Case 200501219: Tayside NHS Board

Introduction

1. On 8 August 2005 the Ombudsman received a complaint from a woman (referred to in this report as Ms C) about the decision of one of the conveners used by Tayside NHS Board's Primary Care Division not to convene an Independent Review Panel to examine her complaint. (I explain these panels and the function of a convener at paragraphs 6 to 7.) I found that the convener had correctly followed the procedures in reaching her decision. Therefore, I did not uphold the complaint.

2. Ms C complained to her father (Mr C)'s general practitioner practice (the Practice) about his care and treatment there. As she was dissatisfied with their response, she asked the Health Board for an Independent Review of that complaint. She complained to the Ombudsman because the convener declined her request.

3. The complaint from Ms C which I have investigated concerned the convener's decision not to convene an Independent Review Panel. (I am also investigating Ms C's complaint about the Practice, and that will be reported separately.)

4. Following the investigation of all aspects of this complaint I concluded that the complaint should not be upheld (see paragraphs 29 to 32).

Background

5. The references in this report to the NHS complaints procedures are references to the procedures which applied at the time in question. But it should be noted for information that the procedures have since changed. In particular, Independent Review no longer exists (except, temporarily, in a few cases).

6. Ms C's complaint to the Practice was considered under the first stage of the NHS complaints procedures - local resolution. Complainants who were dissatisfied with the outcome of local resolution could ask for an Independent Review (IR) of the complaint by an IR Panel (IRP). This was known as the second stage – the IR or IRP stage.

7. Requests for IR were made to the relevant Division of the Health Board. Divisions or Boards were required to appoint at least one person (who could not be one of their own employees), including at least one person who was a non-executive of the Division or Board, to act as a convener in the IR process. Conveners were required to be impartial (although they were able to use the premises and staff of the Division or Board). Although in practice their actions were beyond the control of the Division or Board, the Division or Board remained formally responsible for them. Ms C's complaint is, therefore, against Tayside NHS Board.

8. Complainants who were dissatisfied with, for example, a convener's decision to refuse an IRP could ask the Ombudsman to consider their complaint. (In the current NHS complaints procedures, complainants who are dissatisfied with the outcome of local resolution can approach the Ombudsman direct without going through any further stage.)

9. A convener's decision to refuse an IRP is a discretionary decision. The Scottish Public Services Ombudsman Act 2002 (section 7 (1)) does not allow the Ombudsman to question the merits of a decision which has been taken without maladministration by or on behalf of a Health Board in the exercise of a discretion vested in them. In other words, the Ombudsman has no power to question a decision not to convene an IRP unless the convener has not followed the relevant procedures in making that decision.

10. The procedures I have summarised at paragraphs 6 to 8 are contained in two documents which were produced by the then Scottish Office (now the Scottish Executive):

- *Complaints – Listening … Acting … Improving – Guidance on Implementation of the NHS Complaints Procedure*, March 1996;

- *The NHS Complaints Procedure – Guidance for Family Health Services (FHS) Complaints*, May 1999.

11. I shall refer to these documents as the Guidance. The following extracts from the Guidance explain the convener's role when deciding whether to convene an IRP:

- '[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;

- 'The convener may decide that local resolution has been adequately pursued – in that the complaint has been properly investigated and an appropriate explanation given – and that nothing further can be done, although the complainant remains dissatisfied;

- 'Conveners … should not set up an [IRP] where … it is considered that establishing a panel would add no further value to the process … [or where] it is believed further action as part of Local Resolution is appropriate and practicable;

- 'It is not the convener's role to try and resolve the complaint … Convening should not be a re-run of the action taken during Local Resolution … **It is not the convener's role to seek a view on the merits of the complaint or to investigate it** [the Guidance's emphasis]. (Note: Although the three statements in this sub-paragraph make the same point, I include them all to demonstrate how much importance is attached to it in the Guidance);

- 'Where the convener considers that a complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement, he/she must take appropriate clinical advice in deciding whether to convene a panel;

- 'Clinical advice [to the convener] should relate to whether the response already made to the clinical aspects of the complaint at local resolution has been thorough, correct and fair, and in terms the complainant can understand. If not, whether further local resolution or a panel would be an appropriate next step. In reaching a view on this the clinical adviser may need to consider whether appropriate care or treatment was provided but clinical advice should not be given to the convener in the form of a report passing judgement on the quality or adequacy of the clinical care given to the patient;

- 'Before making the decision … the convener will … consult with a

nominated independent lay panel chairman from the Health Board list. The purpose of this contact is to provide the convener with an external independent view and to aid him/her in assessing the grievance'.

Investigation and findings of fact

12. I examined the Guidance, the complaint correspondence provided by Ms C and the files for the local resolution and IR stages of the complaint. Ms C has provided comments on a draft of this report, both she and the Board having been given that opportunity.

13. In making her complaint to the Practice, Ms C explained that her father, Mr C (who was aged 88 at the time), was seen by one of the Practice's GPs in August 2004 because of the concern of Mr C's chiropodist about his swollen feet. The GP prescribed metolazone for the swelling in addition to the frusemide which Mr C was already taking for this purpose. From that time Mr C gradually became increasingly tired, weak and confused. In December 2004 Mr C was distressed by disorientation and memory loss and was prescribed aspirin. During the rest of December his condition worsened, for example, he became depressed and lost his appetite.

14. Ms C also said that when she asked the Practice on 31 December 2004 for an appointment to speak to the GP by telephone, she was told that the GP had an appointment to speak to Mr C that day. She, therefore, assumed that at least one of them would receive a call. The GP did not telephone Ms C or Mr C.

15. Ms C's complaint to the Practice added that Mr C's condition continued to worsen. In early January 2005 another GP at the Practice suggested that he was suffering from cramp and advised Ms C not to worry about Mr C's weight loss and poor appetite. On 10 January 2005 the original GP made a home visit because of Ms C's worry. That GP immediately admitted Mr C to the local community hospital.

16. Despite enquiries to the nurses, Ms C said that she did not see the doctors at the community hospital during the two days of Mr C's stay. A nurse there told Ms C that Mr C had lost essential salts because of the strong diuretics he had been taking before admission to the hospital. Because of her continuing concerns, Ms C arranged for Mr C to be transferred to a major hospital. A nurse there said it was a shame he had not been admitted earlier and a consultant said she had done an excellent job in getting him there. Ms C particularly wished to

know why the GP did not admit Mr C direct to the major hospital.

17. Finally, Ms C's complaint to the Practice said that she considered that they should have monitored Mr C's blood while he was taking the metolazone; she realised from Mr C's clinical records that they had not done so.

18. In his response to Ms C at the local resolution stage, the GP said that Mr C had had problems with swelling of his feet for several years. At the August 2004 consultation with Mr C, which Ms C also attended, treatment options for this were discussed, although the GP felt under some pressure to do more and decided to try metolazone as he had some experience of it for patients with resistant swelling. When he saw Mr C again in October 2004 he learned that Mr C had not yet taken the metolazone.

19. The GP said that he saw Mr C in November 2004 for what he felt was a virus. In December 2004 Mr C was concerned about his memory so the GP prescribed aspirin in case Mr C had suffered a small stroke of some kind. He said that with hindsight he regretted not having considered electrolyte imbalance as a cause of the symptoms in November and December. And although his regular habit was to check Mr C's blood, he did not do so in December.

20. The GP's complaint response also explained that on 30 December 2004, the district nurse told the GP of Ms C's concerns about Mr C's memory. He, therefore, decided to contact the family and placed a telephone appointment in the computer system for the following day to remind himself. On 31 December Ms C requested a telephone appointment and was told by a receptionist that the GP already intended to telephone that day. However, the GP was unable to do so and, believing that the situation was not urgent, he decided to telephone instead after the New Year holiday. He did not know that Ms C had asked for a call. When he did learn, on 5 January 2005, that she had been expecting a call, he telephoned her that day to explain. On hearing her concerns during that call, he agreed to refer Mr C to a memory specialist.

21. The GP added that, earlier on 5 January 2005, Ms C had telephoned the Practice for a home visit for Mr C. The GP was in the reception area at the time and told the receptionist that he would make that visit after his morning surgery. As Ms C wanted a more urgent visit, the duty doctor made it instead.

22. The GP said that after his morning surgery on 10 January 2005, he responded

to a request for a home visit, where he learned that Mr C had not eaten for a week and was sleeping for much of the time. On examining Mr C, he was concerned about his appearance and found him to be clinically dehydrated. He admitted him to the community hospital for rehydration and blood tests. The community hospital was used by the Practice for certain types of case, was considered to be very adequate for so-called intermediate care and was often preferred by patients because of its location. The GP considered on 10 January 2005 that Mr C's condition was manageable at that hospital. When Ms C requested a transfer to the major hospital, the GP was content to arrange this.

23. The GP also told Ms C that, on becoming aware of her concerns about Mr C's care, he arranged an analysis of the situation (which he called a Significant Event Analysis) in February 2005 to enable the Practice to assess what had happened and whether there were any lessons to be learned. The main outcome of this was that the Practice decided:

- to be more careful about the use of diuretics for swelling in elderly patients;

- to restrict the use of metolazone and closely monitor electrolytes and weight at an early stage;

- to ask the Committee on Safety of Medicines to request that the warnings in the *British National Formulary* be strengthened in regard to the risk of electrolyte imbalance with the use of metolazone.

(The Formulary is an authoritative medical publication, containing information about medicines and their use.)

24. The GP concluded his response to Ms C's complaint by repeating his apologies and assuring her that her concerns about Mr C's management had been taken seriously, with a view to avoiding a repetition. He had already met Ms C but offered to discuss the matter further by having another meeting or through further correspondence. Before requesting an IRP, Ms C asked the GP for a copy of the Practice notes of the Significant Event Analysis and the document to the Committee on Safety of Medicines, and the GP provided these.

25. When Ms C requested an IRP, she complained that the GP had not apologised until she complained and that, contrary to the GP's statement, he did not regularly check Mr C's blood as his last blood test had been in May 2004. Despite the GP's

statement about having experience of prescribing metolazone, he did not check Mr C's blood before prescribing it for him in conjunction with the frusemide. She said that on 31 December 2004, there were two appointments for the GP to telephone – one to telephone Mr C and one to telephone Ms C, neither of which had been honoured. Also, when Ms C telephoned the Practice on 5 January 2005 for a home visit, she considered that the GP could not have been unaware of the urgency expressed by the telephone call. She said that it was particularly negligent of him not to have spoken to her himself and for him to have sent the duty doctor, who knew nothing of Mr C's condition. Ms C also made the point that the GP's home visit on 10 January 2005 was not made until 13:45 and so must have had to wait until the GP had had lunch, following his morning surgery. It had taken 11 days since the two missed telephone appointments (31 December) for him to attend in person. Finally, Ms C's complaint to the IRP convener said that on 10 January 2005, Mr C should have been admitted direct to the major hospital, not to the community hospital, which the GP himself had described as lacking many of the more specialised pieces of equipment available in the major hospital.

26. The convener set out her decision in a letter to Ms C. She said she had consulted a lay chairman and a clinical adviser. She considered that the GP's response to the complaint was appropriate. She noted that the Practice had tried to learn from the complaint. Regarding the telephone situation on 31 December 2004, she noted that the GP had given an account of that to Ms C. And she noted that, although the GP's response to the complaint had not addressed Ms C's concerns that she saw no doctor during Mr C's two days in the community hospital, he had apologised for the events that had occurred and given assurances about seeking to avoid a repetition.

27. The convener concluded that the complaint had been answered appropriately at local resolution and that no further action by her was appropriate. She gave details about how Ms C could complain to the Ombudsman if she was dissatisfied with the decision.

28. In her complaint letter to the Ombudsman, Ms C explained her dissatisfaction with the convener's decision. In essence, this was that the convener had not adequately investigated the complaint. She also disagreed with the convener's statements that the Practice had learnt from the complaint and that the GP had apologised for two specific issues.

Conclusions

29. I am satisfied that the convener was accurate in considering that the Practice had learnt from the complaint because of what the GP had explained about the Significant Event Analysis and about the Practice GPs (and district nurse) who had attended it. It is true that the GP did not apologise specifically for the two issues referred to in paragraph 28. But his letter said that his apologies were for 'what has happened'. I consider that that apology covered the general situation. Therefore, I do not consider the convener's letter to have been at fault in making the statements described in Ms C's letter to the Ombudsman.

30. Turning to the convener's decision, I note that, in line with the Guidance (see paragraphs 10 to 11): she consulted a lay chairman and a clinical adviser; she considered whether the complaint had been properly investigated and an appropriate explanation given and whether an IRP would add any further value; and she did not investigate the complaint or judge the clinical care.

31. For the avoidance of doubt, it is worth repeating (see paragraph 9) that it is not my role to consider the merits of the convener's decision but to consider whether it was taken with due regard to the procedures in place. I, therefore, give no opinion about the decision.

32. I am satisfied from the evidence available to me that the convener did follow the Guidance in reaching her decision not to convene an Independent Review Panel and, therefore, I do not uphold Ms C's complaint.

28 March 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr C	The complainant's father
The Practice	Mr C's general practitioner practice
IR	Independent Review
IRP	Independent Review Panel