S.131/01-02

**Scottish Public Services Ombudsman Act 2002**

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against
Lanarkshire Primary Care NHS Trust (the Trust)

Complaint as put by Mr P

1. The account of the complaint provided by Mr P was that following the death in hospital on 7 August 1999 of his wife, Mr P complained to Mrs P's general practitioner (GP) about the care and treatment provided to his wife by the Practice. Mr P was dissatisfied with the responses he received and on 12 May 2000 he requested an independent review. On 23 May, the Trust's Convener acknowledged Mr P's letter, and on 7 June, he wrote again to Mr P explaining and apologising for the delay in dealing with his request. The Convener wrote again to Mr P on 27 June saying that the local Health Board had yet to appoint a Lay Chairperson to assist in his case. On 20 July, the Convener told Mr P that a chairperson had still not been appointed. On 21 August the Convener referred the complaint back to the Practice for resolution as he felt that Mr P had not received an adequate response from them. On 22 September the GP replied more fully to Mr P. However, Mr P remained dissatisfied and, on 24 October, requested an independent review. On 9 November the Convener responded that, as the Chief Executive of the Trust said that the local resolution process had not been exhausted, he was unable to proceed with Mr P's request for an independent review. On 12 November Mr P wrote to the GP outlining concerns that he felt remained unresolved. On 4 December Mr P and his family met the Trust's Medical Director who was acting as a mediator between them and the Practice, to discuss their ongoing concerns. On 6 December the GP wrote to Mr P and said that he agreed that an independent review offered the best chance of resolution. On 17 January 2001 the Medical Director met with the Practice. On 9 March Mr P again requested an independent review. On 2 April the Convener replied that he was seeking confirmation from the Trust that the local resolution process had been exhausted before considering his request. On 6 June the Convener wrote to Mr P saying that he was now considering his

request. On 23 August, the Convener refused an independent review on the grounds that the complaint had been thoroughly and fairly dealt with through local resolution.

2. The matter investigated was that the handling of Mr P's complaint by the Trust and their Convener was dilatory and unsatisfactory, and was not in accordance with the NHS complaints procedure.

Investigation

3. The statement of complaint for the investigation was issued on 25 January 2002. Comments were obtained from the Trust and relevant documents were examined. Evidence was taken from Trust's Chief Executive, Principal Convener and Convener. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

National guidance

4. In May 1999 the then Scottish Office produced guidelines on the operation of the NHS complaints procedure that includes:

> '**Primary Care Trust's … Role in Family Health Services Local Resolution: Honest Broker**
>
> 1.11 … When a Primary Care Trust [is] acting as intermediary between patients and practitioner, providing conciliation or dealing with a request for Independent Review, it will be essential for the Trust to establish clear and constant lines of communication between patient and practitioner. This might be best done via a named person in the Trust who can at all times give accurate information about a complaint's progress.
>
> 1.12 All Primary Care Trusts ... should designate a member of staff who will act as 'honest broker'. This could be the complaints officer or perhaps another senior manager. Where a complainant does not wish to have a complaint dealt with by the Practice, or is having difficulty in getting the complaint dealt with by the practitioner, the designated officer will, if both parties agree, act as 'honest broker' between the

complainant and the practitioner to facilitate dialogue between them so that local resolution can take place.

‘**Conciliation**
1.15 Health Boards must make available lay conciliators where Trust’s feel these may be useful for complainants and Practices … Conciliation is essentially a process of reaching agreement between practitioner and complainant. As a result conciliators should never be required to report to Primary Care Trusts … on the outcome of conciliation … Nor should conciliators provide information which might then be used by the Primary Care Trust … should a complainant prove dissatisfied with local resolution and ask for an independent review.’

‘**Independent Review:**
2.2 … Any request for an independent review received … by any member of/or employee of the Primary Care Trust … should be passed to the convener immediately through the convener’s office.’

‘**Action by the Convener**
2.9 In reaching a decision, the Convener must:

- consult an independent lay panel chairman nominated by the Health Board;

- take appropriate clinical advice where the complaint relates in whole or in part to action taken in consequence of the exercise of clinical judgment.

This process must be completed within ten working days of the date of receipt of the complainant’s request by the Convener …’

‘**Clinical Complaints**
2.11 Clinical advice to the Convener should come from an independent practitioner from the same profession as a practitioner who is being complained about …

‘**Decisions of the Convener**

2.13 After seeking appropriate clinical advice the Convener must decide whether to:

- refer the complaint back for further local resolution, possibly suggesting conciliation;
- set up a panel to consider the complaint;
- take no further action.’

‘**Referring back for Local Resolution**

2.16 Where … the convener feels that local resolution has not adequately addressed the complainant’s concerns in whole or in part, he/she should refer the case for further local resolution, possibly recommending the use of conciliation (see Annex 1C). The complainant and the complained against should be informed in writing of the reason for this decision.

2.17 If the complainant remains dissatisfied following the reference back to local resolution he/she may ask the convener to reconsider whether an independent review panel should be convened.’

**‘Conciliation (Annex 1C)**

1. … [Conciliation] is a process of examining and reviewing a complaint with outside assistance … Health Boards must make conciliators available to Trusts where this assistance is requested … both parties must agree to the process being used.

2. The aim of conciliation is to enable both parties to address the issues … with the aim of reaching an agreement that both parties will accept …

3. Conciliation may also be a useful means of resolving complaints where the complainant has requested independent review but the convener believes further resolution would be appropriate … Primary Care Trusts should ensure their induction training for conveners …

equips them to consider it as a means of resolving appropriate complaints.'

Chronology of events

5. The main events during the Trust's handling of Mr P's complaint are as follows:

**12 May 2000**

Mr P requested an independent review.

**18 May**

The Trust's Chief Executive forwarded Mr P's request to the Principal Convener.

**23 May**

The Convener sent an acknowledgement letter to Mr P.

**7 June**

The Convener wrote to Mr P apologising for the delay in dealing with his request for an independent review. He explained that his meeting with the Medical Director was cancelled at short notice due to unforeseen circumstances and had been rearranged for the beginning of July. It could not be rearranged earlier because of holiday commitments.

**27 June**

The Convener wrote to Mr P advising that he had met with the Deputy Medical Director to discuss the contents of Mrs P's medical records but that a Lay Chairperson had not yet been appointed by the Health Board.

**20 July**

The Convener wrote to Mr P saying the Health Board had still not provided a Lay Chair. He said that the urgency of the requirement had been stressed and he was actively pursuing the appointment of a Lay Chair.

**21 August**

The Convener wrote to Mr P saying he had considered his case with the Lay Chair and was referring his complaint back to the Practice for further

resolution as he felt that Mr P had not received an adequate response from the Practice.

The Convener wrote to the GP advising that he was referring the complaint back to allow the Practice an opportunity to respond more fully to Mr P's questions and to provide answers to all of the outstanding points. The Convener asked for this to be done as soon as possible.

**29 August**
The GP advised the Convener that he would write again with a copy of his letter to Mr P as soon as possible. He said there might be a slight delay as he did not have the medical records but he had requested them (he received them on 31 August).

**22 September**
The GP replied more fully to Mr P (the letter was not received by Mr P until 13 October).

**8 October**
Mr P wrote to the Convener about another matter he had raised earlier and he also asked the Convener when to expect a reply from the GP and asked the Convener to expedite a reply for him.

**10 October**
The Convener replied addressing the other issue and saying 'I trust the Local Resolution process is proceeding'.

The GP sent a copy of his letter of 22 September to Mr P, to the Convener saying that he felt he had covered the points raised as carefully as possible. The letter is stamped as having been received on 13 October.

**12 October**
The Convener wrote to Mr P advising him that he would take steps to ensure progress as soon as possible.

The Convener also wrote to the Chief Executive asking him to instigate further local resolution as soon as possible.

**18 October**
The Convener wrote to the Chief Executive saying he had received a copy of the Practice's letter to Mr P (dated 22 September) and asked him to coordinate responses to Mr P and the Practice to successfully resolve the complaint.

The Convener wrote to Mr P saying further local resolution should be co-ordinated by the Chief Executive but if Mr P remained dissatisfied at the conclusion then he could ask again for an independent review.

**24 October**
Mr P wrote to the Convener saying that he did not feel that the important issues had been addressed by the Trust and he asked again for an independent review.

**25 October**
The Trust's Clinical Risk Manager wrote separately to the GP and Mr P advising that she had recently been informed that the Convener had referred Mr P's request for independent review back for local resolution. The Clinical Risk Manager said she would be happy to help if needed.

**1 November**
The Convener wrote to Mr P in response to his letter of 24 October saying that once the Chief Executive had confirmed that the local resolution process had been exhausted, the Convener would consider his request for an independent review.

The Convener wrote to the Chief Executive asking if the local resolution process had ceased.

**6 November**
The Clinical Risk Manager responded to the Convener's letter of 1 November to the Chief Executive saying she felt that local resolution had not been exhausted as Mr P had rejected an offer to meet the Practice even with the Medical Director acting as an honest broker. She had also advised Mr P to outline outstanding issues to the Practice.

**9 November**
The Convener wrote to Mr P saying he was unable to proceed with Mr P's request for an independent review because the Chief Executive had informed him that the local resolution process had not been exhausted. He said he could not consider the request until the Chief Executive confirmed that no further progress was possible.

**10 November**
The Clinical Risk Manager wrote to Mr P asking for a written account of the areas he felt had still not been resolved.

**12 November**
Mr P wrote to the Practice outlining outstanding concerns and copied the letter to the Clinical Risk Manager.

**4 December**
Mr P and other members of the family met with the Medical Director to discuss their ongoing concerns. The Medical Director said she would ask the Practice to respond to Mr P's letter of 12 November and would ask the Practice to meet with her within one month to discuss the issues and questions raised by the family.

**6 December**
The GP wrote to Mr P saying that he did not feel he could add anything to his letter of 22 September and agreed that an independent review offered the best chance of resolution.

**11 December**
Having received the Practice's letter of 6 December, Mr P telephoned the Trust to ask what the next stage was. He was advised that the Medical Director would probably meet the GP and, if that was the case, she would probably ask Mr P to confirm the issues he would like raised and elaborate on any questions. He was also advised that the Medical Director's diary was full until after Christmas.

**15 December**
Mr P wrote to the Medical Director listing unanswered questions.

**20 December**
The Convener asked the Chief Executive if there had been any developments.

**22 December**
The Trust wrote to Mr P advising him that the Medical Director had arranged to meet representatives of the Practice on 17 January 2001 and that his most recent correspondence to the Medical Director would be considered at the meeting.

**29 December**
The Clinical Risk Manager told the Convener that local resolution was still in progress and a further meeting was due to take place on 17 January 2001.

**17 January 2001**
The Medical Director and Clinical Risk Manager met three GPs from the Practice.

**9 March**
Having received copies of the minutes of the Medical Director's meeting with the GPs, Mr P wrote to the Convener asking again for an independent review because he considered that his family's concerns had still not been answered (received by the Trust on 19 March).

**2 April**
The Convener replied he was seeking confirmation from the Trust that local resolution had ceased before considering Mr P's request for independent review.

The Convener wrote to the Chief Executive asking whether local resolution had ceased.

**10 May**
The Principal Convener wrote to the Chief Executive asking for a response to the Convener's letter of 2 April.

**30 May**
The Chief Executive responded saying Mr P met with the Medical Director on 4 April to discuss his wife's medical records and given that he had since requested an independent review, the Chief Executive concluded that Mr P felt local resolution was unsuccessful in resolving his complaint.

**6 June**
The Convener wrote to Mr P saying he was now considering his request for independent review.

**15 June**
In response to a letter from the Convener the Chief Executive replied that the meeting between the Medical Director and Mr P on 4 April was in response to a request from Mr P to view his late wife's medical records. It was not part of the local resolution process.

**20 June**
The Chief Executive wrote to a GP (Dr A) confirming his appointment to provide clinical advice to the Convener in his consideration of Mr P's request for an independent review.

**4 July**
The Convener wrote to Mr P saying the Lay Chair was on annual leave and that he would be meeting with the medical adviser Dr A as soon as possible.

**26 July**
The Convener met the medical adviser to assess the complaint.

**23 August**
The Convener wrote to Mr P refusing an independent review on the grounds that the complaint had been thoroughly and fairly dealt with through local resolution.

<u>The Trust's official response</u>
6. In the Trust's written response to the Ombudsman's office the Trust's **Chief Executive** said in part:

'The Trust accepts that there was an unacceptably long time span between Mr P's first request for Independent Review on 12 May 2000 and the final response from the Convener on 23 August 2001. This was due to a combination of factors:

1. The Trust and the Practice's desire to try and resolve Mr P's concerns at local level ...

2. The delay in the appointment of the Lay Chair ... the Health Board ... advised that they were experiencing great difficulty in supplying Lay Chairs ... as several had withdrawn their names and others were just not available at that time. The Health Board advertised for replacement personnel and interviews were held in July 2000 to appoint additional people. As soon as the Trust was advised of the appointment of the Lay Chair for this particular review, information was forwarded to him and a response provided to Mr P with three weeks ...

3. Staffing Difficulties Within the Department The Department is a small department comprising a Clinical Risk Manager and a Secretary. The Secretary also provides the administrative support to the Conveners for the Independent Reviews. The Secretary was seconded to a promoted post within the Trust at the beginning of December 2000. Her position was filled by an agency member of staff until the middle of January 2001 when a temporary appointment was made. On 29 March 2001, the Clinical Risk Manager went on sick leave, which became long-term and this post was covered from 17 April 2001 by a temporary appointment. This inevitably resulted in continuity difficulties and was a cause of certain matters not been followed up as quickly as they should have been.

4. Delay in response to Mr P's letter of 9 March to the Convener's address which included a request for an Independent Review. Although Mr P's letter was dated 9 March 2001, the postmark on the envelope was 19 March 2001 and due to the fact that this was placed in the wrong P.O. box, the Trust did not receive it until 29 March 2001. There was then a further delay following the Convener's request on 2 April

2001 to [the Chief Executive] as to whether Local Resolution had been exhausted and [the Chief Executive's] reply of 6 June 2001. In the intervening period, Mr P had met with [the Medical Director] on 4 April 2001 primarily to afford him the opportunity of seeing his wife's complete original records, although other matters were also discussed. As a result of this meeting, [the Medical Director] wrote apologising for the delay in his having access to his wife's medical records and the confusion about drug information but offered the opportunity to discuss the matter further if she could be of any help. At the beginning of May, efforts were made contact Mr P to establish whether he was now satisfied following his meeting with [the Medical Director] or whether he still wished to proceed with his request for Independent Review. An answer to this was obtained from Mr P on 11 May 2001 but regrettably there was a delay in advising the Convener's office of this until 30 May 2001.

The Trust recognises that the medical advice sought to consider the first Independent Review was not appropriate. As it was a complaint about a GP practice, the advice should have come from an Independent Practitioner and not from the Trust Medical Director or … her Deputy … this did not happen on the second occasion for the request for Independent Review as the Trust recognised the error that had been made. The Trust also recognises that when the Convener decided that local resolution had not adequately addressed a complaint, no offer was made of conciliation as part of the local resolution process.

This Independent Review was one of the early ones involving the Trust and both the Trust and the Convener were on a steep learning curve.

The following action has been taken:

- A comprehensive review of the operation of the complaints system has been undertaken

- A senior member of staff is now overseeing the work of the complaints department …

- Systems are now in place which will enable effective tracking of all complaints to be achieved.

- Separate files are now maintained for the Conveners correspondence on the Trust Complaints correspondence.

- Relevant staff are aware of who should be contacted to provide clinical advice, depending on the type of complaint.'

Evidence of the Convener

7. **The Convener** said once he had received Mr P's request for an independent review on 23 May 2000, he discussed it with the Principal Convener because this was one of the first cases he dealt with. They decided to approach the Medical Director of the Trust for clinical advice. The Convener had been told that the Medical Director was a qualified General Practitioner. Unfortunately, two meetings scheduled with her were cancelled. The Convener was very conscious of the time that had passed and so he sought clinical advice from the Deputy Medical Director who he met on 27 June. After discussing the case with the Lay Chair, who was finally appointed in August, the Convener decided to refer the complaint back for further local resolution because he felt the Practice had not fully responded to Mr P's questions.

8. On 24 October, Mr P informed the Convener he remained dissatisfied and asked again for an independent review. The Convener asked the Chief Executive if local resolution had ceased because he could not progress the matter until he had confirmation of that in writing. He believed it was clear from the guidance on the NHS complaints procedure for Conveners that he could not proceed until somebody from the Trust, usually the Chief Executive, confirmed that local resolution had ceased. On 6 November the Clinical Risk Manager wrote to him saying that local resolution was not exhausted, so he could take no further action at that time. The Clinical Risk Manager, the complainant and the Practice exchanged further correspondence. The Medical Director had attempted conciliation but she was not appointed as such by the Trust. In his view it was therefore inappropriate for her to act as a conciliator given that she was an employee of the Trust and not independent. The

Convener had not recommended conciliation in this case because the parties were so far apart in their views.

9. On 2 April, following Mr P's third request for an independent review, the Convener requested confirmation from the Chief Executive that local resolution had been exhausted. He did not receive a reply and raised his concerns with the Principal Convener who wrote to the Chief Executive on 10 May asking for a response to his letter. On 30 May the Chief Executive replied that Mr P felt that local resolution was unsuccessful in resolving his complaint. The Convener then sought a meeting with the Clinical Adviser who had been appointed but this was delayed because of holiday leave. He met the Clinical Adviser on 26 July and the Lay Chair on 6 August. At the meeting, they both concluded that all issues had been fully responded to by the Practice and an independent review would be of no benefit. He wrote to Mr P on 23 August 2001 informing him of his decision. He could not recall why it took so long for him to write to Mr P but he had spent time in preparing a comprehensive response.

10. The Convener accepted that the case missed the set time targets by a wide margin but believed he and the Trust had learned from the experience and cases were resolved much more quickly now. He believed the Trust, the Medical Director and the Clinical Risk Manager had acted in good faith but had delayed the process. He felt that the timescales which Conveners have to meet are unreasonably tight because of obstacles, such as difficulty in obtaining patients' medical records and the time taken for other parties to reply to correspondence, which are outwith the control of Conveners. He felt the Trust went to extremes by initially not doing enough to resolve the complaint and then prolonging the process unnecessarily. He believed that clarifying the situation, and even investigating, was part of the Trust's role, rather than just offering help.

<u>Evidence of the Principal Convener</u>

11. **The Principal Convener** had very little involvement in Mr P's complaint but she was aware of some of the difficulties in meeting the timescales. She had been concerned about the length of time the Health Board was taking to appoint the Lay Chair for the case and wrote to that effect to the Chief Executive. At that time there was a shortage of Lay Chairs

and appointments were taking up to three weeks when they should only have taken two days. The Chief Executive contacted the Health Board who then recruited more Lay Chairs. At that time the Medical Director oversaw the Convener's office and she was anxious to resolve complaints and became very involved thereby causing considerable delays. The Medical Director had arranged other meetings in response to the first two requests made by Mr P for an independent review even though local resolution appeared to have ended. Before the Convener could consider requests for independent review, local resolution had to be exhausted. However, the Medical Director's enthusiasm to mediate in complaints meant that local resolution continued longer than it should have done. It was difficult for the Convener to properly manage the case when the Medical Director actively tried to conciliate and arranged meetings with both the complainant and the Practice. The problems that arose because of the Medical Director's involvement were resolved when she left the Trust. The office now used an independent conciliator who is extremely successful.

Evidence of the Chief Executive

12. **The Chief Executive** said if a complaint is made against a GP Practice, the Practice is responsible for managing and hopefully resolving the complaint. The Trust has a role in the process as honest broker and also to ensure that requests for independent review are considered. He believed that the Trust should act as honest broker sparingly in order to encourage Practice's to make every effort to resolve complaints. On occasions when the Trust do act as honest broker it is necessary to have the right skills to mediate in order to reach a satisfactory resolution between the complainant and the Practice. If complaints were referred back by a Convener for further local resolution, the Chief Executive referred the matter to the Medical Director for action who then undertook the role of honest broker. He explained that the Medical Director had overseen the complaints department which was managed by the Clinical Risk Manager. The Clinical Risk Manager was accountable to the Medical Director. The Medical Director and the Convener's office tended to communicate directly rather than all cases going through him.

13. The Chief Executive said as soon as the Principal Convener informed him about the problems the Health Board had in appointing a Lay Chair for Mr

P's case, he telephoned the Health Board. They had administrative difficulties in providing Lay Chairs and did not get an encouraging response from advertising the position. Another factor contributing to the delay in this case was that the Clinical Risk Manager went on sick leave and it was not clear in the beginning that it would be long-term. The cover arrangements made were therefore short-term. Also at that time there was no system in place to identify work that needed progressing in individual caseloads. A tracking system had since been put in place to ensure that if a member of staff was off sick, even for one day, outstanding issues could easily be identified. The Chief Executive understood that the Medical Director did not get involved in Mr P's complaint until Mr P said he was making no progress with the Practice and that she acted with the best of intentions. The Medical Director's involvement also contributed to delays in the process, in that, it usually took several weeks before meetings she requested could take place because of her workload. It was usual practice to give his view on whether local resolution had ceased although that was ultimately up to the Convener to determine. Giving his view was reasonable as complainants sometimes requested independent reviews while the local resolution process was ongoing.

14. The Chief Executive said it was clear with hindsight that parts of the system were not responding quickly enough to the situation Mr P presented. There was a lack of clarity about who should give clinical advice and how the Trust should have dealt with complaints relating to GPs, who are independent practitioners, as opposed to complaints against the mainstream service managed directly by the Trust. Systems were not in place to ensure continuity to cover for sick leave. This was also one of the first cases for the Convener's office which at that time lacked experience. As a result of this case, the Trust had reviewed the systems of handling complaints and the management arrangements, people involved and the system are now different. The relationship with the Convener's office is also more constructive, and they too have built up experience. The new Director of Clinical Standards and Health Improvement (DCSHI), which incorporates the Medical Director's role, was now responsible for General Practice, supporting staff dealing with complaint handling and providing coaching skills. Response times to complaints is monitored regularly by the clinical governance committee and the Trust management team and is now relatively quick and slightly better than the average for Scotland.

Findings

15. Mr P has complained about the way the Trust and the Convener handled his complaint concerning the care and treatment provided to his wife by her GP Practice. The target timescales from receipt of requests for independent review to the Convener's decision is ten working days. The Chief Executive has accepted that the delays were unacceptable and due to a number of factors (see paragraph 6 above). I note with approval the measures introduced by the Trust to address those factors contributing to the delay (see paragraphs 6 and 14). Nevertheless, the Medical Director's involvement also contributed significantly to those delays. Although I accept that the Medical Director was acting in good faith, it seems to me that she attempted to take on the role of a conciliator which in terms of the guidance on the NHS complaints procedure was clearly inappropriate. If conciliation was considered necessary then a conciliator should have been appointed by the Health Board and the conciliation proceedings kept confidential. I am pleased to note that the Trust now uses an independent conciliator to good effect. There also appeared to be no need for an honest broker to facilitate dialogue between Mr P and the Practice once the Practice had responded more fully to Mr P in their letter of 22 September 2000; dialogue took place and the two parties simply disagreed. It was then up to the Convener to consider the request for independent review. Although I do not consider it inappropriate for the Convener to have sought to confirm that local resolution was concluded, in this case he seemed to rely on the Trust to make that determination which was inappropriate. I **recommend** that the Trust ensure that all staff involved in complaints handling are aware of the limits of the Trust's role as honest broker and of the difference between that role and conciliation.

16. Finally, the Chief Executive accepts the medical advice sought at the first request for an independent review was not obtained from an appropriate person in terms of the guidance on the NHS complaints procedure, that is, advice should have been obtained from another GP not connected with the complaint. I am pleased to note that the Trust have already taken action to ensure appropriate advice is obtained in future cases. However, I am also concerned that the clinical advice sought and received at both the first and third request for independent review went beyond what was appropriate and

did in effect amount to a judgment on the clinical care given to Mrs P by her GP. I **recommend** that the Convener looks again at the complaints procedures and if necessary seeks additional training on this aspect. I uphold the complaint.

Conclusions

17. I have set out my findings in paragraphs 15 and 16. The Trust have agreed to implement the recommendation in paragraph 15 and they have asked me to convey through this report – as I do – their apologies to Mr P.

Gillian Stewart
Acting Investigations Manager
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services
Ombudsman Act 2002

September 2003