you want to change anything in your responses? If so what do you want to change and why?

At the end of the final section of the programme you can compare your answers with our comments.

If you feel that you have understood:

- What needs to be included in terms of reference and who to consult

Then move on to the next section.
7. LEARNING THE LESSONS

In **Module 2** you considered issues around learning lessons form complaints and the importance of ensuring patient safety. As a Reviewer you can help achieve this in two main ways:

- Suggesting to NHS Trusts, Local Health Boards and FHS practitioners any areas where they may wish to review their service as a part of further action recommended in your decision on the review;

- Bringing any lessons learned from a complaint to the attention of the Independent Review Secretariat and/or the Welsh Assembly, particularly regarding:
  - Quality or patient safety issues
  - Complaints handling
  - Examples of good practice that could be shared with the NHS.

### Activity 9: Learning the lessons

Look at case studies 1 and 2.

1. Did you identify any patient safety issues?
2. Do you think there are any issues that the Independent Review Secretariat should be aware of to follow up?
3. Should the complainant be informed of any further action and, if so, by whom?

If you feel that you have understood:

- How to follow up recommendations and lessons learnt

Then move on to the next section.
8. JOINING THE PANEL AND KEEPING GOOD RECORDS

Once you have drafted the terms of reference, your role as a Reviewer is finished. The Panel Chair will decide decisions about how the panel will conduct its business with the members. It is important to make a smooth transition to becoming a panel member once the role is completed and a panel has been agreed. The person chairing the panel assumes overall authority from the time the Reviewer’s decisions are completed and letters informing the parties have been sent. From that time it is crucial for all three members of the panel to work together as an efficient team. When the panel convenes and is introduced to the parties, it is usual for the Chair to indicate which panel member acted as the Reviewer. This demonstrates continuity and helps clarify for the parties how the process leading up to the panel has been carried out.

Administration

It is very important to keep all emails and make written notes of all phone calls and meetings relating to this complaint, including times and dates. This is so that you can justify your actions and decisions, should the complainant take the case to the Ombudsman.

You must keep all the files and records secure as outlined in Module 2 (pg 49). At the end of the Review return these to the Independent Review Secretariat. They will keep one complete master copy of the file and will dispose of all copies. You may keep copies of any personal notes on a case for up to 18 months in case the Ombudsman investigates the complaint, but remember to send the originals to the secretariat for the master file. No e-mails or files should be stored on your computer at the end of the case. If necessary print out copies of any e-mails and pass them on to the Secretariat.

Everything relating to the complaint is part of the official complaints record, The Secretariat keeps the master files for all complaints for 10 years, unless stated otherwise (for example, obstetric complaints are kept for 25 years).

CONGRATULATIONS!

YOU HAVE NOW COMPLETED THIS MODULE

Postscript - your continuing learning and development

Working through this module may have helped you identify areas of further learning which you need to address. Make a note of those learning needs and prepare a plan now for how you will meet them as you gain more and varied experiences as a lay member. Keep this with your development plan (see the resources at the end of the Foundation Module) and refer to it to measure your progress.
FURTHER INFORMATION

*Seven Steps to Patient Safety* (October 2003)

[www.npsa.nhs.uk/admin/publications/docs/sevenstepsoverview.doc](http://www.npsa.nhs.uk/admin/publications/docs/sevenstepsoverview.doc) describes local benchmarks of a patient safety culture in the NHS

[www.cgsupport.nhs.uk/Resources/Case_studies/default.asp](http://www.cgsupport.nhs.uk/Resources/Case_studies/default.asp)
These are case studies, including one from Manchester Children’s Hospital, about tackling complaints and incidents locally.

[www.cgsupport.nhs.uk/default.asp](http://www.cgsupport.nhs.uk/default.asp)
Clinical Governance Support Team website describes expectations of clinical governance in NHS bodies and by health professionals
NOTES ON SELF ASSESSMENT QUESTIONS

Activity 1: Reviewing the complaint

1. Was the request for a Review received within 28 days of local resolution?

   Comment: Yes

2. If not, are there good reasons for this delay?

   Comment: In this case there was no delay, but if there is you need to find out why and if this is reasonable. It is up to you to decide whether to accept the request, but the complainant can appeal to the Ombudsman about your decision so you need to make sure that you understand the reasons and can justify your decision for refusing or accepting the request.

3. Do you have the complainant’s written statement setting out the complaint and why the complainant is still dissatisfied?

   Comment: Yes.

4. If the complainant is not the patient, has consent been obtained?

   Comment: The patient is dead and the complainant is next of kin so separate consent is not required.

5. Do you have all the paper work from Local Resolution? Is there any other information you need?

   Comment: It seems to be complete. It can be useful to make a chronology to identify what occurred in local resolution. This will expose any gaps in documentation.

6. What are the key issues in this complaint? Look at the letters from the complainant or written on her behalf and list the key issues for the complainant that are identified.

   Comment: These are listed in the letter from the Trust of 3 September. They mainly seem to arise from different expectations of what the hospital could do and whether more active intervention would have prevented her husband dying.

7. How was the complaint handled at local resolution?

   Comment: The reply was prompt and addresses all the points. A meeting was offered and held away from the hospital in the CHC office, to avoid additional distress for Mr P. However, as Mrs P requested that the
consultant complained against should not attend, some issues could not be addressed in the detail that might have reassured Mrs P.

8. Is this a clinical complaint? Do you need clinical advice?

Comment: Yes – it raises questions about both clinical and nursing issues and so you will need advice from a medical and nursing adviser.

9. Are there any disciplinary issues, patient safety or other issues to take into account?

Comment: Not at this stage. Clinical advice can be sought on this.

10. What do you think the complainant is hoping to achieve from the Review?

Comment: Making the complaint seems to be part of the grieving process. She is finding it difficult to let go of her belief that with different treatment her husband might have recovered.

Activity 2: Understanding clinical advice

11. Are there any further actions that can be taken locally?

Comment: No, since the complainant is not prepared to meet the surgeon responsible for her husband’s care, which she has already refused.

12. Are there any unresolved clinical issues?

Comment: No.

13. Are you satisfied that this clinical advice is fair and adequate?

Comment: Both reports seem balanced, thorough and clearly written.

14. Is the clinical advice suitable to be shown to the complainant? (i.e. is there any thing in it that might upset the complainant?)

Comment: Yes, They may help the complainant accept the situation. Transparency can be important, particularly if the complainant fears a ‘cover up’ or that professionals will always stick together.

Activity 4: Deciding what action to take

B. Looking at Case Study 1 - In this case the Reviewer decided to hold a Panel. Compare your reasoning with the Reviewer in this case by:

a) Listing your reasons for holding a panel
Comment: There are discrepancies in the accounts that may be clarified with an investigation, the dentist delayed in relaying to the complaint which seems unreasonable. Also the implications of the event had serious and disproportionate repercussions for the NHS, involving two hospitals and the ambulance service.

b) Listing your reasons for why a panel should not be held.

Comment: Many of the discrepancies involve subjective perceptions and it will be difficult to establish ‘facts’; Dr C’s clinical care was acceptable and he co-operated with conciliation but this failed – a panel may not satisfy the complainant either.

Which is more persuasive? If you decided not to hold a panel in this case, consider what actions you might recommend to ensure that lessons are learnt in this complaint and make a list of these.

Comment: The out of hours cover arrangements were inadequate and this might be raised with the practice and local Health Board through the IRS.

Activity 6: Good practice in reviewing complaints

1. Referring the complaint back to the NHS Trust for further local resolution, the Reviewer advised the Trust to hold further meetings with the complainant and asked that copies of minutes of further meetings be supplied to him, so that he could monitor how local resolution was progressing.

Comment: Inappropriate. It is not part of the Reviewer’s role to seek to monitor the course of local resolution

2. Rejecting the request for a panel, the Reviewer told the complainant and the GP complained against that she was including a copy of the clinical advice she had received because she felt it would reassure the complainant that the case had been considered objectively.

Comment: Appropriate. This is a good idea. You may need to tell the parties the qualifications and role of the clinical adviser, though you do not need to give their name or that of their NHS organisation.

3. Agreeing the request for a panel, the Reviewer told the NHS Trust that was complained against that he was including a copy of the clinical advice because it expressed explicitly and in clinical terminology why the Trust had failed to provide appropriate care to the complainant’s late relative and he hoped they would have their clinicians read and learn from it.

Comment: Appropriate. This is a good idea. In fairness you may also need to send a copy to the complainant.
4. The Reviewer in his letters to both parties said that the panel proceedings would be tape recorded because the Chair did not want to take notes and that the transcripts would be available for the parties to comment on before the report was drafted.

Comment: Inappropriate. Decisions about the proceedings are up to the Chair not the Reviewer. The Reviewer’s role finishes when the terms of reference are drafted.

5. The letter to the complainant turning down the request for a panel said that the complaint had been thoroughly investigated already and found to be largely without foundation or outside the remit of the NHS and that since the complainant continued to press for a panel, she was either being vexatious or was confused and might want to seek counselling help.

Comment: Inappropriate. Reviewers should be objective and factual in replies and never engage in making any personal comments or judgements. The complainant can appeal to the Ombudsman about the Reviewer’s decision.

6. Replying to an NHS Trust’s request to see a copy of the clinical advice, the Reviewer refused on the grounds that this would not be fair to the complainant as supplying the advice would give an advantage to the Trust in preparing their defence.

Comment: Inappropriate. Clinical advice is available to either of the parties under the Data Protection Act. In general if it is sent to one of the parties, it should be sent to both. However, Independent Review Panels are not about prosecution or blame, but about trying to resolve a complaint for the complainant and learn any lessons for the NHS.

7. The Reviewer’s letter to the elderly patient’s relatives, who were bringing the complaint on her behalf, admitted that in its investigation the NHS Trust had intentionally breached patient confidentiality with third parties, particularly social services, but that this was justified in order to complete a thorough investigation despite the fact that they remained dissatisfied with the results.

Comment: Inappropriate. The allegation of breach of confidentiality is a serious complaint that should be investigated by the Trust concerned. It is not up to the Reviewer to comment.

8. The Reviewer’s letter agreeing a panel sent to the husband making a complaint on behalf of his wife (who had given her signed consent for him to act on her behalf), said that the panel would have to interview them separately so they could be sure of the facts in the complaint.

Comment: Inappropriate. How the panel conducts its business is a decision for the Chair, not the Reviewer. To imply that the complainant
and patient will give different ‘versions’, in other words may be lying, is likely to exacerbate the situation and make any attempt by the panel to resolve the complaint likely to fail. Lastly, anyone interviewed by the panel has the right to have someone of their choice attend with him or her.

9. The Reviewer’s letter to the GP complained against said that it was the doctor’s responsibility to make the two locum GPs who were also complained against attend the panel, even though one of them had moved overseas.

Comment: Inappropriate. Where the complaint is against a Locum, the practice will be expected to answer the complaint as well as they can. No one can be required to attend an Independent Review Panel. As long as the practice can show that they have made every effort to investigate the complaint and contact the doctor concerned, they cannot be asked to do anything further. (See Guidance: paragraph 1.30). The Secretariat could try to trace the locum who is still in the UK through the General Medical Council’s registration database and then write requesting his attendance or a statement.

10. Writing back to the NHS Trust to say a panel had been agreed, the Reviewer said the panel chair wanted to include in the panel papers the notes of two conciliation meetings previously held with the parties.

Comment: Inappropriate. All discussion and information provided during the process of conciliation are confidential and without prejudice so that staff can be open about the events leading to a complaint and both parties can hear and understand each other’s point of view and ask questions. Notes of conciliation meetings can only be included in the papers if one of the parties has submitted this to the Secretariat as part of the evidence. (See Guidance: paragraph 1.81).

Activity 9: Learning the lessons

Look at case studies 1 and 2.

1. Did you identify any patient safety issues?

Comments: Case study 1 – Improvements to the out of hours service
On call arrangements in hospital A.
Comments: Case Study 2 – No.

2. Do you think there are any issues that the Independent Review Secretariat should be aware of to follow up?

Comments: Case Study 1 – as above

3. Should the complainant be informed of any further action and, if so, by whom?
Comments: If a panel is held, this will be done in the Panel report with recommendations to the complained against (Guidance paragraphs 2.76-2.79). If you refer the case back for further action, you can ask the complained against body to keep the complainant informed of action they take in your letter to them.
CERTIFICATION OF COMPLETION: MODULE 3

When you have completed this module, please provide the following information and submit this form to:

The Manager
Independent Review Secretariat - All Wales
PO Box 2, Bronllys
Brecon, LD3 0XR

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I certify that I completed this module on (date)________________

The amount of time taken to complete the module was approximately ______

As a result of undertaking this module, I have identified the following issue(s) which I would like to discuss with the Independent Review Secretariat:

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

As part of my development plan as a lay member, I intend to take the following actions to continue my learning:

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

(Signed)______________________  Date________________

You should make a copy of this form and keep it with your development plan.
MODULE 4 – CHAIRING THE PANEL

- You should only undertake this module after you have successfully completed the first three modules. Panel chairs must understand the Reviewer role and, in particular, its relationship with the role of the Lay Adviser as this person, in most cases, goes on to chair the panel if one is established.

- All lay members must be competent to carry out the role of Reviewer or Lay Adviser before they take on the more complex role of Panel Chair.

- It is good practice for individuals who chair Panels also to serve from time to time as independent panel members.

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AIMS OF MODULE 4

By the end of the module you will know how to:

1. Chair the Panel
2. Draft the Panel Report
3. Comply with performance standards

You will do this by considering aspects of anonymised case studies in the accompanying volume and relating them to the elements in the Panel Chair's role, then answering a series of self-assessment questions. You can compare your responses with comments at the end of the module.
INTRODUCTION

Before you start

Review the *Guidance* now if you need to, especially paragraphs 2.41-2.72; 2.74; 2.87-2.88 and 2.91

Keep your copy handy while you are working through the case studies as you will be asked to review and consider how to apply sections of it relating to particular aspects of a case.

You can use this module in several ways:

- If you anticipate starting to chair panels, it is an essential part of developing your competency for the Panel Chair role
- If you are already experienced in the Panel Chair role in the complaints process, it can be an exercise in self-validation of your knowledge and skills
- Once you are regularly chairing panels, the module can be used for periodic reference and review.
1. THE ROLE OF THE PANEL CHAIR

Normally the person who advises the Reviewer (see Module 3) will chair a panel if it is set up. If for any reason the Lay Adviser is not able to chair the panel, the Reviewer will chair the Panel or, if the Reviewer has not completed the learning module for panel chairs, an alternative Chair will be appointed.

The key responsibilities of the Panel Chair are:

- deciding how the panel should operate in conjunction with panel members and assessors
- ensuring that panel members and assessors have received appropriate documentation from the Independent Review Secretariat
- deciding, with the panel, arrangements for meeting the complainant and the complained against and then meeting parties prior to the panel and explaining procedure
- writing the draft report with reference to the clinical assessor’s report and seeking help from the other two panel members, and
- ensuring that the work of the panel meets the target time for completion of its final report, including the report of the assessor.

These responsibilities are outlined in more detail in the key tasks below. The two panel members will be expected to support the panel chair in carrying out his or her role.

Key tasks

<table>
<thead>
<tr>
<th>Major elements</th>
<th>Minor elements</th>
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<tr>
<td>Advise on Terms of Reference (if Lay Adviser), then proceed as below</td>
<td>See Reviewer/Lay Adviser module</td>
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<tr>
<td>Chair the panel when established</td>
<td>▪ Agreeing procedure and performance standards with IR Secretariat</td>
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<td>▪ Communicating with other panel members</td>
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<td>▪ Meeting parties on the day of the panel and explaining procedure</td>
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<td>▪ Managing the contribution and conduct of parties, supporters, witnesses, assessors and panel members</td>
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<tr>
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<td>▪ Guiding the panel’s deliberations with assessors and enabling the contribution of other panel members</td>
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<td>▪ Handling multi-agency panel arrangements</td>
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**Draft the report**

- Agreeing arrangements for producing the report with IR Secretariat
- Circulating to parties and witnesses their parts of the report for comments on factual accuracy
- Drafting the final report following template for panel reports
- Incorporating assessor’s report and recommendations
- Seeking comments from panel members on draft report and securing their agreement for final version with any amendments

**Comply with performance standards for report production**

- Ensuring signed panel report reaches Independent Secretariat within time limits
- Dealing with any exceptional circumstances, including confidentiality or references to third parties
- Complying with any requests from the Ombudsman
- Post-panel security of documents and communications, including immediate return of papers to Secretariat for safe keeping (on submission of final report)

**Successful panels**

In attempting to resolve complaints, it is important to respond to the individual circumstances and wishes of the complainant. Panels therefore can be flexible in the way that they deal with each case, as long as they follow the guidance of the Welsh Assembly Government. The Guidance states that:

1. The Panel’s proceedings must be confidential.

2. The Panel must have access to all the records held by the NHS body about a complaint it is reviewing. This will include access to the relevant parts of the patient’s medical records.

3. The Panel must give the complainant and any person complained against a reasonable opportunity to express their views on the complaint.

If any of the panel members disagree about how the panel should go about its business, the panel chair’s decision will be final.
Activity 1: What makes a successful Panel?

Below are eight “hall-marks” of successful independent review relevant to the role of panel chairs which have been adapted from the Health Service Ombudsman’s *Annual Report 2000-2001*.

Read through all the statements first, then go through them one by one again thinking about your own views about chairing panels. Using the box to the left of the statement, rank each one on a scale of 1 - 8:

1 = the statement you agree most with
8 = the statement you agree least with

<table>
<thead>
<tr>
<th>Rank</th>
<th>“Hall Marks of Successful Independent Review Panels”</th>
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<tr>
<td></td>
<td>All the parties have a clear and common understanding of the terms of reference for the Panel</td>
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<td>The panel hearing is not adversarial with the complainant and complained against acting as if they are prosecutor and defendant.</td>
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<td>The conduct of the panel depends on the individual case. The Panel Chair should decide the best way to conduct the panel in consultation with the complainant.</td>
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<td></td>
<td>Planning is important to ensure that all who have relevant information are interviewed or asked to contribute what they know</td>
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<td></td>
<td>The conclusions members reach are based on the evidence they have heard, or read and the recommendations are based, in turn, on those conclusions</td>
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<td></td>
<td>Reports are well structured and reflect the panel’s considerations in full</td>
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<td>There is a clear understanding that the lay chair will write the report and about the responsibility for circulating it and producing the final version of the report</td>
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<td></td>
<td>Steps are taken to be fair, and to be seen to be fair, to all parties</td>
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Keep these statements and any views you have on your choices in a convenient place. Refer to them as you work through this module. Revisit them at the end of module to see if your views have changed. If they have changed, make a note of what that change was and why it happened.

If you feel that you have understood:

- The role of the Panel Chair
- Hallmarks of successful panels

Then move on to the next section.
2. PREPARATION FOR THE PANEL

Arrangements for the Panel

You have been appointed to chair the Panel. Though you must comply with common standards, each case heard by a Panel is also unique in terms of its personalities, issues and previous history of attempted resolution. Chairs will need to work with the Reviewer and Secretariat to ensure that the process takes account of the distinctive features of each case. The venue for the Panel will be selected by the IR Secretariat and, where possible, non-NHS premises will be used.

The timetable

At the start you will need to work out the timetable with the Independent Review Secretariat. All panels have to conform to standards and timescales laid down in the Guidance. The overall target for completing the process (including writing and agreeing the final report) is six months from the date of the statement giving the complainant’s reasons for asking for an Independent Review.

Membership of the panel

With the Secretariat, the Chair will want to ensure as far as possible that members appointed to the Panel can achieve the right balance of breadth and depth of questioning. For example:

- If the complaint involves intimate medical or personal details, it may be less embarrassing for the complainant if the Chair and at least one member of the panel are of their gender. All Panels should seek to have both genders represented as Panel Members.

- If the complainant’s first language is not English and the complainant is a Welsh speaker, it may be important to have a Welsh speaker on the Panel as well as a Welsh-speaking assessor. The complainant should be asked well in advance in such cases what would be most comfortable for them.

- If the complainant is from a minority ethnic community, it may be reassuring for the complainant to have a panel member from that community, where this is possible, who may understand some of the cultural issues that may have led to the complaint.

Once they are appointed, telephone or email contact between the Chair and other panel members, in addition to the contact which the IR Secretariat will have made with them, ensures that everyone has all of the appropriate papers and is actively preparing for their roles on the panel. It is particularly important to talk to the third panel member who will not be as familiar with the case as the Chair and Reviewer. It also gives the Chair the opportunity to discuss how the panel may be conducted (whether all the parties are to be
interviewed separately or in a single hearing or, in exceptional circumstances, some other arrangement).

**Clinical assessors**

As Chair you will need to make sure that the clinical assessor(s) appointed to advise the panel have the relevant expertise. One clinical assessor is the norm. More than one assessor is usually needed, however, if the complaint spans different disciplines, (e.g. medicine and nursing, or nursing and physiotherapy), or the complexity of the case suggests that, for instance, a primary care and a hospital-based clinical view are both needed.

Normally it is not necessary for the Chair to contact a clinical assessor before the day of the panel. Occasionally, however, the nature of the allegations in the complaint means that it will be necessary for one or more of the panel’s assessors to physically examine the patient who is the subject of the complaint or to consult recent x-rays or other test results just prior to the panel convening. On these occasions, and in consultation with the Secretariat, the Chair will need to discuss and agree a procedure for this in advance with the relevant assessor so that the information from the examination can be available in the most usable form for the panel. Notes of such pre-panel discussions should be made and retained by the Chair for reference. These notes form part of the formal complaints record.

See *Guidance* paragraphs 2.46ff.

** Witnesses and further information**

The Chair will decide, usually in discussion with the Reviewer, whether any witnesses or statements are needed at the panel. Careful scrutiny by the Reviewer in consultation with the Lay Adviser should have identified any oral or written evidence needed, but it is important to consider this one final time so that the panel has the benefit of all available information bearing on the key events. Chairs need to consider in this regard any procedural and policy issues of NHS Trusts or Local Health Boards bearing on the complaint about which a manager or senior clinician might need to give evidence. If any additional witnesses or statements are identified, the IR Secretariat should be informed as soon as possible so that arrangements can be made. The Chair may wish to give a particular witness some indication of the areas of the complaint in which they will be asked to provide information.

The Chair should also confirm with the Secretariat whether either of the parties have asked if they wish any witnesses to the events complained about to be present which have not already been identified by the Reviewer and Lay Adviser.

The Secretariat will also inform the Chair if any health staff who have been asked to provide oral or written evidence for the panel have declined to cooperate with the panel’s request. Any refusals to cooperate should be noted by the Chair in the Panel’s report.
Note taking

The Chair needs to discuss and agree in advance with the Secretariat the arrangements for taking notes at the meeting, as someone must do so on behalf of the panel as a whole. While the Chair and members will need to take notes for their own reference, it is difficult to do this on behalf of the panel while also questioning and listening to the evidence.

Multi-agency panel arrangements

Some complaints involve more than one NHS Trust, or a Trust and Family Health Services practitioner, or an NHS body and a social services provider. As Chair you may decide to hold a joint panel to avoid duplication and delay as well as making a thorough investigation more likely. Multi-agency panels have implications for the appointment of the panel’s assessors, e.g. a social care assessor may also be required.

See Guidance paragraphs 2.67-2.68

Activity 2: Preparation

You are preparing to chair the panel in case study 3. Read the complaints file (documents 3-A- 3-F) and then identify any aspects of procedure and performance that you believe need special emphasis at the panel.

- Do these have any implications for the selection of clinical assessors or for the identification of witnesses or the need for written statements from third parties?
- Are there any points you want to take up with the Independent Review Secretariat?
- What areas you will want to cover when making initial contact with the third member of the panel - list these. Draft a note for your file resulting from this conversation.

Comments on these self-assessment questions are included at the end of the module.

If you feel that you have understood:

- Arrangements for the Panel including note-taking
- Working with clinical assessor(s)
- Confirming witnesses
- Multi-agency arrangements

Then move on to the next section.
3. BEFORE THE PANEL HEARING

Pre-hearing meeting

Panel members should meet with the assessor(s) before the hearing starts. This helps the Chair to confirm all the arrangements before the formal hearing begins and identify what the panel proceedings need to find out. The Chair will outline to the panel how s/he plans to conduct the panel with the parties all present or heard separately and the reasons for this decision.

The pre-panel meeting is also the time for the assessor(s) to give the panel members their preliminary views on the clinical issues involved with the complaint (see Guidance paragraphs 2.51-2.52). In the pre-panel meeting the assessor(s) should alert them to particular clinical issues that need to be explored. Panel members should at this stage ask only the minimum number of questions needed to clarify any points the assessor(s) have raised or which are suggested in the complaints file. Clinical Assessors must not advise the Panel at this stage about what they would have done in a similar situation or suggest any conclusions or recommendations. It is up to the Chair to ensure that Clinical Assessors do not dominate or guide the initial exchange with the panel, so that it does not prejudice the presentations the parties are about to make. Further deliberations with the assessor(s) should only come after all the parties and evidence have been heard.

At the pre-meeting the Chair will take the lead in deciding what questions will be asked and who will ask them. It is very important that all members take part in the interviews. It can give a very poor impression if all the questions come from one Panel member or if the assessor(s) dominate the proceedings.

Activity 3: Pre-hearing meeting

In the meeting before the panel hearing, the following suggestions are made. As the panel chair, how do you decide these?

1. In case study 1, a panel member suggests that Mr AB should be interviewed separately from his son. The rationale is that because he has written all the complaints letters, it would help the panel to get “his side of the story” if he were seen on his own. Do you agree with this?

2. In another case the complainant has expressed a strong desire to be present during any interviews with professionals. However, the three doctors from the same practice who are the complained against, on the advice of their representatives from different defence bodies who are supporting them at the panel, have asked to be interviewed separately from the complainant and also separately from each other. What factors should the Panel take into account in making a decision?
3. At the pre-meeting the IR Secretariat officer shows you an email just received from the complainant saying it would be too distressing for her to give her evidence about her miscarriage last year to the whole panel and the two assessors, but she offers to speak privately to the Chair provided her husband can be there to support her. Is there a way forward without having to abandon the panel?

4. The pre-panel meeting with the panel members is going well and the parties are already in the building, but the clinical assessor has not yet arrived. The IR Secretariat officer rings her and discovers that she has the wrong date in her diary and other clinical commitments mean that she will not be able to attend at all that day. What options does the Chair have? Does the panel have to be cancelled?

5. At the pre-panel meeting you tell the other members that you have had a telephone call that morning from the defence body representative of the complained against surgeon. He says the clinical advice given to the Reviewer was wrong and has written evidence to prove it. He says that unless the panel disregards the clinical advice, he will advise his member not to participate in the panel. Can the clinical assessor assist the Chair in dealing with this problem? How should it be handled later in the panel?

**Welcoming the parties**

Attending a panel hearing is stressful for everyone. By the time of the Panel hearing, all parties will have invested a good deal of time and emotional energy in preparing themselves for it.

Before the parties meet the Panel, the Chair should meet the complainant and complained against separately along with their supporters (e.g. family member, officer from the CHC, a trade union or a defence body representative) away from the room where the panel is to convene. The IR Secretariat officer should be present to give information about reimbursement of allowable expenses or other administrative details.

The contact with parties at this stage must be limited to welcoming, confirming that they have received all the relevant papers and brief explanations of panel procedure including how notes will be taken, arrangements for tape-recording (if agreed by the parties in advance), the role of the assessors, and when draft sections will be available for comment. The Chair may want to repeat some of this information once the parties are in the room and before they begin their presentation. The pre-panel meeting is not an occasion for any party to initiate discussion of any issues which are part of the complaint, or for introducing any new evidence. Some examples of things that may arise are explored in Activity 5.

The role of supporters should be explained at the initial meeting with the parties. Some types of supporters increasingly see their role as providing advocacy. The Chair should clarify that in a complaints panel setting
“advocacy” means being able to advise and support one of the parties during the proceedings, rather than conducting matters on their behalf in a legalistic or adversarial sense. If there is a request for a supporter to address the panel before it convenes, the Chair should determine the rationale for this and decide whether to allow it, explaining the decision at the appropriate point in the panel proceedings so that it is noted in the final report.

See *Guidance* paragraphs 2.61-2.69.

**Activity 4: Welcoming the parties**

A. You are chairing the Panel in case study 4. Considering the personalities and issues involved, write a brief outline of how you would go about meeting each of the parties and explaining to them the panel procedure, objectives and timescales. Are there particular points you would want to emphasise?

B. Now consider the Panel in case study 1 and do the activity again. Would you go about meeting the parties and explaining the procedure the same way as in case study 4? If you would do things differently in case study 1, what factors have influenced your decision? Make a note of what you would do differently and why.

**Activity 5: Dealing with the unexpected**

You are the Panel Chair. When you go to welcome the parties, they raise important issues that may affect the hearing. How would you handle the following situations? What decisions would you have to make on the spot about this and how would you explain your decision once the panel proceedings were underway?

1. The complainant shows you an independent “second opinion” about her mother’s condition and prognosis which she has obtained from a well-known consultant outside of Wales. The complainant would like the panel to consider this evidence and has made photocopies for everyone.

2. One of the parties phones up before the hearing to say they are not going to attend as they are self-employed and have been offered a very well-paid day’s work. They ask for the panel to be put back to another day.

3. In a FHS complaint, the GPs complained against produce practice records to support their account of what happened. This is new evidence bearing on the terms of reference and has not been referred to before.

4. The complainant has brought his son-in-law who is a lawyer and tells you that he will speak for the complainant in the interviews.
5. The complainant has told the Secretariat that s/he will be attending the hearing with a representative from the CHC. On the day of the panel, three people come with the complainant, only one of whom is from the CHC. They all want to attend the interviews and two ask to address the panel.

6. In the initial meeting discussion, the complainant indicates that he is unhappy with the terms of reference. Though he agreed with them initially, after discussing things with other relatives, he now wants other issues addressed by the Panel.

7. Just before the hearing you are told by one of the people named in the complaint that they have been contacted and questioned by the Clinical Assessor before the Panel. She was upset by the line of questioning and threatens not to attend the hearing.

If you feel that you have understood:

- Managing the pre-hearing meeting
- Welcoming the parties
- Dealing with the unexpected

Then move on to the next section.
4. THE PANEL HEARING

Managing the conduct of the hearing

Every Panel hears evidence from different people with conflicting and competing interests and widely varying degrees of expertise. It is very easy for Panels to get diverted to new issues outside the terms of reference, or to get stuck on irresolvable or technical issues or go over the same ground again and again.

Drift and digression are constant risks which Chairs must counter by adopting a panel management approach that is open and facilitative while always adhering to and reflecting the terms of reference.

Subject to the views of the complainant, which should be sought in advance and not on the day of the panel, managing the panel with all the parties present may have advantages, especially if there are widely-varying versions of events. This approach requires more careful handling than when the parties appear separately. These aspects are entirely in the hands of chairs and depend on their skill and good judgement.

See Guidance paragraph 2.62 for different ways in which panels may work

Activity 6: Managing the proceedings

Below are some things that may happen during a hearing, consider each one and write down how you would deal with the situation, some comments are made on these self-assessment questions at the end of the module.

1. You have decided to conduct the panel by having the parties present together to hear each other’s presentations. The complainant has asked for this because, she says, this will be the first opportunity she has had to confront the practitioner complained against face to face. How will you plan this, taking account of the risks and opportunities it presents? What do you do if the complained against practitioner objects to this arrangement?

2. In the pre-panel meeting you have agreed with the clinical assessor his approach to questioning the complained against surgeon, but when he puts his questions during the panel his questions take on an increasingly accusatory tone and the surgeon’s supporter from a defence body interjects with you that this is unfair. What do you do?

3. The panel members have agreed how they will ask their questions of the complainant and her husband. The member who was the Reviewer, however, makes reference in his questions to issues that are not part of the terms of reference because they were settled prior to the panel. The complainant appears unwilling to go into these matters, but the Reviewer
persists because he says they are necessary background. How do you get the questioning back on track?

4. The complainant is very emotional about having to tell her story again at the panel, but says she is OK to proceed. But mid-way through her story about what happened on the labour ward, she breaks down sobbing and this also distresses her husband. What do you do as the Chair?

At the end of the interviews

At the end of the interviews, the Chair should thank the parties and explain what will happen next. The Chair should explain that sections of the draft report relating to their presentations (but not the panel’s findings, conclusions or recommendations) will be sent to parties and witnesses by the Secretariat for correction of matters of fact. If the parties have any comments they will need to give them to the Secretariat within 7 working days. The Chair should make clear that no new information or issues can be added as part of this process.

The panel’s deliberations

Once the parties to the complaint have made their presentations and left the room the Panel can begin deliberating in private with its Assessors. This process must be managed by the Chair to ensure that a balanced approach is taken to all the terms of reference and to make sure all members contribute.

The Chair and panel members must focus on the terms of reference. It is the responsibility of the Assessor(s) to clarify and comment for the panel members on those aspects of the complaint involving clinical judgement and the expected standards of professional behaviour. Without this the Panel cannot determine the questions of reasonable expectations which are part of most terms of reference. This requires the Chair to act as a good moderator and facilitator, so that members can ask questions of the Assessor(s) on clinical issues and make sure they understand the reasons for the advice.

The Panel may receive conflicting clinical advice from different Assessors. It can decide not to accept clinical advice in preparing its report. However, this is very rare and they must state the reasons and include the Assessors’ report at the end of the Panel report.

It is essential before the panel meeting ends for the Chair to confirm with the Assessor(s) how their report (preferably a joint report if there is more than one Assessor) will be made and that it will be supplied to the Secretariat within the 10 day time period following the date of the panel.
Activity 7: Drawing conclusions

1. Review the discussion in Module 2 for Panel Members about making decisions on the balance of probabilities. Identify examples in any of the four case studies where this principle of decision-making has been used.

2. The Health Service Commissioner (England) stated in December 2003: "If only all health service staff made sure that they listened to patients and their carers, communicated clearly with them and with each other, then made a note of what had been said, the scope for later misunderstanding and dispute would be reduced enormously." If you were chairing the panel in case study 3, how could you help the panel to focus on this aspect of the case during the panel's deliberations with its assessors? How could you do it at the panel in case study 4?

If you feel that you have understood:

- Managing the panel proceedings
- How the panel deliberates and draws conclusions

Then move on to the next section.
5. **THE REPORT**

**Arrangements for producing the report**

The IR Secretariat aims to complete the final report within 25 working days following the date of the Panel. The Chair’s draft report should be ready for circulation by 15 working days after the Panel date.

These are tight deadlines and the Panel should agree the timetable with the IR Secretariat at the end of the panel meeting, such as:

- Date for sending sections to the parties for checking accuracy
- Date by when the Clinical Assessor(s) will provide written reports
- Date for sending out the draft report to the Panel and Assessor(s)
- Date for completing the final report.

The Chair is personally responsible for drafting the panel’s report and recommendations and for doing their utmost to ensure its completion within the time limit of 25 working days following the Panel date.

Before the Panel disperses the Chair should ensure that Assessor(s) and panel members understand the timescales involved and what they are responsible for.

See **Guidance** paragraphs 2.69-2.72

See **Guidance** paragraph 2.89 and timetable

**Drafting the report**

The final report should be concise but comprehensive. The structure should be simple and the language unambiguous. Jargon and technical terms must be clearly explained (a short glossary may help).

Each of the terms of reference must be adequately addressed in the report, but no extraneous issues should be introduced. Sometimes issues may come up that are outside the terms of reference, but you would like to include in recommendations to the body complained against. If the Chair, with the panel members’ agreement, wishes to raise other issues arising from the Panel with an NHS body, this should be done in a letter accompanying the final report.

In particular when you are considering your recommendations, you may want to make sure that any issues relevant to clinical governance are highlighted which need to be drawn to the attention of practitioners or NHS bodies and ask the Independent Review Secretariat to follow this up.

See **Guidance** Section 3.14; and paragraph 2.70
The assessor(s)' report

There should be no surprises in the Clinical Assessor(s) written report since the preliminary conclusions will have been given during the panel's deliberations in private. The Assessor(s)’ draft report should accompany the Chair’s draft panel report when it is sent to the panel members for comment. The Chair should ensure that the Assessor(s) have complied with their guidance and have not included inappropriate information in the report, such as information about or provided by an identifiable third party for which there has been no authorisation.

See Guidance paragraphs 2.66 and 2.74

Incorporating comments and amendments

The draft sent to panel members should be the Chair’s final version, using numbered paragraphs to facilitate comments and feedback. The Chair should include a covering letter to panel members, with a reminder about confidentiality, explaining how to make their comments, e.g. by email or telephone, and identifying any particular aspects on which the Chair is seeking confirmation or which have been raised by the parties about their specific sections.

Panel Members’ amendments will normally be agreed and incorporated into the report by the Chair. It is important to arrive at a final text which all panel members can sign. If disagreement exists amongst members of the panel about the content of the final draft report, the Chair must make every effort to resolve this and make sure the Secretariat is aware of any likely delays. In exceptional circumstances, however, a panel member retains the right not to sign a final panel report. If this happens, the panel member must give their reasons in writing to the Chair and send a copy to the IR Secretariat. All communications between panel members about agreeing the report become part of the formal complaint record will have to be disclosed if a data subject access request is made under the Data Protection Act.

See Guidance paragraph 2.71

Activity 8: The panel report

In the case studies you have read three independent Panel reports. As a Panel member you will also have been involved in commenting on draft reports of Panels you have attended. If you have a report of a panel on which you have sat, consider the questions below. If not, use the reports from the case studies 1, 3 and 4.

1. Is the structure clear?
2. Is the report concise?
3. Does it keep within the terms of reference?
4. Is there any unexplained jargon?
5. Are the recommendations related to the findings?
6. Are the recommendations realistic? What chance do you think they have of being implemented and why?
7. How do you think the parties would respond to the report?

**Record keeping and the Ombudsman**

Following a Panel the complainant or the complained against may decide to appeal to the Health Services Commissioner for Wales (Ombudsman). In order to demonstrate that you acted fairly, it is important to keep good notes and records.

When undertaking an investigation, the Ombudsman has wide powers to require the production of written records relating to panel procedure beyond what was available to the panel itself, including file notes, telephone logs and emails made or received by the Chair and other panel members.

Before the panel disperses, the Panel Chair should remind panel members and assessors of the requirement to safeguard patient identifiable information according to Caldicott principles. The Secretariat can advise Chairs further about these issues.

When the complaint is closed, papers should be returned to the Secretariat (See Module 3, pg 77).

The IR Secretariat will alert a Panel Chair when any request for information is received from the Ombudsman and advise about the nature of what is required by way of documentation, up to and including a formal investigation of the handling of the complaint.

See *Guidance* 4.2, and paragraphs 2.81-2.88

**Feedback after panels**

All parties attending panels are encouraged to complete feedback forms after the panel is over. The Secretariat will send these to the parties. This is important to help improve the experience for the parties as well as ensuring that lessons are learnt for the NHS. You and the Secretariat can use this feedback to identify good practice and as part of your own professional development.
Activity 9: Handling Feedback

A. Consider the report of the panel in case study 3 (Document 3-G), then read the feedback form completed by the complainant following the hearing (Document 3-H). Note the observation by the complainant that the other two panel members remained silent throughout. What impression has this made on the complainant? Had you been chairing this panel, what would you have done to facilitate a more even spread of contributions?

B. Now consider the report of the panel in case study 1 and the feedback forms completed by the complainant and the complained against practitioner afterwards (both contained in Document 1-E). If you had chaired this panel what would be your reaction to these views, especially the dentist’s, about the panel experience?

If you feel that you have understood:

- Arrangements and responsibilities for drafting and completing the panel’s report
- Incorporating the assessor(s)’ report
- Requirements for record keeping in relation to the Ombudsman
- Role of post-panel feedback from the parties

YOU HAVE NOW COMPLETED THE FINAL MODULE

CONGRATULATIONS!

Postscript - your continuing learning and development

Working through this module may have helped you identify areas of further learning which you need to address as you progress in developing your expertise as a panel chair. Make a note of those learning needs and prepare a plan now for how you will meet them as you gain more and varied experiences of panels. Keep this with your development plan (see the resources at the end of the Foundation Module) and refer to it to measure your progress.
NOTES ON SELF ASSESSMENT QUESTIONS

This is a list of all the questions you were asked earlier in the module. Below each question are some comments reflecting the handling of the real case which you may wish to compare with your answer.

Activity 2: Preparation

You are preparing to chair the panel in case study 3. Read the complaints file about local resolution (Documents 3-A to 3-F) and then identify any aspects of procedure and performance that you believe need special emphasis at the panel.

- Do these have any implications for the selection of clinical assessors or for the identification of witnesses or the need for written statements from third parties?
- Are there any points you want to take up with the Independent Review Secretariat?
- What areas you will want to cover when making initial contact with the third member of the panel - list these. Draft a note for your file resulting from this conversation.

Comment: The complaint involves two main issues:

- An allegation of negligence and neglect of the complainant’s elderly mother who died in hospital.
- Local resolution has been very protracted.

These are serious matters and the panel must be able to satisfy the expectation of the complainant that it has given them due weight. The complainant will already have received a copy of the independent clinical advice at review stage – this often helps the complainant understand that the complaint is taken seriously. The choice of expert advisers from elderly care medical and nursing disciplines will be an important sign that this has been taken on board. You may want to consider asking a senior manager responsible for complaints handling to give an account of the reasons for the delays.

Activity 3: Pre-hearing meetings

In the meeting before the panel, the following suggestions are made. As the panel chair, how do you decide these?

1. In case study 1, a panel member suggests that Mr AB be interviewed separately from his son, who has brought the complaint. The rationale is that because she has written all the complaints letters, it would help the panel to get “his side of the story” if he were seen on his own.
Comment: Mr AB has given his written consent for his son to act for him and the panel must assume, therefore, that his account is truthful and accurate. No panel can ask to interview any party or witness on their own and to try to do so would be seen as intimidating.

2. In another case the complainant has expressed a strong desire to be present during any interviews with professionals. However, the doctors and the representatives have asked to be interviewed separately. What factors should the Panel take into account in making a decision?

Comments: The complaint is more likely to be resolved if the complainant feels that the hearing has been open and fair. They may fear (with some justification) that the complained against is more articulate than them and will give a false impression or bad mouth them and they will not have the opportunity to comment. Normally the complainant’s wishes should be respected. However, there may be circumstances where the complainant has been abusive or threatening to the complained against and this would not be fair on the person complained against.

3. At the pre-meeting the IR Secretariat officer shows you an email just received from the complainant saying it would be too distressing for her to give her evidence about her miscarriage last year to the whole panel and the two assessors, but she offers to speak privately to the Chair provided her husband can be there to support her. Is there a way forward without having to abandon the panel?

Comment: The Chair can agree for the complainant or any of the witnesses to be interviewed by a single Panel member. The clinical assessor will need to be present if any questions about clinical or professional issues are included. In some cases, you can arrange to interview the complainant in their home, if they are ill or unable to attend a formal Panel.

4. The pre-panel meeting with the panel members is going well and the parties are already in the building, but the clinical assessor has not yet arrived. The Secretariat officer rings her and discovers that she has the wrong date in her diary and other clinical commitments mean that she will not be able to attend at all that day. What options does the Chair have? Does the panel have to be cancelled?

Comment: If there had been two clinical assessors then, with the agreement of the parties, the panel could have proceeded with only one assessor. But if the panel has only one assessor, as is the norm, and that person is unable for whatever reason to attend, then the Chair has no option but to adjourn the panel and ask the Secretariat to find another convenient date for everyone to attend. The expenses of everyone who did attend must be met.

5. At the pre-panel meeting you tell the other members that you have had a telephone call that morning from the defence body representative of the complained against surgeon. He says the clinical advice given to the Reviewer was wrong and has written evidence to prove it. He says
that unless the panel disregards the clinical advice, he will advise his member not to participate in the panel. Can the clinical assessor assist the Chair in dealing with this problem? How should it be handled later in the panel?

Comment: The complained against cannot require the Panel to disregard the initial clinical advice. Any additional written evidence they produce can be accepted and treated as new evidence at the discretion of the Chair (see Guidance 2.63) who will want to discuss this with the panel’s assessor. The assessor’s views will be more relevant for the panel than the advice received by the Reviewer. If the complained against does refuse to attend or is dissatisfied with the Chair’s decision, they can complain and refer the case to the Ombudsman. The panel can continue without the presence of the complained against practitioner and the Chair will note the reason for this in the final report.

Activity 4: Welcoming the parties

A. You are chairing the Panel in case study 4. Considering the personalities and issues involved, write a brief outline of how you would go about meeting each of the parties and explaining to them the panel procedure, objectives and timescales. Are there particular points you would want to emphasise?

Comments: Though there is a lot of animosity directed at the GP, you believe as Chair that the proceedings will be benefit if both parties are present during the interviews and they have agreed to this. The GP is rather keener on it than the complainant. You need to make sure that both parties and their supporters, particularly Ms S’s partner who has written the complaints letters, understand this and know when they will have the opportunity to speak or ask questions. You need to agree with Mr J that he will be able to speak at a particular point. At this first meeting you may be able to get a sense of whether the complainant is likely to find the hearing distressing and consider how you will manage this. You also want to be assured that the GP complained against will respect the complainant’s strength of feelings, even if he doesn’t agree with her story, so that the joint arrangement doesn’t break down.

B. Now consider the panel in case study 1 and do the activity again. Would you go about meeting the parties and explaining the procedure the same way as in case study 4? If you would do things differently in case study 1, what factors have influenced your decision? Make as note of what you would do differently and why.

Comment: In this Case, the parties are being interviewed separately because that is what they want. You know there are some follow up questions it would be useful to ask, so you will need to explain that after you have interviewed Mr AB, you will interview Dr C. If Mr AB and his father are able, you may ask if they will wait after this so that the panel can ask any follow up questions as a
result of the interview with Dr C. Dr C needs to know this and feel comfortable with it too. Mr JB has mentioned wanting compensation, so if you think this is still an issue you may want to reiterate that this is not within the remit of the panel.

Activity 5: Dealing with the unexpected

You are the panel chair, when you go to welcome the parties; they raise important issues that may affect the hearing. How would you handle the following situations? What decisions would you have to make on the spot about this and how would you explain your decision once the panel proceedings were underway?

1. The complainant shows you an independent “second opinion” about her mother’s condition and prognosis which she has obtained from a well-known consultant outside of Wales. The complainant would like the panel to consider this evidence.

Comment: The Chair has discretion to accept this as new evidence and will want to ask the clinical assessor’s opinion about it. The complainant should also be asked to explain why she did not submit this information earlier so it could be considered by the panel members as part of the complaint’s file. All of this will be noted by the Chair in the panel’s report.

2. One of the parties phones up before the hearing to say they are not going to attend as they are self-employed and have been offered a very well paid day’s work. They ask for the panel to be put back to another day.

Comment: The Panel has no power to compel anyone to attend. It the Panel is postponed it is unlikely to be able to convene it again for some time, well past the time limits. The Chair has the option of going ahead with the hearing without either the complainant or the complained against present, but you will need to consider what the Panel will be able to achieve by doing this, especially if it is the complainant who does not attend. You may also be able to arrange to interview and take evidence by phone. If the Panel goes ahead, this should be noted in the report and how you feel this affected the quality of the Panel’s investigation should be noted in the report.

3. In a FHS complaint, the GP complained against produces practice records to support its account of what happened. This is new evidence and has not been referred to before.

Comment: It is up to the Chair to decide to accept this. You need to be fair to all parties but you also want a thorough investigation. You may want to find out why it was not produced before. Was it a genuine oversight, or is this a tactic? Are the additional practice records genuine? You decide on a short adjournment so that all the parties and the panel can consider the new evidence. The assessor should be asked for his view on the authenticity of the “new” evidence.
4. The complainant has brought his son-in-law who is a lawyer to support him and tells you that he will speak for the complainant in the interviews.

Comment: The family relationship is not relevant. A lawyer can attend in the capacity of a friend but not as a lawyer and cannot represent the complainant or complained against. This needs to be explained to them before the hearing and also the reason why the Panel is not a formal investigation where representation is allowed. The Chair will need to use his/her judgement about whether the lawyer should be able to address the Panel. If the person interviewed finds it difficult to express him or herself or is very nervous, it may help if the person who accompanies them asks them questions to help them give the evidence they want.

5. The complainant has told the Secretariat that s/he will be attending the hearing with a representative from the CHC. On the day three people come with the complainant, only one of whom is a CHC officer, who all want to attend the interviews and two want to address the Panel.

Comments: It is important to be flexible. Normally the only reason for refusing should be if the room is too small or there is any reason to feel this might be intimidating for those complained against. The Chair has discretion about who addresses the panel and anyone asking to do so must say why they wish to do this. The Chair’s decision is final. The fact that some of the supporters are not from the CHC is not relevant.

6. In the discussion, the complainant indicates that they are unhappy with the terms of reference. Though they agreed with them initially, after discussing with other relatives, they now want other issues addressed by the Panel.

Comment: The Panel must adhere to the terms of reference. Sometimes there is room for flexibility, but it is not fair on those complained against to change the terms of reference. The complainant can refer the matter later to the Ombudsman if they are not happy with the Chair’s decision.

7. Just before the hearing you are told by one of the people named in the complaint that they have been contacted and questioned by the Clinical Assessor before the Panel. She was upset by the line of questioning and threatens not to attend the hearing.

Comment: This is inappropriate behaviour by the Clinical Assessor and would be grounds for the person contacted to complain to the Ombudsman. If possible the Clinical Assessor should be replaced or asked to withdraw if there are two assessors. If this is not possible, it may need all your skills of diplomacy to persuade the person to take part in the hearing as it is important to go ahead for the complainant’s sake. The Clinical Assessor’s behaviour should be reported to the Independent Review Secretariat.
Activity 6: Managing the proceedings

Below are some things that may happen during a hearing, consider each one and write down how you would deal with the situation, some comments are made on these self-assessment questions at the end of the module.

1. You have decided to conduct the panel by having the parties present together to hear each other’s presentations. The complainant has asked for this because, she says, this will be the first opportunity she has had to confront the practitioner complained against face to face. How will you plan this, taking account of the risks and opportunities it presents? What do you do if the complained against practitioner objects to this arrangement?

Comment: You need to establish whether there have been any previous meetings between the parties as part of Local Resolution. Even if there have been and this is not the first opportunity to see each other face to face, you may still feel there is value in having everyone present together, provided the complainant accepts that the hearing is not adversarial and the complained against practitioner agrees with the arrangements. If she or he objects, however, you have no choice but to interview the parties separately.

2. In the pre-panel meeting you have agreed with the clinical assessor his approach to questioning the complained against surgeon, but when he puts his questions during the panel his questions take on an increasingly accusatory tone and the surgeon’s supporter from a defence body interjects with you that this is unfair. What do you do?

Comment: You are the Chair and you are responsible for assuring that the panel is conducted in a fair way, it may therefore be necessary for you to take a firm line with the Assessor as you should with the parties or Panel Members. A short adjournment or a comfort break can be helpful to give you time to speak to the assessor about this.

3. The panel members have agreed how they will ask their questions of the complainant and her husband. The member who was the Reviewer, however, makes reference in his questions to issues which are not part of the terms of reference because they were settled prior to the panel. The complainant appears unwilling to go into these matters, but the Reviewer persists because he says they are necessary background. How do you get the questioning back on track?

Comment: The Chair should remind everyone that the panel is guided by its terms of reference and that these are the only issues for the Panel today. The same views as in (2) above apply here.

4. The complainant is very emotional about having to tell her story again at the panel, but says she is OK to proceed. But mid-way through her story about what happened on the labour ward, she breaks down
sobbing and her husband is also distressed by this. What do you do as the Chair?

Comment: You can adjourn the hearing for a short time to give them time to recover themselves. You can ask them what they want to do. It is not always necessary for the complainant to go through the ‘story’ again. You have all read the papers and are familiar with the issues. You could ask “is there anything you want to add to the story we have read in the papers already?” A fresh glass of water and a box of tissues need to be within easy reach.

Activity 7: Drawing conclusions

1. Review the discussion in Module 2 for Panel Members about making decisions on the balance of probabilities. Identify examples in any of the four case studies where this principle of decision-making has been used.

Comment: Decision making on the balance of probabilities was used in case study 1, the dental complaint, because the panel had to decide which of two contradictory versions of events were the most likely to have happened even though neither could be “proved” conclusively. It was also used in case study 3, though here a mitigating factor was the fact that the GP had never received key correspondence from the hospital due to a clerical error and this inevitably affected his understanding of the seriousness of the patient’s post-operative situation.

2. The Health Service Commissioner (England) stated in December 2003: “If only all health service staff made sure that they listened to patients and their carers, communicated clearly with them and with each other, then made a note of what had been said, the scope for later misunderstanding and dispute would be reduced enormously.” If you were chairing the panel in case study 3, how could you help the panel to focus on this aspect of the case during the panel’s deliberations with its assessors? How would you do it for the panel in case study 4?

Comment: Bearing the Ombudsman’s views in mind, the Chair could identify in advance the issues which particularly concerned communications issues and raise these with the panel at the pre-meeting so that they could be incorporated into the questioning in a systematic way. For case study 4, this could include how the telephone conversation asking for a home visit was handled by the GP. For case study 3 it could include how health professionals should communicate better amongst themselves and then with the family so that unrealistic expectations about the patient’s prognosis and the care plan did not arise and the family could be more involved in the process as the patient’s life ended.
**CERTIFICATION OF COMPLETION: MODULE 4**

When you have completed this module, please provide the following information and submit this form to:

The Manager  
Independent Review Secretariat - All Wales  
PO Box 2, Bronllys  
Brecon, LD3 0XR

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I certify that I completed this module on (date)______________

The amount of time taken to complete the module was approximately ______

As a result of undertaking this module, I have identified the following issue(s) which I would like to discuss with the Independent Review Secretariat:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

As part of my development plan as a lay member, I intend to take the following actions to continue my learning:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

(Signed)______________________  Date______________

You should make a copy of this form and keep it with your development plan.
CASE STUDIES

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CASE STUDY 1 (Module 2)

1-A PANEL PAPERS

Case number 457

A panel will be held on 3 June 2004 beginning at 10 a.m. in Committee Room 3 at Somewhere Local Health Board Headquarters, to consider the complaint by Mr JB on behalf of his father, Mr AB, about Dr C.

Panel Chair: Mr L
Panel Members: Mrs P (Reviewer), Mr S
Dental Assessors: Dr J and Dr K

Independent Review Secretariat: Ms T

The following papers are attached:

- Typed letter from Mr JB to the Local Health Board dated **26 January 2004** requesting Independent Review
- The reply to Mr JB’s complaint from Dr C dated **5 December 2003**
- Further letter from Mr JB to the Local Health Board dated **14 March 2004**
- Clinical advice received by the Reviewer dated **17 April 2004**
- Terms of Reference for the Panel

The following papers will be available at the panel:

- Photocopies of Mr AB’s dental records from Dr C’s practice for the previous **five year period prior to 20 August 2003**
- The hospital records from Hospitals A and B where Mr AB was taken by ambulance on **20 August 2003**
A covering note from the Secretariat gives this additional information about dates of key documents:

- Mr AB authorises his son, Mr JB, to act as his representative and gives his permission for access to his records and personal information for the purposes of the investigation of the complaint.

- Mr JB’s original letter of complaint to Dr C of 14 September 2003 was handwritten. He received a response from Dr C on 5 December 2003, as a result of which he requested an independent review in his letter dated 26 January 2004. This letter is virtually identical to the handwritten letter of 14 September 2003, so a separate copy of the handwritten letter is not attached.

- The letter of 5 December 2003 is the only correspondence from Dr C to Mr JB.

- The letter of 26 January 2004 was taken as the substantive statement of his case.

- Following the request for independent review, the Reviewer decided to refer the case back to the Local Health Board and recommended conciliation. A conciliation meeting was held between Mr JB and Dr C on 6 March 2004. A summary report was available, but this simply said that the two parties went through their versions of the facts and could not agree on the key points, so no progress was made. It has not been included in the papers.

- After the conciliation attempt, Mr JB said he remained dissatisfied and subsequently wrote another letter to the Local Health Board on 14 March 2004, essentially reiterating the allegations made in his original complaint letters of 14 September 2003 and 26 January 2004 which he attached. Dr C was also shown this letter and asked for his comment. He telephoned the Local Health Board saying he had nothing to add to his original response to Mr JB of 5 December 2003. His letter in reply to the original complaint is therefore his substantive response to the complaint and to the request Mr JB has made for the panel.
Letter from Mr JB, the complainant

26 January 2004

To: Complaints Manager of the Local Health Board

I refer to my original letter of complaint to Dr C of 14 September 2003, which you will have on file. I only received a reply to that letter at the beginning of December and it didn’t answer my questions. Neither did it explain why it had taken so long to be sent. That is another reason why I am writing to you now asking for an independent review of my complaint about Dr C and how this dentist treated my elderly father and caused him considerable pain and distress. I am not satisfied with the answers Dr C has given. I want a panel to sort this out. This letter contains everything I want to say. I don’t want to have to write about all of this again.

My father is 77 and his diabetes is not well controlled at times. We are not satisfied by what has been done to deal with his distress and the risks he was exposed to because of what happened and I want a panel to tell me what action will be taken against this dentist.

As I have said in previous letters, this is what I am complaining about. My father went on his own to the dentist’s surgery on the 20th of August last year to have three teeth out. The dentist did not wait long enough after giving the injection to kill the pain - he told me he was “not fully numb” - before starting to remove the teeth and did not stop when my father said he was hurting. This should not have happened. After the teeth were out, he had to wait a very long time at the surgery until the bleeding stopped. Dr C put pressure pads in his mouth and told him to keep biting down on these until it stopped which it eventually did. The practice was very busy with other patients by then.

He left the dentist’s and got on the bus to go back to the sheltered accommodation where he lives. He is a very independent man and he has been to this dentist before on his own so neither of us had any reason to believe it would be any problem this time. Some blood had
spattered down his shirt while he was waiting for it to stop. Dr C had another patient and did not come out of his room to see that everything was alright before he left. The nurse had seen him after he got out of the chair, but she was also busy with a patient when he left and so no one checked that the bleeding had really stopped. He thought it was OK to leave.

Imagine how it must have felt while he was sitting on a crowded bus for blood to start coming out of his mouth! He tried to stop it by using a folded handkerchief. The nurse had told him that if it started again he could use a rag to staunch it and on the bus this is all he had. It was soaked by the time he got home.

He called the surgery and got to speak to Dr C who told him to keep biting down on the folded handkerchief until the bleeding stopped. But it didn’t stop for over an hour and when he rang back all he got was a recording telling him about opening times. Nothing about what to do.

He rang his GP and they suggested that the warden where he lives call an ambulance.

That’s how he came to be taken to hospital but they don’t do dental emergencies there. Why did the ambulance not know this? They said they couldn’t stitch it and he had to be taken by another ambulance to another hospital! After a couple hours waiting, they found a dentist to put a stitch in and the bleeding stopped.

It was late by now and my father had not eaten for hours. He was worried his diabetes was going to get out of control. The first I knew anything was wrong, was when the second hospital rang me to say my Dad was there. I went down there immediately and made sure he had something to eat. They kept him in overnight, just in case the bleeding started again, and we went home in a taxi first thing in the morning. He still had on the bloodstained shirt from the dentists.

While he was at the hospital a doctor gave him some tablets and said it would keep his diabetes from getting any worse because of missing his regular meals.
All of this was so unnecessary. He just had three teeth removed, but he ended up in two hospitals very upset, missing meals, away from home overnight in a strange place and worried about his diabetes because he didn’t have his regular tablets. His confidence is very low now. I think there should be some compensation for my father because of the way he was treated. I think Dr C should be made to account for treating him badly and I want a panel to do something about this.

Yours truly

Mr JB (son of Mr AB)
Response from Dr C to Mr JB’s original letter of complaint of 14 September 2003

5 December 2003

Dear Mr JB

I was very sorry to receive your letter of complaint of 14 September. Forgive me for the delay in replying to it before now but I only work part-time at the practice.

I was upset to hear that your father, who is a lovely old gentleman, is not happy with the care I provided when he came to the surgery on 12 April. I have been in practice here for 13 years and have never been complained about before.

I do not agree with what you say in your letter about my treatment. I have checked with the staff at the practice to make sure that I have remembered correctly what happened on the day your father attended for his extractions. As you were not there that day, let me put the facts straight for you in this letter.

Your father came to the surgery alone. I was aware of the patient’s age and medical condition (late ’70s, with diabetes) and provided for that. According to the notes, the teeth to be extracted were very loose and so I was able to remove them with little effort. I checked areas around the teeth to be extracted in order to confirm that the local anaesthetic previously administered had been effective. I told the patient prior to the extractions that he should raise his hand if he felt discomfort or wished me to stop at any point. I can tell you that there was no such indication nor any other sign noted by me or my nurse during the extractions that your father was feeling pain or discomfort.

There was some bleeding post-extraction, but insufficient to warrant the insertion of sutures. As the teeth were easy to extract, I would not have done any stitching as this would have delayed normal healing. I did put
several pressure pads in your father’s mouth and explained how he should bite down on them until the bleeding stopped and that he should stay in the waiting room at the surgery until then. This is standard practice.

I checked the patient thoroughly before allowing him to return home, in view of his age, and also that he had attended the practice unaccompanied. I explained what to do should he experience any difficulties later including the application of pressure should there be any further bleeding. I’m sure I did not say that he should use cotton wool as that is not appropriate to use for stopping gum bleeding. You claim that the patient was still bleeding and had soiled clothing on leaving the surgery, but that cannot be true.

According to the notes, I also told your father that there would be a delay in the provision of a denture subsequent to the extractions due to the need for healing and I confirmed the cost of the denture would be met partly by the NHS and partly as private treatment because of his special requirements.

I did try to ring your father at home during the afternoon to check that everything was alright, but the number in our records was incorrect and I wasn’t able to contact him. This practice has an answering machine which provides a message explaining how to access of an out-of-hours emergency service when we are closed.

I deeply regret that you and your father feel unhappy about the treatment and I hope that this letter will set the matter right. I have sent a copy to the Local Health Board and I am sure they will be able to help you if want to discuss this any further.

Yours sincerely

Dr C

cc. Local Health Board
14 March 2004

To: Independent Review Secretariat

We had a conciliation meeting as you recommended last week. I don’t know why I agreed to this in the first place now. Dr C was very rude to my father and myself. He said I didn’t understand what had happened since I was not there when he treated, or rather mis-treated, my father. That is very insulting. Does he think I am making this up? Would he like to see my father’s blood stained shirt? He did not apologise one bit. So this meeting did not achieve anything except wasting a whole day of our time to come into town to be insulted. I had to take a day off work for which I will not get paid.

Are you now going to agree to my request in January and set up a panel to get to the bottom of this?

Mr JB on behalf of Mr AB
Clinical Adviser's Report

Name of Adviser: Dr AN Other
Position: Dental Adviser, Somewhere Local Health Board

Independent Review Case Number 457

Was the explanation given to the complainant adequate? If not what additional information should have been given to the complainant relating to each element in the complaint?

In view of the discrepancy of the accounts relating to the extractions on 20 August 2003 and the sequelae as reported by the patient’s son, the rather late response from Dr C in his letter of December 2003 cannot be regarded as adequate. He might have been advised to try to address the wider issues about the patient’s reported distress, even though Dr C does not agree with Mr JB’s version of events.

Are there any outstanding issues not dealt with in the reply? If so what are they?

I reviewed the practice records and radiographs relating to the patient Mr AB. It is noted that the dentist had extracted three other teeth from the same patient apparently without incident ten days previously to the events described in the correspondence. This is not part of the complaint however. Obviously Dr C could not comment on the hospital experiences of Mr AB, even though these things are all connected in the complaint.

Are there any other clinical issues that have not been addressed? If so, what are they?

The central clinical issue is whether what Dr C did for Mr AB was good practice or not, including the arrangements for aftercare. I do not see anything in the records to suggest that it was not good and well-intentioned. It does not seem to have worked out that way for the patient, but I do not believe there are any other clinical issues to be uncovered.

Are there any practical actions that could take place to provide a better explanation to the complainant? If so what would you suggest?

Conciliation has been tried and it is regrettable that it did not succeed. I think this was because Mr JB did not want to hear “the facts” again from Dr C. He felt the dentist insulted him and his father. He wants someone to admit that his father had a very bad experience and say they are sorry. He says he also wants “compensation”, but no money has changed hands in this treatment so what that means is not clear. I do not think Dr C is going to apologise because he doesn’t believe he did anything wrong. I hope the panel can provide something practical that will satisfy Mr JB and his father.

Signed         Dr AN Other           Date 17 April 2004
Terms of Reference for the panel

Complaint by Mr JB on behalf of his father, Mr AB, about Dr C.

1. To review the standard of teeth extraction performed by Dr C on Mr AB on 20 August 2003, taking into consideration the implications of the patient’s health status and his reported experiences of aftercare and to determine whether this was of a standard which could reasonably be expected.

2. To consider the adequacy of the practitioner’s records of Mr AB’s dental treatment.

3. To consider the discrepancy of the account of complainant and practitioner relating to the extractions on 20 August 2003 and the subsequent reported experiences of the patient.

4. To advise the practitioner concerned and any appropriate NHS bodies of recommendations following the review which could improve the care of patients.
1-B THE DENTAL ASSESSOR’S REPORT

Two dental assessors were arranged, but bad weather on the day of the panel meant that one assessor could not get to the venue where the panel was sitting. The Chair decided not to postpone the hearing and proceeded with only one assessor, after informing all parties of his decision which they supported.

At the hearing of this case the dental assessor gave his views during the panel’s deliberations and summarised them in this written report which was annexed to the panel’s report.

“It was a difficult case to assess as I could not examine the patient and radiographs were not available to the panel. It is noted that the dentist providing clinical advice to the Reviewer was able to see the x-rays and he not find anything unusual.

The correspondence is extensive, but much of it does not relate to clinical issues.
It seems that the treatment carried out on Mr B was necessary to his continued well-being. It is likely that the three teeth extracted were chronically infected and that chronic gum inflammation was present.

There may have been pain felt on extraction. This sometimes cannot be avoided and is not a sign of careless treatment by the practitioner.

The secondary bleeding following extraction probably stemmed from the breakdown of a clot in the chronically infected gums. This is well-documented when chronically infected teeth are removed. I can find no evidence that the dentist did not give proper care, but I cannot determine the extent to which Mr AB understood that this bleeding might occur and what he should do if it did.
What seems clear is that when it did occur, there was a breakdown in the emergency procedures at the surgery and, surprisingly, at the initial hospital to which Mr AB was taken by ambulance.
The practice where Dr C works needs to investigate having a simple contact number in emergencies, especially for frail patients like Mr AB, which can put them in contact with a qualified practitioner to give advice or make a home visit if required.

The Local Health Board may wish to examine the adequacy of emergency cover for its dental practices at night and over weekends. The problem, in retrospect, seems to have been caused by complications of the removal of infected teeth and not a lack of skills, compounded by lack of adequate emergency cover.”

Dr J, BDS, Senior Lecturer in Community Dentistry, University School of Dentistry
1-C WHAT HAPPENED NEXT

In the case you are considering, the panel decided to hear evidence jointly from Mr JB and the patient Mr AB and separately from Dr C. The parties said they did not wish to be present together.

None of the parties were accompanied. Mr JB had talked to the local CHC and agreed that he could handle things himself, especially as his father was going to be with him and he would be the best person to ask him the questions rather than someone he did not know very well. Dr C did not have representation from his defence organisation and told the Secretariat that as far as he was concerned the case was not worth having a panel about.

On the day of the panel, the original dental records were available, but the radiographs which the clinical adviser had seen had gone missing somewhere in the Local Health Board which was trying to locate them. There were also the hospital treatment records from the two hospitals that had seen Mr AB in casualty. The clinical assessor had access to these.

Panel members did not ask for any written statements in this case and no witnesses were requested by either of the parties. One of the assessment questions asks your views on this.
Held on 3 June 2004 to consider the complaint brought by Mr JB on behalf of Mr AB about treatment provided by Dr C.

Membership of the panel:

Chair: Mr L
Members: Mrs P, Mr S
Dental Assessor: Dr J, BDS, Senior Lecturer in Community Dentistry, University School of Dentistry

Summary of complaint

Mr JB made a complaint requesting an Independent Review to the Local Health Board 26 January 2004 containing allegations regarding the standard of teeth extraction performed on his father Mr AB, by dentist, Dr C, on 20 August 2003 and the lack of aftercare from the practice which had caused his father considerable distress.

Following the request for independent review, the Reviewer referred the case back to the Local Health Board and suggested that a conciliator should try and help resolve the complaint.

A conciliation meeting was held between Mr JB and Dr C on 6 March 2004. Afterwards Mr JB said he remained dissatisfied and subsequently wrote another letter to the Local Health Board on 14 March 2004, essentially reiterating the allegations made in his original complaint letter and the first request for an independent review of his complaint on 26 January 2004. The second request was agreed by the Reviewer.

Terms of Reference

1. To review the standard of teeth extraction performed by Dr C on Mr AB on 20 August 2002 taking into consideration the implications of the patient’s health status and his reported experiences of
aftercare and to determine whether this was of a standard which could reasonably be expected.

2. To consider the adequacy of the practitioner’s records of Mr AB’s dental treatment.

3. To consider the discrepancy of the account of complainant and practitioner relating to the extractions on 20 August 2003 and the subsequent reported experiences of the patient.

4. To advise the practitioner concerned and any appropriate NHS bodies of recommendations following the review which could improve the care of patients.

How the panel proceeded

The panel met on 3 June 2004 for one day at the headquarters of the Local Health Board. Mr JB with his father Mr AB were interviewed together. Dr C was interviewed separately. None of the parties was accompanied. No other witnesses were called. No written statements were requested.

The dental records were available at the panel but the radiographs had not been traced which had been available to the clinical adviser in advising on the case. The Local Health Board accepts responsibility for the fact that the panel did not have these available. The panel’s assessor has commented on this in his report. The panel only had one clinical assessor due to bad weather on the day of the panel. The panel and parties agreed to proceed on that basis.

Findings of fact

The panel considered the following facts to be demonstrated by the evidence:

1. Mr AB had extractions on two occasions with Dr C. On the first occasion he experienced some pain, but this does not appear to have been a matter for comment at the time and did not figure in the complaint.
2. At the second treatment, a few days later, three more infected teeth were removed, causing considerably more pain than on the earlier occasion and some bleeding for which the dentist gave him pressure pads. Bleeding seemed to cease.

3. He left the surgery alone late morning and returned home to his warden-assisted accommodation by bus.

4. The bleeding began again while he was on the bus. This frightened Mr AB who did not expect this to happen and he applied a pad of his own devising (a folded handkerchief) while on the bus and continued to do this when he got home.

5. Mr AB being diabetic took care to eat something when he was home, some cold soup.

6. The bleeding did not stop. Mr AB rang the surgery in the early afternoon. An answering machine message told him to ring another number. That referred to surgery opening hours but did not give advice about whom to contact for emergencies during the week, only at weekends.

7. Mr AB rang his GP’s surgery. They advised him to ask the warden of his sheltered housing to call an ambulance if the bleeding did not stop. An ambulance was called.

8. The ambulance took Mr AB to Hospital A but as no-one could suture his bleeding gums in A&E, he was transferred later, at night, to Hospital B. An oral surgery registrar stitched the gum and stopped the bleeding. The hospital kept Mr AB in overnight as a precaution. His son arrived. He was given some medication for his diabetes by a hospital doctor. Mr AB and his son returned home by taxi the following day.

9. Mr AB considered that because he could not stop the bleeding and had not been given, or could not recall being given, any advice about what to do in case of an emergency, he became increasingly alarmed that he was at risk of bleeding to death.

10. As a result of his experience, Mr AB lost confidence in Dr C as his dentist and has registered with another dental practitioner to continue the treatment and now has a denture with which he says he is well satisfied.
Panel’s findings relating to the Terms of Reference

1. To review the standard of teeth extraction performed by Dr C on Mr AB on 20 August 2003 taking into consideration the implications of the patient’s health status and his reported experiences of aftercare and to determine whether this was of a standard which could reasonably be expected

The Panel accepts the views of its clinical assessor that some pain and bleeding were to be expected given the treatment and the nature of the condition of Mr AB’s teeth. The secondary bleeding is explainable by underlying bacterial infection and blood clots breaking up, not by poor dental treatment technique. The Panel concludes, therefore, that the standard of clinical care provided by Dr C was what could reasonably be expected.

There are conflicting accounts of what advice regarding aftercare was provided by Dr C and understood by Mr AB. The practice has an information sheet with instructions that would have been helpful to Mr AB, but he does not recall having been given it. Dr C cannot confirm that a copy was given to the patient. We conclude, therefore, that more could have been done to confirm that Mr AB was given proper aftercare instructions and that he understood this advice about what to do if something went wrong.

2. To consider the adequacy of the practitioner’s records of Mr AB’s dental treatment

Despite minor errors in dates that do not affect the veracity of the record, the panel found no reason to seriously question the practice’s record keeping. The clinical assessors suggested that Dr C might review his standards for making clinical notes as they found one or two aspects were ambiguous, but not crucial to following the care provided.
3. To consider the discrepancy of the account of complainant and practitioner relating to the extractions on 20 August 2003 and the subsequent reported experiences of the patient

The panel found a number of differences in the accounts given by Mr AB and Dr C as to what happened during the treatment on 20 August and its aftermath, in particular:

**The length of time between administering the local anaesthetic and the commencement of the extractions -**
Mr AB thought it was a very short time, not enough for him to have become “fully numb” and he therefore suffered pain unnecessarily. Dr C recalled that he did not commence extraction until he was confident Mr AB would not be in pain. In any case, two of the three teeth he removed were very loose.

**The length of time given to Mr AB to recover and for his post-extraction bleeding to subside -**
Mr AB’s account suggests he remained in the chair for a short time and was attended by Dr C’s nurse who gave him a pad to help stop the bleeding. He said he felt under pressure to leave for home so that the next patient could be seen. Dr C told us that the patient was under no pressure to leave and would have had a rest in the waiting room until he was ready to leave.

**Whether Dr C personally checked that Mr AB was fit to travel and return home unassisted bearing in mind his age and diabetic condition -**
Mr AB said he only saw the nurse who advised him that he could go home and that if the bleeding returned he should staunch it with “a rag or a piece of cotton wool”. Dr C is clear that he saw Mr AB in the x-ray room at the surgery and inspected his mouth before he was content for him to leave. In his view, the nurse might have given different advice, but he does not know what she might have told the patient.

The accounts given by Mr AB and Dr C, though differing, were both plausible. The panel considered that it did not have enough evidence to confirm one account over another.
One aspect, however, rose above the differing accounts of events. This was Mr AB’s understandable and mounting anxiety at the continued and, in his perception, escalating bleeding. This began on the bus and continued when he was unable to stop it at home. His fear for his own safety was compounded when he was unable to contact the practice directly on the phone and ended up being taken by ambulance to two hospitals before a suture was inserted. The hospital records show that the bleeding was not particularly severe and not life-threatening, but Mr AB was not to know that. In the circumstances, it is quite understandable how Mr AB came to be in such an anxious state and why his son, being told the story, also became very concerned for the distress his father had experienced.

**Recommendations**

The panel and its adviser, while accepting the reasonable standard of clinical care, recommend that the practice review the means by which it ensures that patients are given to understand the arrangements for aftercare. Patients have a right to expect this. In particular, in the panel’s view, the practice should have a tested system in place to allow patients to speak to a dentist out of hours during the week, not just an emergency service at weekends. If that had happened in this case, then Mr AB could have been reassured and given advice that would have reduced his sense of alarm. Most probably two hospital visits by ambulance would have been avoided.

We recommend that Dr C and his senior colleague at the practice should consider putting such an arrangement in place, even though it is likely to be used only rarely.

In addition, we recommend that the Local Health Board review arrangements for out of hours dental emergencies on week days as well as weekends to see if there is scope for offering patients a more consistent service.

Though the treatment of Mr AB at the two hospitals is outwith our terms of reference, as it was not an element in Mr JB’s complaint, the panel and its assessor found it very disturbing that it was not possible for a fairly simple suture to be inserted at Hospital A as there was no oral surgeon on call. We believe and recommend that the Local Health Board should review the need for such provision in the A&E service it commissions at that hospital.

Signed and dated by each panel member

Attached – clinical assessor's report
Feedback from Mr JB, the complainant

We would be grateful if you could complete and return this form in the enclosed pre-paid envelope. The information you provide will enable us to make necessary improvements to the service.

Please read the comments and tick the appropriate box. If you would like to make any other comments, there is a space for this on the other side of the form.

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The Process:

I found any written information to be helpful, but complicated.

I was kept informed of progress, but things moved very slowly.

I would like to express my thanks to all concerned – particularly the dental assessor and everybody I met at the Review Panel.

I must also point out that from the start no help was given to me by the (complained-against) dentist’s Practice. I was even given the wrong contact details for the Complaints Procedure. I’m still under the impression that it was hoped that I would just “forgive and forget” about what happened to my father. All that has happened since could have been achieved months ago – and some of the blame seems to be directed at me. I’m no dentist and I put my trust and dental care in the hands of somebody who did not do their job properly.

Name (optional): Mr JB (complainant) on behalf of Mr AB (my father and the patient)

Date: 18 August 2004
Feedback from Dr C, the complained against

We would be grateful if you could complete and return this form in the enclosed pre-paid envelope. The information you provide will enable us to make necessary improvements to the service.

Please read the comments and tick the appropriate box. If you would like to make any other comments, there is a space for this on the other side of the form.

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Please give details of your experience of Independent Review and any other comments you wish to make, especially anything that might help others in similar circumstances in the future, in the space below:

I still don’t understand why it was necessary to take up a great deal of everyone’s time and at public expense to have this review. What did it achieve?

It was clear from the assessor at the panel that my clinical care for Mr AB was reasonable, given his condition. I could not control what happened afterwards, especially at the two hospitals. I know Mr JB was unhappy and I’m sorry his father had a bad experience, but he wasn’t present during his treatment and really doesn’t understand some things very well. Perhaps he feels guilty that he didn’t come with his father?

I’m now going to have to explain all of this back at my practice where I’m only a part-time dentist and really don’t have much influence about how it is managed.

Name (optional): Dr C

Date: 30 September 2004

PLEASE RETURN YOUR COMPLETED FORM TO THE INDEPENDENT REVIEW SECRETARIAT IN THE ENCLOSED STAMPED ADDRESSED ENVELOPE

THANK YOU FOR YOUR HELP
2-A REQUEST FOR AN INDEPENDENT REVIEW FROM THE CHIEF OFFICER, SOMEWHERE IN WALES CHC

3 October 2003

To: Independent Review Secretariat

Dear Lay Reviewer

Re: Mrs LP

I write on behalf of the above named who has complained at the care and treatment given to her late husband Mr GP whilst a patient at BLANK Hospital, this primarily in the days prior to his death.

Mrs P is of the opinion that more should have been done for her husband in terms of the treatment given, and also believes that the full facts of her late husband's situation are not totally recorded in the hospital's notes and records. The complaint has been earlier submitted to the Chief Executive of the BLANK NHS Trust, and in an effort to resolve the matter a meeting was held in this office between both parties, with the Trust being represented by the Director of Medical Services, and the Secretary to the Board. Whilst this addressed some issues there were a number of outstanding concerns.

Accordingly, on 7th August 2003 we wrote again to the Trust with a listing of these unresolved matters (copy enclosed). On 3rd September 2003 the Medical Director provided a detailed written response which is also enclosed herewith for your reference.

We must now regrettably advise that Mrs P remains dissatisfied and remains convinced that not enough was done to save her late husband's life. She also has a continuing and particular concern in respect of the potential final operation on her husband, for which he was in the process of being prepared, only for it to be cancelled at the eleventh hour.

On the foregoing basis, and on behalf of Mrs P, we would now formally ask that this complaint be referred to the Independent Review process.

Yours sincerely

Chief Officer to the Council

Enclosures
2-B  LETTER OF COMPLAINT TO THE CHIEF EXECUTIVE, BLANK NHS TRUST

7 August 2003

Dear Chief Executive,

Mrs LP re: the late Mr GP

I again write on behalf of Mrs P of the above address in respect of the care and treatment which her late husband Mr GP received whilst an inpatient at BLANK Hospital through several months last year.

You will be aware that Mrs P has previously raised several issues of concern in respect of the circumstances that prevailed during the final days of her husband’s hospitalisation, and the particular period prior to him passing away. There have been several exchanges of correspondence on the issue, and more recently a meeting in these offices between Mrs P, her daughter, the Director of Medical Services and the Secretary to the Board.

Mrs P has now had time to reflect on the content of the meeting and to review the notes which were taken there to reflect the content of the discussions. Regrettably I must inform you that Mrs P remains dissatisfied and now desires further explanations to help her understanding of the situation.

Generally Mrs P has described there being a lack of attention to her husband at times when she was not present on the hospital ward. She did of course remain with him at the hospital for some considerable time, monitoring his diet and his medication to assist the hospital staff. She is aware that this monitoring was not nearly as thorough at times when she was not present and believes this caused deterioration in her husband's condition.

Additionally Mrs P has a lack of understanding on the various drugs and other medications given to her late husband through his period of illness. She has listings of all of these of course from the hospital notes that are copied and in her possession, but she has no real understanding on their quantities and purpose. Accordingly she would appreciate an interpretation being given to her on the various drugs that were administered to Mr P.

Mrs P has also questioned as to why her husband was not prescribed drugs to control his heart rate, being aware that he had a fast heart rate due to the high levels of potassium present within him, and she has asked what is your policy in this respect? Mrs P has also enquired on the levels of morphine present in her husband's liver, given his medical condition.

Mrs P continues to reflect that her husband was making good progress for the most part of his lengthy stay in hospital. She was continually reassured by both
the doctors and the nursing staff that her husband was doing well and was making good progress towards recovery 'and would soon be alright'. She finds it difficult to comprehend the sudden change in his circumstances. She needs an understanding of what caused the dramatic change.

In the period of post-surgical recovery Mrs P remains adamant that the drain line was pulled out from Mr P's surgical wound, and she believes that this situation contributed to his untimely death. She says that this incident has never been properly addressed by anyone and is not reflected in the notes. Can this again be researched please.

Mrs P also has concerns at the septicaemia that beset her husband and would like further information in this regard.

However the major concern that still needs to be addressed to the satisfaction of Mrs P is the specific reason as to why a further operation was not undertaken on Mr P in those few days prior to his death. Mrs P is not convinced by the explanations that he had at that time been through enough pain and suffering, that he was not strong enough for this further surgery, that his life was coming to an end anyway, and that therefore the additional surgery would not have prolonged his life span in any meaningful way. Importantly this operation was seemingly planned to occur, and Mr P had been told of it and had been prepared for the surgery, and then it was cancelled at the eleventh hour.

Worryingly for Mrs P, she and her husband were then told together that the surgery was "not going to happen" when they had been optimistic of its success, and this caused significant mental anguish and trauma as I am sure you will understand.

Mrs P is of the firm opinion that discussions on the further surgery and its potential outcome should have taken place beforehand with the appropriate consultants and staff, prior to preparing Mr P for Theatre. The manner in which this was handled had initially raised their expectations, given great hope and then dramatically destroyed this hope.

Mrs P has also questioned as to why advice and guidance on her husband's condition was not sought from other consultants and specialists within the Trust or indeed from elsewhere within the country. There is a belief that not enough advice was sought to endeavour to save the life of her husband. Mrs P has formed an opinion that as further complications developed with her husband's deteriorating medical condition, then others, perhaps more accustomed to dealing with these particular symptoms and problems, could have given a much more accurate guidance on effective treatment.

Mrs P has also commented on the immediate hours prior to her husband's passing. She was aware that his life expectancy was short at that time, and had been prepared by the hospital staff for this. She was however informed that his
treatment would continue, but be somewhat lessened in the circumstances. This she understood and accepted. Sadly however, and to her great surprise, almost immediately after being so informed she witnessed the treatment being discontinued rather than lessened. This caused further trauma and is an added concern on which your comments would be appreciated.

Separately, Mrs P would also again draw your attention to the fact that Mr P was on an earlier occasion asked to raise himself up in the bed because he had slipped forward. She remains adamant that this action, undertaken without assistance, caused sufficient strain to burst open his stomach wound, and he then required further surgery. Had this not been asked of him at that time the healing and recovery process would have continued. Specifically Mrs P would also like this issue reviewed once again.

In making this further request Mrs P wishes to point out that for the most part of her late husband's hospitalisation, which continued for a period of seventeen weeks, she was quite satisfied at the care and treatment standards provided to him. Indeed she has been quite complimentary about the initial operation and the post operative period whilst Mr P was seemingly making a good recovery. She also speaks highly of the care given him on the coronary care unit.

We trust you will be able to review and respond in a meaningful manner to each of these further enquiries and so satisfy the continuing concerns of Mrs P. We will be pleased to host a further meeting or for Mrs P to receive a detailed written response, whichever method you feel will be most appropriate in the circumstances and which will be both comprehensive and easily understood.

Yours sincerely

(signed) Chief Officer to the Council

cc Director of Medical Services, BLANK NHS Trust
3 September 2003

Mrs LP, complainant

Dear Mrs P

I refer to the CHC Chief Officer’s letter to the Chief Executive, in which he outlined areas of ongoing concern following our meeting on the 7 June 2003. As you may be aware, the Chief Executive has now left this area to take up another post. Before he left, he asked me to consider the matters the Chief Officer has raised and to respond to you both. Accordingly, I am also sending a copy of this reply to the Chief Officer.

I will deal with each point in turn as follows:

The care of your late husband when you were not present: You will recall that when we met, we discussed this, particularly in relation to the day Mr P was referred to the Coronary Care Unit. I was able to reassure you then that the very detailed nursing records indicated that the nurses had appropriately cared for Mr P on that day. The records reveal a similar picture throughout his stay and I would like to allay your fears that Mr P was not given appropriate attention when you were not present.

Your lack of understanding regarding your husband’s medication: I recall at our meeting that we discussed at some length your husband's poor health over a number of years, outlining from his medical records the various treatments he had received including the drugs and their purpose. Mr P was receiving diamorphine in a dose sufficient to provide pain control. There was no indication to look at morphine levels in his liver. The high potassium levels were being investigated by the doctors but treatment could not be given until the underlying cause was identified.

The deterioration in Mr P's condition: The CHC Chief Officer has highlighted your perception that your late husband was making good progress towards recovery and that his deterioration represented a sudden dramatic change. As I explained in detail at our meeting, the doctors knew that Mr P was dying and the medical records show that they were keeping you informed of the situation. You stated at the meeting that you could not accept this. I can only repeat that, sadly, family members have difficulty sometimes in coming to terms with what is going to happen despite the efforts made by the medical team in trying to prepare them.

Removal of the drain line: We did discuss this at our meeting and I note you are still of the view that the drain line was displaced. Having looked at all the notes again, I may be able to shed some light on this. The nursing notes documented at 6 am on 25 October 2002 state that there was "some slight ooze" to the wound
as Mr P had "been pulling at the drain". At 8.25 am, the doctor saw Mr P on a ward round and wrote in the notes that Mr P had "pulled the drain out" during the night. This would have been based on the information given by the nurse about Mr P's condition over night. Our interpretation is that the drain was not pulled out and the doctor's entry at 8.25 am is misleading in this regard. It appears from both the nursing notes and the consultant, Mr M's response at the time of your original letter of complaint that the drain had not come adrift, but that there had been leakage around the drain and through the wound. I am sorry that you have been distressed by your recollection of this event and I hope my further comments are helpful.

The development of septicaemia: The septicaemia was a blood borne infection as a result of Mr P's lower resistance due to his other health problems.

Decision not to perform a further operation: As I explained at the meeting, the doctors decided against a future operation as they knew your husband was dying and they were clearly acting in his best interests. In accordance with your wishes, a second opinion was sought from Mr T who agreed with Mr M's judgement. As we discussed (and outlined in the chief executive’s letter to you of 5 February 2003) Mr T discussed the situation with you at some length.

Obtaining a further medical opinion: The CHC chief Officer asks why advice and guidance was not sought from other Consultants, within the Trust or from elsewhere in the country. As mentioned already, a second opinion was sought from Mr T and I did explain at the meeting the role of a General Surgeon, reassuring you that all three surgeons at BLANK Hospital were competent to treat your husband (this was in response to your query as to why Mr P was not transferred to another hospital).

Discontinuation of treatment: Treatment was not discontinued. Treatment was given with the aim of reducing any distressing symptoms. It was realised that there was no treatment that would effect a cure. The locum consultant in palliative care explained to you that the treatment being given was to provide quality of life for as long as your husband was alive and she also pointed out that this would not in any way shorten his life.

Occasion on which Mr P raised himself up in the bed: This again was discussed at our meeting when I explained that patients need to be mobilised as lying flat can cause problems. I said, too, that Mr P's wound would have burst in any event as it simply was not healing from inside.

I hope this information is helpful to you. I do understand that you are finding it difficult to come to terms with what happened and, clearly, cannot accept the explanations which have been given. I feel I cannot add anything further on these issues but would be happy to provide information on any other matters which are troubling you but which you have not yet drawn to my attention.
As I mentioned before, I am sending a copy of this letter to the CHC Chief Officer who, hopefully, will be able to allay your fears and to advise you on a way forward which will help you in your present situation.

With all good wishes.

Yours sincerely

(signed) Director of Medical Services

cc. Chief Officer, Somewhere in Wales CHC
2-D  CLINICAL ADVISER’S REPORT

Name of Adviser: Mr AN Other
Position: Consultant Surgeon, Somewhere Else NHS Trust

<table>
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<tr>
<th>Independent Review Case Number 470</th>
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<tr>
<td>Was the explanation given to the complainant adequate? If not what additional information should have been given to the complainant relating to each element in the complaint?</td>
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The record keeping in the notes was excellent. All discussions regarding management were documented throughout as were the discussions, which were held at the various times, with the relatives of the deceased. The centre of the complaint appears to be concerning the decision made by the Consultant Surgeon and the Consultant Anaesthetist that further surgery was inappropriate and would be unsuccessful, and only prolong the life of Mr P unnecessarily. This is all fully documented in the notes. The complaints procedures were fully followed and appear to have been frank and open, and appear to answer the comments and criticisms raised by the P family. It is perhaps a shame that Mrs P did not allow Mr M to attend the meeting held at the Community Health Council on 7th June 2003 where he could have explained his reasons for deciding to carry out the final operation on Mr P on 24th October and also his reasons for not carrying out yet a further laparotomy on 27th/28th October 2002.

I believe that appropriate care and treatment was provided, and that this was explained in straightforward and simple terms to the relatives. A further surgical opinion was sought by Mr M on 27th October and the opinion of Mr T is fully recorded in the notes and confirms that a last ditch operation was not in Mr P’s interests. It is always more difficult not to operate than to operate, and I understand that this was difficult for the P family to come to terms with especially as they had been told by what I presume was a more junior surgeon, that only an immediate operation would prevent death. This surgeon was, however, not fully aware of the consequences of a further anaesthetic, and it was only when a more senior anaesthetic opinion was obtained that it became apparent that further surgery would be futile.

Are there any outstanding issues not dealt with in the reply? If so what are they?

The relatives of Mr P were unhappy with several aspects of Mr P's treatment leading to his death. The Medical Director arranged a meeting to be attended by himself, the relatives and a member of the community health council. He offered for Mr M to attend but this was rejected by the relatives of Mr P. The meeting was held on 7th June when the concerns of the relatives were addressed by the Medical Director. Following this
meeting the relatives of Mr P remained unhappy with the outcome and in a letter of the 3rd August 2003 it would appear that the major concern of the family was why the final operation was not carried out. A further letter of explanation was written by Medical Director on 3rd September 2003 explaining the reasons why it was felt inappropriate to carry out the last operation. This explanation was rejected on 25th September 2003 and the complaint was referred to the Independent Review Panel.

Are there any other clinical issues that have not been addressed? If so, what are they?

None.

Are there any practical actions that could take place to provide a better explanation to the complainant? If so what would you suggest?

I believe that the complainants have had full proper and understandable answers to the clinical aspects of their complaint but I suspect that further local resolution will not be possible unless Mr M is able to attend.

Signed Dr AN Other Date 17th December 2003
2-E REPLY FROM THE REVIEWER

8th January 2004

PERSONAL
Mrs L P (complainant)
Address

Dear Mrs P

REQUEST FOR AN INDEPENDENT REVIEW

I am Mr AS, the independent lay reviewer who has been appointed to consider your request for an independent review of your complaint regarding the treatment and care given to your late husband, Mr GP, by staff working at the BLANK NHS Trust.

In order to carry out the independent review I, and an independent lay adviser who was appointed to assist me, have carefully considered all the documentation provided by yourself and the Trust. Advice has been sought from an independent clinical adviser about the appropriateness of the clinical care given to your late husband, and the extent of the action taken by the Trust when responding to your concerns has been assessed.

The outcome of this review is that I am not recommending that any further action be taken with regard to your complaint. The reasons for this decision are as follows:

The view of the independent clinical adviser is that your late husband received appropriate care and treatment, and that the documentation kept at the time shows that decisions regarding his treatment were discussed with you and your family. A copy of the independent clinical adviser’s report is attached for your information.

It is noted that a further surgical opinion was sought regarding the proposed care for your late husband, which agreed with the treatment plan proposed by Mr M, although this clearly failed to reassure you.

The Trust appears to have made every effort to respond to your concerns and criticisms as fully and openly. Full written responses have been given to the concerns you raised, and staff also met with you to try and allay your concerns. I do not believe that further correspondence will be beneficial at this stage, nor is a further meeting likely to offer any different explanation that will satisfy you. I note that you did not feel able to meet with Mr M, the consultant in charge of your late husband’s care, at the time of the meeting, but am satisfied that you received adequate answers to your questions from the Medical Director.
I appreciate that you may well be disappointed by the outcome of this review, but I do not feel that there are any further explanations that the Trust can give to help you, nor are there any underlying issues that warrant holding an independent panel.

You do have the right to refer your complaint to the Health Service Ombudsman requesting a review of the way in which your complaint has been handled, if you remain dissatisfied. Details of how to do this are attached.

I am extremely sorry that you have had cause to complain about the treatment and care your late husband received and my thoughts are with you and your family at this very difficult and sad time.

Yours sincerely

Mr AS
INDEPENDENT LAY REVIEWER

cc Chief Officer, CHC
Mr T J, lay Chairman
Chief Executive, BLANK NHS Trust

enc Anonymised version of independent clinical adviser’s report
Information about the Health Service Ombudsman
CASE STUDY 3 (Module 4)

3-A CHRONOLOGY OF COMPLAINT AT LOCAL RESOLUTION

19.03.03  Death of Mrs X
26.03.03  Mrs J meets with Dr Y, his registrar and the Trust Complaints Manager to discuss the care her mother received prior to her death
25.05.03  Letter from Mrs J to the Chief Executive of BLANK Hospital regarding the care her late mother received
27.09.03  Response from Chief Executive
16.11.03  Further letter from Mrs J reiterating her concerns
02.12.03  Further response from Trust Chief Executive (attached for information)
27.12.03  Further letter from Mrs J reiterating her concerns
17.02.04  Letter of 27.12.03 sent again, with covering letter
03.03.04  Response from Chief Executive, referring Mrs J to letters of 27.09.03 and 02.12.03
02.04.04  Letter requesting independent review requested (attached for information)

Note: The letters from Mrs J dated 25.05.03, 16.11.03, 27.12.03 and 02.04.04 highlight the same concerns regarding the late Mrs X’s care, so only the letter requesting an independent review has been reproduced in this case study.

Similarly, the letters from the Trust dated 27.09.03 and 02.12.03 cover the same issues, so only the latter has been reproduced in this case study.
2 April 2004

Dear Sir/Madam

**Re: The late Mrs X**

My mother, Mrs X, was admitted to BLANK Hospital on February 27\(^{th}\) 2003 and died on March 19\(^{th}\) 2003. During her stay at the hospital there were several issues with regard to her care that were of great concern to myself and family. I have been in correspondence with the hospital. Some of the omissions in my mother’s care have been acknowledged and apologised for. However I remain concerned about the lack of care & attention from both medical & nursing staff during the weekend of March 15\(^{th}\) –17\(^{th}\) 2003 and on the day of her death March 19\(^{th}\) 2003. I consider that there was negligence in my mother's care and that this has not been adequately acknowledged in the hospital correspondence and no steps taken to address these concerns.

There seems to have been a breakdown in communication between medical and nursing staff, lack of recording of vital data, lack of adequate concern and a lack of intervention during my mother's deteriorating condition. In addition there was a lack of communication with relatives when her condition became critical.

The specific complaints that I wish to bring to the Independent Review are to do with my mother's care on the weekend prior to her death and the lack of care & treatment in the hours leading up to it. The apologies given by the Trust do not go far enough and avoid some of the key issues. I want a specific acknowledgement of, and apology for, the following:

**The neglect over the weekend of 16\(^{th}\) and 17\(^{th}\) which: a) hastened my mother’s decline and death - through dehydration and rapid renal failure; b) caused unnecessary suffering.**

My mother's condition deteriorated seriously over the weekend and she became severely dehydrated. She had been vomiting and was showing signs of dehydration. However, no treatment was initiated over the weekend. The letter from the hospital concludes that no treatment was given because no treatment was required! I do not accept this.

**The failure to give prompt medical attention on the afternoon and evening of 19\(^{th}\).** In spite of her deterioration, no doctor saw my mother until the evening. I have received no explanation for the delay in the doctor’s attendance.
The failure to alert me and other relatives of her decline on 19th until after her death. I was therefore unable to be with her on her last evening. I phoned at around 4.00pm and was told that she was not too well but that there was no need for me to come. There was no attempt to contact me or other relatives.

I would also like to be reassured that necessary action has been taken to avoid a similar failure in care in the future.

Yours sincerely

I J (Mrs)
Dear Mrs J,

I am in receipt of your further letter of 16 November 2003, expressing your concern that the Trust’s letter of response to your complaint dated 27 September 2003 has not fully addressed all of your concerns.

I am sorry you felt we have not acknowledged the deficiencies you perceived in service delivery and the measures we would take to address them. The ongoing concerns that you have raised have been reviewed along with the Trust’s earlier response to your complaint and I hope the following additional information is helpful.

**Nursing care**

In our earlier response we have acknowledged and apologised for the inability to provide your late mother with a pressure-relieving mattress until several days after her admission. It was also noted that the nursing staff sought specialist advice from the Tissue Viability Nurse as to the best method of treating her pressure sores. I am sorry that they did not respond to your suggestion of using foam pads for her heals. Any such aids would be used only if they were proven to provide benefits to the well being of the patients. My earlier response did indicate that the ward nurses reported having changed Mrs X’s position as often as she was able to tolerate it.

With regard to assessment of Mrs X’s pain, my earlier response has indicated that all ward nurses will be reminded of the importance of assessing patients pain, recording their findings and giving adequate analgesia. The Trust does already have a specialist pain nurse who provides teaching and support for nurses at ward level, and it is hoped these additional measures will improve the service further.

**Communication**

In my response of the 27 September 2003 I extended my apologies to you for any lack of communication between the nursing staff and on-call medical team on the weekend of 16 and 17 March 2003. As you will be aware, and as you discussed during your earlier meeting with Dr Y and Dr P, the on-call medical team did not include any of Dr Y’s team. On reviewing Mrs X’s medical notes, which I understand you have a copy of, there is no reference either in the nursing or clinical notes to indicate that the ward staff had requested that Mrs X should be reviewed by a doctor or that a doctor had reassessed Mrs X’s condition at this time. I feel sure the nursing staff would have requested this if there had been any significant deterioration in Mrs X’s condition during the period.
Although Mrs X’s observation charts at the time indicate that her blood pressure was between 80-90 / 50-60 during the period, looking back at the blood pressure recordings since her admission, Mrs X was recorded to have a blood pressure ranging from 70-120 mm HG systolic. On the majority of occasions the systolic being between 80 and 90 mm HG. The nursing staff did not raise any concerns about Mrs X’s condition at the time and did not feel it necessary to ask the medical team to see her.

I fully appreciate your concern that following the weekend Mrs X’s condition deteriorated rapidly, however, there was no indication at this stage that the current treatment should be escalated or that further intervention was required. When Mrs X was seen on Monday 18 March no changes were made in Mrs X’s treatment plan. During the ward round on Tuesday 19th, following further assessment, appropriate adjustments were made to Mrs X’s medication and further investigations ordered. Had any further intervention been required at this stage it would have been arranged accordingly.

**Medical care / treatment prior to death on 19 March 2003**

In my response of 27 September 2003 a full and detailed explanation was given to you regarding the rationale for your mother’s treatment from the time of her admission. On the morning of 19 March the doctor assessing Mrs X’s condition noted her to be "well". He also noted that Mrs X had diarrhoea on two occasions that morning. In response to noting a reduced urine output he ordered additional intravenous fluid to be administered, changes in the medication and hourly urinary output to be monitored.

The records indicate that in response to extra intravenous fluid being given there was a slight increase in Mrs X’s urine output. There was no corresponding increase in Mrs X’s blood pressure. The nursing staff contacted the duty doctor at 16.00 regarding Mrs X and this is recorded in the nursing notes. At 20.00 there is no further record of the nurses having contacted the duty doctor to inform them about Mrs X’s condition. There is no reference in the medical notes to indicate that the doctors attended the ward at this time or that any changes to Mrs X’s treatment were ordered. The nurses were advised to monitor Mrs X’s blood pressure and the nursing records indicate that a nursing care plan was commenced at this time to monitor the same. You will note from my last letter that the Trust is implementing written guidelines to instruct all staff to record the details of requests for doctors to attend the wards and for a record of any action taken when there may have been no changes to the current treatment.

I accept that the absence of recording of vital signs after 21.00 on the night of your mother’s death is less than satisfactory. This does not mean however that the nurses were not monitoring your mother’s condition. It is not possible to determine whether more frequent or closer monitoring of your mother’s condition would have altered the outcome but I agree it would certainly have indicated and reassured you that the nursing staff were closely monitoring your mother’s condition if there was confirmation in the notes. In addition, as you correctly ascertained from your mother’s prescription chart, analgesia had
been prescribed to be given as required on a 4-6 hourly basis on 13 March. Although Mrs X is noted to have been complaining of abdominal pain at 21.00 on 19 March there is no indication that analgesia was provided. It is possible that it may have been offered but again there is no reference to this on the prescription chart. I can only apologise for the failure of the staff to make adequate records of the care provided to your mother at this time. With the absence of such records it is difficult to reassure you.

In conjunction with the Training Manager, the Nursing Director ensures that a comprehensive programme of in-house and external training days are available for all levels of ward staff where in particular the importance of comprehensive records is always emphasized. I will also ensure that we constantly reinforce this extremely important area of work.

I acknowledge your comments in relation to the necessity for robust procedures for the delivery and maintaining of patient care throughout the hospital. In the light of your concerns which I would wish to assure you I take very seriously the performance of the ward will be monitored very closely, in particular in relation to any other similar concerns that might be brought to my attention.

Whilst increasingly robust and prescriptive guidelines can be issued in respect of every aspect of patient care, it is important that staff adhere closely to them and I will do everything I can to ensure that this is the case.

I can only extend to you my most unreserved apologies for any shortcomings in the care provided to your mother during her stay on the ward. I do not feel I am able in add anything further but would like to reassure you that every effort is being made to put improved systems in place to ensure the accurate and effective monitoring of patient care.

Should you remain dissatisfied with any particular issues discussed in my additional response, please do not hesitate to contact me and request further clarification. Additionally you may wish to request an Independent Review of your mother’s case. I have enclosed a copy of the Trust's complaints leaflet outlining how to make such a request.

Yours sincerely

Chief Executive
BLANK NHS Trust
Dear Reviewer

Re: Independent Review Request concerning the late Mrs X
Complainant: Mrs IJ (Mrs X’s daughter)

I append below my Report as Clinical Adviser regarding this case: in doing so I have acted entirely on information supplied to me by the Independent Review Secretariat consisting of relevant Medical and Nursing Records, together with a record of subsequent correspondence dealing with the complaint.

I am also able to state that I have no personal knowledge of Dr Y, Consultant Physician to the BLANK NHS Trust, nor any other medical or nursing staff mentioned in the case.

I have acted, in drawing up this Report, in my capacity as Consultant Physician with an Interest in the Elderly. I am a GMC Accredited Specialist both in General Medicine and Geriatrics.

1. Overview

In summary, Mrs J is critical of both nursing and medical care in relation to her mother’s admission and, whilst admitting that she was dying, alleges that failure of medical and nursing intervention hastened her death, and that she may have suffered unnecessarily during the process. Mrs J also alleges that it should have been clear to nursing and medical staff that her mother’s condition was deteriorating rapidly, and that this should have been communicated to the family, allowing them to be with Mrs X at her death.

2. The complaints process

The process has been unduly protracted, and outside normal governance. The Trust has acknowledged this, citing several reasons, which include difficulty in obtaining a statement from a doctor who had left the Trust’s employ, and also Mrs J being away on holiday.

I note that a meeting took place on 26th March 2003 between Dr Y together with his Registrar, and the Complaints Manager. I was somewhat surprised that a senior member of nursing staff involved with Mrs X’s case was not present. It was admitted that the meeting was not able to resolve all outstanding issues.

Letters regarding the complaint from Dr Y and his Registrar, Dr W, are pertinent and full. I have no authenticated record of comment from Sister D, but do have a photocopy of a letter, written in longhand, which I presume to be from her. One page of this numbered either 139 or 159. The letter is
unaddressed and unsigned, but for the purpose of this Report I am assuming that it comes from Sister D. I did not find this Report satisfactory in itself, as it did not seem to touch upon all areas of concern: in addition, there is a statement that it is 'well documented in the nursing notes that the communication between doctors and nurses was clear'. I have to say that I see no such evidence of such communication. I am, in addition, concerned that there has been no further report from nurses who looked after Mrs X. In particular, I would have wished for a report from her Named Nurse (who is not actually designated on the Admissions Sheet).

Letters written by the Chief Executive, of the BLANK NHS Trust, are pertinent and in my view correct: the final response to the complaint is full and explicit considering the information supplied.

The subsequent request from Mrs J for an Independent Review is made with her statement that the Local Resolution Process has failed to address issues to her satisfaction, and indicates specific areas that she wishes to be addressed and, in particular, acknowledged and apologised for.

1. Clinical notes

The Medical Notes do not give me a clear understanding of the management of what was acknowledgeably a difficult case with no clear single predominant pathology. It is, in the main, impossible to determine the name of the doctor writing the entries, although 'bleep' numbers have been written by the entries in most cases.

There is a critical lack of written medical notes between the 15th and 18th March - the 'on-call' weekend in question. This lack of record contributes greatly to the difficulty in resolution.

4. Nursing records

The Nursing Records contain one 'overview' section, and many attached separate sub-sections relating to specific aspects of care, e.g. tissue viability, stool frequency, blood pressure, temperature recording, abdominal distension. This may be laudable, but the central record is often sparse and the process lacks cohesion.

5. Other comments

Mrs J refers to a conversation with a doctor on the 5th March which is not recorded in the Medical Notes, and may have been important.

Mrs J alleges that, over the last weekend, the family 'persistently raised concerns with nursing staff'. This is not mentioned at all in the nursing notes, and I think that this discrepancy needs to be addressed: I also draw attention again to the lack of medical notes during the critical period.
I note that Medical Reports state that Dr Y made himself available to speak to the family, and was available to speak to them by 'phone'. There is nothing in the Medical or Nursing Notes as to whether this availability was communicated to the family, and I have to presume, by inference, that the only medical communication with the family was at the pre-registration or Senior House Officer level.

6. Conclusion

The complainant is knowledgeable, and has gone to a great deal of trouble to make specific allegations, which in my view cannot be satisfactorily refuted by the information contained in Medical and Nursing Records. There has been an attempt at Local Resolution, which ended in an admission that not all outstanding matters could be resolved.

Any further attempt at Local Resolution would have to address outstanding issues. It would require evidence to be sought from nursing staff and doctors concerned with Mrs X’s care at what is now a year after her death, and with Medical and Nursing Records to draw on that may be thought to be deficient in key areas. Short of the Trust giving all benefit of doubt to Mrs J, and accepting the terms that she requires, I cannot see it likely that any further attempt at Local Resolution will lead to satisfaction on either side. The wording of Mrs J’s correspondence indicates very clearly that she believes that nothing further is to be gained by Local Resolution, and is determined to press for a Review.

It seems to me crucial that there is no evidence of full engagement of clinical staff with Mrs X’s family to form a cohesive management plan, and I suspect that it is this more than the specific allegations made that has led to this particular process.

In summary, I have to conclude that in this case, unless the Trust can act as above and satisfy Mrs J’s demands, a further request at Local Resolution, without evidence to satisfy either side, would be unlikely to resolve the matter.

At the same time, I have to say that I find it difficult to conceive that an Independent Review, because of the same constraints of lack of evidence, would be able to address satisfactorily outstanding issues. I initially considered, therefore, a recommendation that neither further Local Resolution nor an Independent Review Panel should be recommended. However, as a specific allegation of neglect has been made by Mrs J, I believe that this case cannot be left without further clinical advice, and it is for this paramount reason that I would, at the last, recommend that the Complainant’s request for an Independent Review Panel be granted.

Yours sincerely

Consultant Physician MA FRCP FRCP (Edin)
3-E NURSING ADVICE TO REVIEWER

[Received in IR Secretariat 26 April 2004]

24 April 2004

Re: Request for an Independent Review Panel with regard to Mrs X

I make this report in my position as Director of Nursing at BLANK NHS Primary Care Trust. I am a Registered General Nurse and Health Visitor. Our PCT provides and commissions elderly care services.

I confirm I have read the complaints file along with the nursing and medical notes for Mrs X during her admission to BLANK Hospital. In particular, I have analysed the concerns regarding nursing care highlighted in letters from Mrs J of 25/5/2003, 16/11/2003 and 27/12/2003 and responses made to these. I have limited my comments to whether the responses made by the Trust regarding criticisms of Nursing Care are full and satisfactory.

General Conclusion

Whilst BLANK NHS Trust appears to have responded in a generally open and transparent manner to the range of criticisms of nursing care, the responses are made largely from entries in nursing documentation. The one report provided by the Ward Sister again repeats much of the nursing care plan entries. I believe it would have been helpful to have interviewed at the Local Resolution stage nursing staff on duty during the critical period of Mrs X’s deterioration.

I also believe it would have been helpful if the Ward Sister could have attended the meeting with Mrs J which took place on 26/3/2003. This might have provided an opportunity to demonstrate multi-disciplinary team working in the care of Mrs X. Whilst there is no indication that there was significant disagreement between the nursing and medical staff about Mrs X’s management, there is little sense of a joined up plan for her care and this may have caused misunderstandings regarding Mrs X’s prognosis within the team and subsequently lack of clarity for her relatives.

Letter of 25/5/03

Main concerns re: Nursing Care are:
Absence of guidance on hypotension: Satisfactory explanation of the nurses’ actions in monitoring hypotension but no specific response to request for guidance on monitoring hypotension.
Pressure area: Satisfactory explanation re: actions taken to reduce risk of pressure area care. Not clear whether the delay in the Tissue Viability Nurse attending for assessment is significant.
Pain control: Satisfactory explanation of nursing actions but response appears to be based on entries in nursing records only. No staff interviewed to gain clearer picture of when and on what basis Mrs X declined analgesia.
Clinical Incident Recording: Satisfactory explanation.
Communication between nursing and medical staff: Apology provided but clearer explanation based on interviews of staff might have been helpful.
Monitoring vital signs after 21.00 on 19/3/2003: Not addressed in response from Trust –see later response.
Nursing Care Plans: Satisfactory explanation given

Letter of 16/11/2003

Pressure Area Care alternatives to mattress. Mrs J suggested foam pads - Satisfactory further explanation but interviews of nursing staff may have clarified suggested difficulties in positioning of Mrs X
Monitoring of vital signs after 21.00 on 19/3/2003: Satisfactory acknowledgement of the absence of monitoring of vital signs and that no analgesia was administered after 21.00 19/3/2003. However, interviews of nursing staff may have clarified precise nursing actions during the critical period.

Letter of 27/12/2003

Weekend prior to death: Mrs X’s deterioration over weekend and dehydration; no treatment was initiated over the weekend; no attendance by medical team over weekend; no evidence in nursing notes about Mrs X’s condition: Limited explanation given. Interviews of nursing staff may have clarified Mrs X’s presentation over the weekend 16th/17th March to explain why they did not feel it necessary to seek a medical opinion. The limited recordings in the nursing records for the weekend of 16th/17th March 2003 do not show that there was overall consideration of Mrs X’s combined symptoms and observations. It is not possible to tell from the records that there was an active decision that referral to medical staff for the weekend of 16th/17th March was not justified
Apparent disregard for concerns and requests raised by Mrs J and other relatives: Limited explanation given. Interviews of staff may have confirmed whether they intended to contact the doctor on Saturday 16th March as Mrs J suggests.
Lack of monitoring and recording over weekend: Satisfactory acknowledgement of concern with suggested action.
Neglect over weekend contributing to renal failure, hastening demise and causing unnecessary suffering: (Remark appears to be directed at medical staff).
Treatment prior to death on 19/3/2003: lack of attention by medical staff: (Remark appears to be directed at medical staff).
Failure to administer pain control: Satisfactory explanation given but as previously indicated - responses are based on entries in nursing records only. No staff interviewed to gain clearer picture of when and on what basis Mrs X declined analgesia.
Failure to monitor vital signs after 21.00: Inadequate response particularly in view of recording in nursing notes that daughter to be contacted once Mrs X deteriorated (see entry 17/3/2003). Interviews of staff might have clarified the extend of Mrs X’s pain in her last few hours and even if analgesia was offered
and declined what alternative steps the nursing staff took to alleviate Mrs X's pain.

I hope these comments in the report are helpful and please do not hesitate to come back to me if you have any queries.

Yours sincerely

Director of Nursing
Somewhere NHS Primary Care Trust in England
3-F REVIEWER’S LETTER TO COMPLAINANT

INDEPENDENT REVIEW SECRETARIAT

30th April 2004

PERSONAL

Dear Mrs J,

REQUEST FOR AN INDEPENDENT REVIEW PANEL re: the late Mrs X

I write further to recent correspondence and our telephone conversation relating to the above referral. Following consultations with the Lay Adviser, Mr B, and having received independent clinical advice on all aspects of your complaint, I am agreeing to set up an Independent Review Panel to consider your complaint against BLANK NHS Trust.

The Terms of Reference for the Panel will be-

1. To consider the adequacy of the medical and nursing care during the weekend of 15th/17th March 2003 and on 19th March 2003.

2. To consider whether or not there was a failure to alert next of kin of the serious decline of Mrs X on 19th March 2003.

3. Whether the apologies given by the Trust were adequate.

4. Where the Trust has already acknowledged inadequacies, to ensure that proper procedures are in place to avoid similar failures in future.

I would be grateful to receive confirmation that you are willing to accept the above Terms of Reference.

Following on from my decision, the appointed lay Chairman now takes full responsibility for the running of the Panel and all future contact will be done on her behalf.

The Secretariat Officer will shortly be making contact with all parties involved in the Review to discuss a mutually convenient venue and date to meet.

Yours sincerely

Lay Reviewer
Report of a Panel held to consider the complaint made of Mrs J, daughter of the late Mrs X, about BLANK NHS Trust held on Monday 30th June 2004

Panel membership
Chair
Members

Clinical assessors
Dr N M, Consultant Physician
Ms C R, Senior Nursing Sister

In attendance
Secretariat Officer

The parties
Mrs J, accompanied by her husband and the CHC Chief Officer
Dr Y, Consultant Physician, who was accompanied by a representative from the Medical Defence Union
Sister D, Senior Nurse, who was accompanied by the Trust’s Director of Nursing.

1. Summary of the complaint

The complaint is about nursing and medical care provided to Mrs X from Friday 15th March to Tuesday 19th March when she died. While she was dying, Mrs J feels that the failure of medical and nursing intervention hastened her death and that may have suffered unnecessarily during the process. Mrs J also alleges that it should have been clear to medical and nursing staff that her mother’s condition was deteriorating rapidly, and that this should have been communicated to the family, allowing them to be with Mrs X at her passing.

2. Terms of Reference

- To consider the adequacy of the medical and nursing care during the weekend of the 15th – 17th March 2003 and on the 19th March 2003.
- To consider whether or not there was a failure to alert next of kin of the serious decline of Mrs X on the 19th March 2003.
- Whether the apologies given by the Trust were adequate.
- Where the Trust has already acknowledged inadequacies, to ensure that proper procedures are in place to avoid similar failures in future.

3. How the panel proceeded

The papers circulated to all parties included the statement of complaint and clinical advice provided to the Reviewer. Mrs X’s health records were available.
4. Terms of reference

4.1. *Was the Medical and Nursing Care adequate during the weekend of the 15th-17th March and subsequently on the 19th March 2003?*

4.1.1 Mrs X was an ill, elderly frail woman in whom a malignancy was suspected. Investigations for cancer were timely and appropriate and the family were kept informed of the findings. Specific reference is made to them being seen and Mrs J confirms this.

4.1.2 Mrs X was on a busy general medical ward. It was noted from Sister D that a nurse workload tool is in place and that the majority of patients had a medium to high dependency rating.

4.1.3 Both Dr Y and Sister D considered that there is normally good communication between nursing staff and doctors on the ward. On this particular weekend Dr Y and his registrar were away at a conference. However, they had arranged for Mrs X’s care to be covered by another medical team and in fact, Dr Y had phoned his secretary on the Friday morning to confirm that this was the case.

4.1.4 Mrs X was seen on Friday 15th after being informed by the nursing staff that her blood pressure was low (noted in nursing care plan under problem “patient’s blood pressure is below acceptable levels”). BP was noted in medical notes to be 70/50 and instruction to repeat in an hour written. The following entry states “BP still low, commenced on gelifusion” However there is no evidence that this was scripted or given. There is no entry prescribing gelifusion to be administered on the 15th on any of the Intravenous fluid charts supplied. There are no written entries in the nursing notes regarding Mrs X's BP later in the day following review by the medical staff or any subsequent management. However further recordings on the TR and BP chart shows Mrs X's BP did increase over the day. Four hourly recordings were requested on the TPR chart. This was acknowledged by the Trust and apologised for.

4.1.5 It had also been noted on the 15th that Mrs X had 'vomited at lunchtime and Dr informed’. She also had 2 episodes of diarrhoea 1 watery (03.00) and 1 soft (11.00am) loperamide 2mgs was given at 12.45pm.

4.1.6 On the 16th March Mrs X’s blood pressure was taken 3 times and, although low, remained steady. Mrs X was having Ramipril which whilst maintaining a low BP would have been prescribed to increase her cardiac output. The nursing notes detail that Mrs X continued to have moderate amounts of watery stools on 5 episodes. Loperamide 2mgs was given at midday and 22.00pm. It is noted that a stool specimen was taken in the morning but there is no entry regarding the rationale for the decision to move Mrs X into a side room during the afternoon or that the family were advised of why.

4.1.7 The Weekly Fluid Balance chart total for the 16th details as intake 1,000 mls, output 100 mls. There is no subsequent recording in the nursing notes that the very low urine output had been noted or concern raised.
There is no indication of a failure to record a volume of urine on the fluid balance chart.

4.1.8 On Sunday 17th March Mrs X's BP was recorded on 3 occasions. One episode of diarrhoea is recorded. It was noted that Mrs X vomited at approximately 7pm. The detailing of the vomit as milky reflects the ongoing observation following the possible episode on 15th.

4.1.9 There is no entry in the nursing notes detailing Mrs X’s overall condition for Sunday 17th or any of the concerns Mrs J stated to the panel that she had reported. It is noted that the nursing records detail that Mrs X was sat out of bed during the 17th.

4.1.10 On the night shift of the 17th March it is recorded in the early hours of 18th 05.00 in the nursing notes that Mrs X was commenced on intravenous fluids due to her low fluid intake. Maxalon was also scripted and given at 22.00 to relieve further nausea and vomiting. Whilst Mrs X’s intake had slightly increased during 17th to 1,200 mls her urine output for the 17th remained very low at 150 mls.

4.1.11 On Monday 18th there is evidence that Mrs X was reviewed by the house officer. Instruction is detailed on the drug administration chart that Ramipril was to be omitted for that evening. One possible cause for her lowered BP would be a side effect from the medication. No further intravenous fluids were prescribed. There is no documentation indicating that Mrs X’s low urine output was noted. No summary of Mrs X’s fluid balance was recorded for the 18th on the weekly fluid balance chart.

4.1.12 Only two BP recordings were completed during the 18th. The morning one is consistent with the readings obtained the day before. The latter one 22.00. shows a further drop to 70/50. No explanation was offered to the Panel as to why the recordings had not been completed but the shortfall was noted by the Trust. There is no written entry to illustrate that this was noted or whether there was a need for medical review. There is again no overall summary of Mrs X’s condition for any part of the day, however Mrs J was informed that she was not so well but had a drip up. Mrs X’s visitors reported that she appeared “brighter”.

4.1.13 On Tuesday 19th March approximately midday Mrs X was seen by the staff grade and reviewed. The subsequent medical management of Mrs X’s condition and further deterioration is well documented in the nursing and medical notes. It is evident that she was frequently and appropriately reviewed.

4.1.14 Overall it has only been possible to gain fragmented information about the overall management of Mrs X’s condition for the identified time period. Both the nursing and medical records are very poor. Key decisions regarding Mrs X’s management are not detailed in the medical notes and the nursing notes are extremely disjointed. It is difficult to gain a clear comprehensive picture of Mrs X’s conditional changes and subsequent medical and nursing management.

4.1.15 It is considered that the medical and nursing care received by Mrs X on the 15th to 19th was adequate but in the following areas not optimal. Reporting of diarrhoea on the 16th and very low urine output from the 17th March. Recording of BP particularly on the 18th.
4.1.16 Whilst it is not considered that there is any evidence that Mrs X ‘suffered’ as a result of these shortcomings or that the outcome for Mrs X would have differed, they clearly added to Mrs J’s distress at not being able to be with her mother when she died.

4.1.17 Although it was stated to the Panel by both Dr Y and Sister D that communication is good on ward between the medical and nursing staff there was very little evidence to illustrate this in Mrs X’s documentation.

4.2 **Whether there was failure to alert the next of kin about the serious decline on the 19th March.**

4.2.1 Overall the evidence of communication with Mrs X’s family and recognition of their concerns is extremely poor. Pertinent information regarding conversations between Mrs X’s family and the ward staff was not recorded.

4.2.2 Mrs X’s condition had deteriorated over the weekend and she remained unwell on Monday 18th. Blood tests at the time suggested that she was dehydrated though by then intravenous fluids had been commenced. Furthermore the drugs that could be contributing towards her deterioration were discontinued. Despite this she did not improve on the following day and had a very poor urine output. she had also developed diarrhoea. In retrospect, many of these symptoms are manifestations of severe heart failure. However, the family were not specifically informed as to how ill Mrs X was.

4.2.3 From Sister D’s discussions with the nurses she considered that they were aware of Mrs X’s overall condition but felt, on the basis of their experience, that this was not immediately life threatening. Whilst they were aware that she was ill with a possible underlying cancer they felt her condition was stable over the weekend and on the basis of observations did not anticipate imminent death. In fact, there was some surprise at her sudden death on the 19th.

4.2.4 Whilst her death may not have been anticipated it should not have been excluded as a possibility. Mrs J’s perception that this was not recognised by the nursing staff was a significant element of the complaint. Unfortunately the nursing documentation provided no evidence to dispel this. It could not be demonstrated to Mrs J that the nursing staff appreciated her concerns both for her mother and that she lived a distance away.

4.2.5 No phone call was made to any members of Mrs X’s family on the evening of the 19th when she further deteriorated and needed to be seen by the on call Doctor.

4.2.6 It is considered that the ward staff failed to inform Mrs X’s family fully of her conditional changes during the 19th and that by waiting for the family to ring lost a opportunity for them to make arrangements to be with her.

4.2.7 It is very regrettable that despite Mrs J’s request on the 17th to be advised of any deterioration in her mother’s condition she was not contacted on the evening of the 19th when she was deteriorating further. It presents as a further example that communication on the ward could be improved. Whilst it might not have been possible for her
to have reached her mother in time her family members who lived locally could have been with her.

4.3  **Whether the apologies given by the Trust were adequate.**

4.3.1. As well as the events of the 15th to 18th March, Mrs J had previously brought up a number of other issues. It is considered that a more thorough investigation and response from Sister D to the Complaints Manager would have demonstrated to both Mrs J and the Panel that the areas of concern raised were considered fully. In addition there would appear to have been no attempt to arrange a meeting with Mrs J to discuss her concerns regarding the nursing aspects of Mrs X’s care.

4.3.2 It is considered that on each occasion an appropriate apology was made. Where apologies were necessary, information was given as to what steps would be taken to prevent this happening again.

4.4  **Has the Trust, having acknowledged inadequacies, ensured that the proper procedures are in plan to avoid similar failures.**

4.4.1 A major failing in the medical notes is lack of documentation particularly concerning the weekend in question. The Trust now produces a hand book for all new staff which gives specific instructions about their duties including the need for clear documentation. In addition all staff have an induction course and this is stressed as part of their training. If medical staff do not follow these instructions they will be held liable for their actions.

4.4.2 The nursing documentation was also extremely weak. There was no care plan reflecting Mrs X’s overall condition, or potential for further deterioration or communication with Mrs X and her family about her progress and management. Consequently the nursing documentation is considered very poor. The Trust reports that it is being urgently reviewed.

4.4.3 The development of guidelines for staff in respect of documenting communication about a patient’s medical condition detailed in the Trust’s response of the 27th September was considered. However there was no clarity that guidelines regarding documentation of communication with relatives were also being completed.

4.4.4 It was noted that the Trust has now compiled guidelines regarding the investigation of received complaints and a day course that had been established to support this. There was no explanation as to why Mrs J wasn’t at that time offered a similar meeting with Sister D to discuss the nursing issues as a way of achieving local resolution.

4.4.5 It is considered that the Trust is putting in procedures as a consequence of the issues raised in Mrs J complaint. A commitment to ongoing staff training and evaluation of these measures will be necessary to ensure similar failures are avoided.
5 Conclusions

5.1 The medical and nursing care received by Mrs X on the 15th to 19th March was adequate but in the following areas not optimal. Reporting of diarrhoea on the 16th and very low urine output from the 17th March. Recording of BP particularly on the 18th.

5.2 Communication between the nursing and medical staff regarding Mrs X's conditional changes and subsequent management was poor.

5.3 Communication between the nursing staff and Mrs X's family was poor. The family were not specifically informed as to Mrs X's severe heart failure or how ill she was.

5.4 The ward staff failed to inform Mrs X’s family fully of her conditional changes during the 19th and that by waiting for the family to ring lost a valuable opportunity for them to make arrangements to be with her.

5.5 Both the medical and nursing documentation was very poor particularly for the period 15th to 18th of March. A clear picture of Mrs X’s overall condition and management can not be obtained.

5.6 A comprehensive investigation of the nursing elements of the complaint was not evident.

5.7 The Trust has recognised the shortcomings the complaint has illustrated and is putting some measures in place to help avoid a similar failure.

6 Recommendations

6.1 Audit measures are put in place to monitor the anticipated improved effectiveness of guidelines regarding communication between medical and nursing staff.

6.2 Guidelines are put in place regarding communication with relatives by nursing and medical staff and its subsequent documentation

6.3 Training and development opportunities are made to support staff in implementing the above.

6.4 Timely review of the nurse documentation format is pursued.
**3-H FEEDBACK ON INDEPENDENT REVIEW**

**Feedback from Mrs J, the complainant**

We would be grateful if you could complete and return this form in the enclosed pre-paid envelope. The information you provide will enable us to make necessary improvements to the service.

Please read the comments and tick the appropriate box. If you would like to make any other comments, there is a space for this on the other side of the form.

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**The member of staff who dealt with your case**

- The member of staff was courteous [✓] [ ]
- The member of staff clearly explained the process [✓] [ ]
- The member of staff was helpful [✓] [ ]

**The Reviewer**

- The Reviewer was impartial and fair [✓] [ ]
- The Reviewer acted promptly [ ] [✓]
- The Reviewer clearly explained his/her decision [✓] [ ]

**Independent Review Panel meeting**

- I felt able to give my point of view [ ] [✓]
- I felt I was listened to [✓] [ ]
- I felt happy about the way the meeting was structured [ ] [✓]
- I was happy with the venue and arrangements [✓] [ ]

**General Information**

- I found any written information helpful [✓] [ ]
- I was treated fairly [✓] [ ]
- I was kept informed of progress [✓] [ ]
- I was satisfied with the outcome of independent review [ ] [✓]
Please give details of your experience of Independent Review and any other comments you wish to make, especially anything that might help others in similar circumstances in the future, in the space below:

The Process:

- The Secretariat Officer was helpful throughout the whole process, providing us with information, answering queries and reassuring us when we had any concerns about the review process.

- The process was unnecessarily lengthy.

- The draft report of the Independent Review Panel meeting was poorly written, disjointed and demonstrated a limited grasp of the important issues.

The Review Meeting:

- The lay chairman facilitated well, intervening to keep the clinical interviewers focussed on the terms of reference.

- The two lay members, apart from the chairman, remained silent throughout, which was disconcerting and we were left unsure of their contribution to the process.

- There was no opportunity at the commencement of the meeting to state my concerns and I was immediately subjected to a detailed questioning process. This was compounded due to time pressures on the part of the panel and we were aware of being rushed through the process towards the close of the meeting.

Name (optional): Mrs J (complainant)

Date 12/09/04
CASE STUDY 4 (Module 4)

4-A PANEL PAPERS

A panel will be held on 6 August 2004 in Committee Room A at the BLANK Conference Centre to consider the complaint of Ms MS about Dr W

Panel Chair: Mr A
Panel Members: Prof C (Reviewer), Mr D
Clinical Assessors: Dr E, General Surgeon and Dr F, General Practitioner
Independent Review Secretariat: Mrs Q
Parties: Ms MS - complainant (accompanied by a representative from the CHC)
Mr JJ - her partner (supporter)
Dr W - GP Practitioner complained against (accompanied by a representative of his defence body)

The following papers are attached:

1. Ms S’s IR request to the Local Health Board 14 January 2004
2. Response to the Local Health Board from Dr W 22 January 2004
3. Clinical advice received by Reviewer 5 March 2004
4. Terms of Reference for the Panel

The papers also include the following that are not included in the case study: photocopies of Ms S’s health records from the GP practice and several hospitals, including a discharge summary dated 27 June 2003 and photocopies of letters to Dr W from consultants at hospitals X and Y.

A covering note from the Secretariat gives this additional information:

- **Referral to General Medical Council**
  Ms S has already made a complaint to the General Medical Council on 21 August 2003. The GMC has advised the Secretariat that the IR panel should proceed in parallel with its own investigation (should it decide to undertake one) and it should be sent a copy of the panel's report.

- **Attempted conciliation**
  Dr W was willing to attempt conciliation. The complainant also appeared to be willing, but following a preliminary discussion with the conciliator on 17 December 2003 she decided against it. She said she did not believe it would address the issues about which she was most concerned. Her request for IR followed after the intervening Christmas holiday.
1. **Ms S’s Request for Independent Review**

14 January 2004

To: Complaints Manager, Local Health Board

Further to my meeting with the conciliator, I should like someone to consider my request for an Independent Review. My concerns are briefly outlined in this letter, and I also request that past correspondence with Dr W is reviewed, together with my hospital records before making any decision.

My main concern is that when my partner Mr J and I contacted Dr W in July last year regarding my swelling, breathless state and immobility he prescribed a medication but did not believe it appropriate to visit me (although I had undergone major heart surgery only weeks before which he knew all about). As I have stated previously, prescription of a medication without consultation in these circumstances is completely unacceptable practice, especially as my symptoms were consistent with a blood clot, which I understand is a post-operative risk. I believe Dr W should have visited me on this occasion. He states that his actions were practice policy and I therefore feel this should be reviewed as a matter of urgency to ensure that no other person is put in my position. Had I not used my own initiative and relied upon the GP’s diagnosis the consequences could have been fatal for me.

I am also concerned about Dr W’s attitude and manner displayed towards me prior to my heart surgery, especially when I encountered resistance from him to have the initial chest x-ray (which, ultimately, determined the need for immediate surgery). He states that this was simply due to concern for my health with regard to the risk of radiation, although this was not mentioned to me at the consultation (a risk I would have been prepared to take, if asked).

The practice policy with regard to patients’ notes also concerns me, as it is the doctor’s responsibility to review these and put all the necessary information on the computer so that the notes can then be kept in storage. It is essential that medical records are accurate and up to date especially if the originals are not made available for consultations.

I am taking this action in an attempt to ensure that no one else is again put in the same position as me. I am an incredibly fortunate individual to have survived this post-operative ordeal and which I believe would in large part have been unnecessary had proper procedures been adopted by Dr W and his practice.

I look forward to hearing from you. Thank you in advance for your assistance.

Ms MS

*Enclosures* - previous correspondence with Dr W and copies of his responses (not included in case study)
2. **Response from Dr W**

The Local Health Board copied Ms S’s letter to Dr W asking for his comments. He replied as follows:

22 January 2004

Dear Sir/Madam

**Re: Complaint from Ms S**

Thank you for your recent letter regarding Ms S’s request for an independent review of her complaint. I presume you already have copies of my letters to her and her partner, but I will enclose further copies with this letter. In them I think I have replied fully to her complaints though clearly without satisfying her. I would like to point out the following:

1. I disagree that there was any failure on my part to treat her chest infection and asthma correctly. In normal circumstances I would not have requested a chest x-ray when her condition was clearly improving. The report clearly states that the lung fields were clear. The discovery of her aneurysm was fortuitous. It was clearly not of very recent onset and was not the cause of her symptoms.

2. I disagree that there is any problem with the practice policy of summarising patient MREs and entering the information in the computer record. Her rather inadequate records were promptly and properly summarised by me on the very day they were received from the health authority in 1998.

It seems to me that neither of these two elements are proper concerns for a full IR panel.

3. I regret, in hindsight, that I did not visit on 9th July after her partner rang to speak to me during the dedicated phone in time at the practice. I did not detect the urgency of the problem, neither do I recall being asked to visit. Had a visit been requested in the normal way I would of course have visited. I did advise her partner that she would need to be reviewed and I assumed that she would make an appointment for the following morning surgery (9th July was a Wednesday and we have no regular PM surgeries on Wednesdays) or call again for help. I was not given the impression that she would not attend the surgery.

I am very sorry that Ms S had to undergo surgery for her aneurysm and very sorry that she developed thromboses and emboli. I can well understand her suffering and subsequent anger. I think that this matter might indeed be the
subject of an Independent Review, so that the facts of the very complex case can be properly examined and understood.

I understand that Ms S has written to the General Medical Council.

Yours sincerely

Dr W
3. **Clinical advice**

Name of Adviser: Dr AN Other  
Position: General Practitioner

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**Was the explanation given to the complainant adequate? If not what additional information should have been given to the complainant relating to each element in the complaint?**

Ms S’s complaint against Dr W relates to his management between March 2003 and the time of her admission of hospital with pulmonary embolus on 12th July that year.

**Complaint about diagnosis and treatment of initial pneumonia condition**  
The complainant says Dr W rejected her request for a chest x-ray. Dr W says he was reluctant because of well-recognised radiation risks from unnecessary x-rays. That was a reasonable response from the GP at this stage of a chest infection. But it should be noted that Dr W did not appear to advise Ms S of his reasons for not acceding immediately to her request and this may have caused confusion and resentment in the patient and her partner.

**Complaints about lack of post-operative GP support**  
The complainant says that, following an operation for false aneurysm on 14th June, there was resistance from Dr W to their request on 2nd July 2003 for a district nurse to visit and remove Ms S’s stitches at home. Dr W points out there was no indication that a home visit was required as the discharge summary did not indicate it would be necessary. This is an adequate response based on the information Dr W had about the patient.

The complainant says no routine visit was made after Ms S’s discharge from hospital. Dr W confirms that it is not routine for GPs to do this. This is an adequate response as it is in line with what the majority of GPs in this country do.

The complainant says there was no consultation after a call made to him by Mr J on Ms S’s behalf on 9th July 2003. Dr W notes that at the time he recommended that Ms S be seen in the surgery and that he prescribed a small dose of a diuretic. He asked that she come to the surgery where he could review her treatment. Dr W says he did not know of the degree of her immobility and that it was proper to prescribe a low dose diuretic without examining her in these circumstances. This is an adequate response as it is what most GPs would do.

The complainant says that they had to arrange Ms S’s admission to hospital on 12th July when this should have been the GP’s responsibility. Dr W has responded that as he had no further contact with Ms S or her partner after 9th July, it would have not been possible for him to arrange a hospital admission. Given the circumstances, this is a reasonable response.
The complainant says that after informing the surgery of the emergency admission above, Dr W did not telephone to find out how Ms S was. Dr W explained that he did not know of the admission and would only receive notification from the hospital on a patient’s discharge. This is normal practice, so in the circumstances I cannot see how Dr W could have replied otherwise.

**Summarising records on the practice computer system**

Ms S complains that her computerised records were incomplete and omitted a case of suspected pneumonia some years earlier. Dr W replied explaining how his “paperless practice” scanned in her records in 1998 which were relevant and that the details from 1995-96 she mentioned were not pneumonia but a chest infection. This is a reasonable response.

Are there any outstanding issues not dealt with in the reply? If so what are they?

The complainant has fundamental disagreements with Dr W about key events and his perception of their importance. The most contentious issue is the management of the telephone call on 9th July. This has not been resolved. It is not possible to be certain from the information available whether a home visit was indeed necessary. Perhaps Dr W could be criticised for leaving the decision to the patient rather than insisting that she attend the surgery. But his decision to prescribe a diuretic was, in retrospect, correct. He should have followed this up with a clinical assessment either on that day or the day following. He recognises this in hindsight.

Are there any other clinical issues that have not been addressed? If so, what are they?

I do not believe there are any outstanding clinical issues that have not been adequately dealt with in Dr W’s replies. The management of her presenting condition in March 2003 seems to have been appropriate.

In June 2003 Ms S’s aneurysm was repaired at a specialist referral centre. In July 2003 she presented with breathlessness and swelling of the ankles and was admitted to a local hospital. Pulmonary embolism - when a clot forms in the veins of the legs or sometimes the pelvis and detaches itself before lodging in the lungs thereby obstructing blood flow - was diagnosed. She deteriorated and nine days later required ventilation. She recovered and appears to be making good progress.

Are there any practical actions that could take place to provide a better explanation to the complainant? If so what would you suggest?

In my opinion Dr W has fully answered all the complaints.

Signed: Dr AN Other Date: 5 March 2004
4. Terms of reference

COMPLAINANT: MS MARY S  
PRACTITIONER COMPLAINED AGAINST: DR W

The following terms of reference were agreed by the complainant and supplied in advance of the panel to the practitioner complained against:

1. To review and report on the care received by Ms S from Dr W of Somewhere Health Centre from March to July 2003.

2. To determine whether the care provided by Dr W, given the complainant’s health history, was of a standard which could be reasonably expected.

3. To consider the following particular issues relating to Dr W’s management of Ms S’s condition:
   
   • the nature and implications of Ms S’s presenting symptoms in March 2003
   • her care requirements in the period immediately after she returned home following her operation in June 2003
   • the summarising of Ms S’s notes onto the practice computer and the practice’s policy regarding this
   • the management of the telephone call from Ms S’s partner on 9th July 2003

4. To advise the practitioner concerned and any appropriate NHS bodies of recommendations following the review which could improve the care of patients.
Panel Chair:  Mr A
Panel Members:  Prof C (Reviewer),  Mr D

Clinical Assessors: Dr E, General Surgeon and  Dr F, General Practitioner

Independent Review Secretariat:  Mrs Q

Parties:  Ms MS - complainant (accompanied by a representative from the CHC)
            Mr JJ - her partner (supporter)

            Dr W - GP Practitioner complained against (accompanied by a representative of his defence body)

1. Summary of the complaint

At the age of 6, Ms S underwent correction of the cor triatium and repair of an atrial septal defect. This is a condition in which an extra membrane forms in one of the upper chambers of the heart and in Ms S’s case, was associated with a hole between two normal atria. It appears that she made a normal recovery from this operation. It appears also from her notes that she consulted her GP infrequently over the years. Ms S is now 37 years of age.

In March 2003 she consulted Dr W about a flu-like illness. She made several visits during March for fresh antibiotics and then requested a Chest X-Ray. As a result of this X-Ray, an operation for a false aneurysm (a situation where blood leaks out of a small hole in the artery and forms a “haematoma” or a collection of blood. This becomes encased in scar tissue and can continue to grow.) was performed 14th June 2003.

After her return from hospital a phone call was made by Mr J on 2nd July requesting a visit by a nurse to remove the sutures, then a call was made on 9th July 2003 reporting that Ms S was breathless and had swelling of the ankles. She was subsequently admitted to hospital where a diagnosis of a pulmonary embolism was made. This is a condition in which a clot forms in the veins of the legs or sometimes the pelvis and detaches itself and lodges in the lungs, obstructing the blood flow.

After her admission her condition deteriorated such that 9 days later she required help with her breathing in the form of artificial ventilation. She subsequently recovered from this and appears to be making good progress.
Ms S’s complaint is about the treatment she received from Dr W from the time of her first appointment in March for a chest infection to the last phone call on 9th July reporting her symptoms of breathlessness and swelling which resulted in her self-admittance to hospital for a pulmonary embolus.

Terms of Reference for the Panel

The Panel was asked to:

1. Review and report on the care received by Ms Mary S from Dr W from March to July 2003.
2. Determine whether the care provided by Dr W, given the complainant’s health history, was of a standard which could be reasonably expected.
3. Consider the following particular issues relating to Dr W’s management of Ms S’s condition:
   • the nature and implications of Ms S’s presenting symptoms in March 2003
   • her care requirements in the period immediately after she returned home following her operation in June 2003
   • the summarising of Ms S’s notes onto the practice computer and the practice’s policy regarding this
   • the management of the telephone call from Ms S’s partner on 9th July 2003
4. Advise the practitioner concerned and any appropriate NHS bodies of recommendations following the review which could improve the care of patients

How the panel proceeded

The panel met for one full day on 6th August 2004 at the BLANK Conference Centre with its two clinical assessors, one a GP and one a general surgeon. Both the complainant, Ms S, who was supported by her partner Mr J and accompanied by a representative of the Community Health Council and Dr W, who was accompanied by a representative of his defence organisation were present for all the interviews.

No witnesses or written statements were required.

The full complaints file and clinical records were available for Ms S’s GP and hospital care.

Copies of relevant sections of the draft report were circulated to the parties for their agreement.
Terms of reference

1. The nature and implications of Ms S’s presenting symptoms in March 2003

Findings of Fact

Ms S had had cardiac surgery as a child. Ms S was asked about the follow up to her cardiac surgery as a child, though she was no longer under a specialist.

On the Monday 5 March Ms S went to her GP with a chest infection. He examined her and prescribed medication. She had had a cough for many years, but had not been informed it was asthma. Dr W diagnosed her as asthmatic and prescribed inhalers.

She visited her GP again at the end of her week of rest (9.03.03), but then her fever symptoms returned and she saw her GP again (23.3.03) and he gave her antibiotics for a chest infection.

She asked her GP for a chest x-ray (27.03.03). Her GP was not keen for her to have an x-ray, but after some discussion arranged for a chest x-ray the next day. When the results came back he referred Ms S to Dr T at BLANK NHS trust and she had an appointment in April.

She had another chest x-ray, which again showed something, and she was told it might be related to her previous history. She had a CT scan the next day and it showed an aneurysm in the ascending aorta, she was admitted to hospital and, after discussion, it was agreed she should transfer to another hospital to see a specialist.

Ms S felt that Dr W’s attitude was dismissive and bullying. Dr W was not aware of this problem until after the first chest x ray. Ms S was concerned that Dr W was not aware of her medical history and her early cardiac surgery was not included in the summarised computer notes. The Panel asked about history taking. Dr W said that he knew she had a heart defect, but it was not at the front of his mind – he was looking at respiratory problems.

Conclusions

Ms S is a lady with an unusual history of major cardio-surgery as a child. This had led her to be fearful of chest infections. It would have been sensible to have given her a full and detailed assessment at this stage and sent her for a chest X-Ray if only to allay her fears.

Medical care was appropriate for a chest infection on 5.3.03. The Panel thought the change of antibiotic to Doxycycline was appropriate for an atypical chest infection.
The Panel found elements of disagreement about the first consultation. Ms S was certain that pneumonia was discussed even then. Dr W admitted that pneumonia was discussed at one of the consultations.

2. Ms S’s care requirements in the period immediately after she returned home following her operation in June 2003

Findings of Fact

Ms S was discharged from hospital on 26th June 2003. Mr J took a copy of the discharge sheet to the surgery on the 28th June. On the discharge sheet there was no indication regarding the removal of the sutures, nursing requirements and post-operative care.

Mr J called Dr W asking for someone to call round and remove the stitches. Dr W asked Ms S to attend the Surgery. After some discussion Dr W agreed to send a Nurse in to remove Ms S’s sutures on the 2nd July.

Dr W did not receive a full discharge summary or any other correspondence from the hospital consultant as these had been incorrectly addressed. No arrangements had been made for removal of the stitches.

Conclusions

The panel found that there was no communication at all between the tertiary care centre performing the surgery and primary care. The cardiac surgery unit had not informed the general practitioner of any specific requirements or warnings that might have been necessary to ensure her full recovery. In light of this, it was reasonable for Dr W to ask Ms S to come to the surgery to have her sutures removed.

The Panel saw the practice leaflet and thought that it needed to be updated to give more information about visiting policy and telephone consultations after 10am.

3. Summarising Ms S’s notes onto the practice computer and the practice’s policy regarding this

Findings of Fact

Practice policy on receipt of a new patient’s notes was for them to be summarised onto the computer.

Vital letters were kept and were scanned in but sometimes there were problems and the dates or other information was missing. The quality of the summarisation was sometimes inadequate.

Conclusion

The practice’s IT policy has some room for improvement.
4. **The management of the telephone call from Ms S’s partner, Mr J. on 9th July 2003**

**Findings of Fact**

There was no communication between Mr Jones’s call for the sutures to be removed on 2nd July and his call on the 9th July to the surgery as to Ms S’s progress.

A few days before the telephone call on the 9th July, Ms S had experienced declining mobility. Her ankles and limbs were swelling up and then she became breathless. Mr J said he was so concerned he rang the Surgery to speak to Dr W. He described Ms S’s symptoms and felt that Ms S needed an examination.

Dr W did not think a visit it was necessary as he did to think it was DVT as both legs were involved. He had prescribed Frusimide, a diuretic, for the swelling and told Mr J he could get it from the Surgery, that Ms S should take the medication, the situation should be monitored and he should be contacted again if the situation deteriorated. Dr W regretted, in hindsight, that he had not visited.

On 12th July Ms S was violently sick. Mr J rang the consultant and she went to the hospital by ambulance.

**Conclusions**

The Panel found that Dr W had not understood the urgency of Mr J’s call for advice. He had not put himself in the position where he could know all the facts and therefore make a full assessment of the patient. Though prescribing Frusimide was the correct medication, he should have visited himself to ascertain the situation.

Normally patients are expected to phone before 10am to ask for a visit. The time the call was made was for “phone consultations” at the surgery and this contributed to the misunderstanding. However, the system of "telephone advice time" and “telephone for visits time” had not been made clear to patients and was not addressed in the practice booklet.

Overall doctor-patient contact was dysfunctional whether from communication failures or personality clashes. Hospital failures to fully inform the GP about likely post-operative problems and care needs made this worse. Clear channels of referral back to hospital if things went wrong were lacking because the tertiary hospital failed to involve the local hospital who made the referral for surgery. This meant that essentially no one was in charge of post-operative care and surveillance.
Recommendations for service improvements

Advice to the Practice

Practice systems

The practice could explore the possibility of a register with details of patient admissions and discharges. Any actions necessary could then be flagged up on a regular basis, such as the need for follow up, nursing care, suture removal or similar recommended requirements.

The practice booklet needs to clarify the practice policy as regards the telephone advice line and requests for urgent advice. Perhaps the advice line needs to have a different number to avoid confusion.

The quality of “phone in” sessions needs to be assessed and monitored. Every patient’s needs must be met with by appropriate and thorough assessment. The skill in triaging techniques needs developing.

IT management and health records

IT management within the practice should be improved. Important letters regarding a patient’s history if not scanned in full, should be retained for reference purposes. Hospital admittance books to be kept with follow-up notes etc.

The practice may benefit from advice from a local general practice department or the RCGP about “best practice” as regards computerised records. The practice are advised that no paper records are ever destroyed during the process of computerisation of records. The medical envelopes move with patients. They are devised to hold all the information from “cradle to grave”.

Communication skills

Dr W admits to abruptness at times. This, we feel, may have led to some communication difficulties in this case. He may consider discussing this issue with a suitable mentor (or similar individual) via his Local Health Board.

Dr W may benefit from some re-training in communicating with patients and carers. There are dedicated courses on improving telephone consultation techniques that Dr W may consider as a part of his continuing professional development plan.

Advice NHS Bodies

The hospital failed to ascertain that the GP received the discharge letter. After such a major and intricate operation they should have contacted the secondary and primary referrers for a discussion of post-operative care requirements. We feel that if Ms S had been advised to receive supervised
mobility under a domiciliary physiotherapist she may well have averted the problems of pulmonary embolism (if this was caused by DVT).

Tertiary Centres must ensure that timely information about post-operative needs is communicated to primary care. A letter may be insufficient for the purpose and faxing should be used for speed and accuracy.

Signed by: Panel Chair and panel members.

Appendices: Separate reports by Dr E and Dr F (not included in the case study)