Parliamentary and Health Service Ombudsman

Clinical advice review
Background paper

Contents

Purpose of this paper

The consultation paper published alongside this background paper sets our role, how we use clinical advice and the background to why this function is being reviewed.

This paper provides further context and detail about our systems and processes in support of that consultation.

It includes process maps and further context that set out in detail how our current approach works, how we check the quality of the advice we receive and other key issues, such as the detail around the current principles that underpin our current process and that the Review Team's Independent Adviser is seeking views on to inform his work.

It also includes some proposals for change around our current processes that have been made by the Review Team as part of the first stage of its work, particularly in relation to our approach to quality.

Any feedback on the detail outlined in this paper would be welcome and can be provided as part of our formal consultation **by 5pm on Monday 15 October 2018**.

As set out in the consultation paper you can respond by either completing our online survey or by emailing your response to ClinicalAdviceReview@ombudsman.org.uk

If you would like this document in a different format, such as Daisy or large print, please contact ClinicalAdviceReview@ombudsman.org.uk

The current approach to clinical advice

This section of the paper sets out in detail the background to our current clinical advice process.

Our data

As outlined in our recently published 2017-18 annual report, as a result of delivering our transformation programme, the total number of investigations we completed in 2017-18 declined. The data in Table 1 below shows, however, that in percentage terms the use of clinical advice in our casework has remained relatively stable.

Table 1 – use of clinical advice in casework

Headline	2015/16	2016/17	2017/18
Cases concluded at assessment stage	3,201	3,366	3,313
% assessments using clinical advice	3.9%	3.4%	7.0%
Cases concluded at investigation stage	3,185	3,715	2,355
% investigations using clinical advice	79%	75%	75%

This data shows that between 2016-17 and 2017-18, although there was a 37% year on year decrease in the total number of investigations we concluded, 75% of these investigations in each year required clinical advice. In the previous year, 2015/16, the figure was only slightly higher, standing at 79%. In addition, while there was a slight increase in 2017-18 in the number of cases concluded at our assessment stage that required clinical advice, overall, the use of clinical advice at this stage remains relatively low.

The Review Team does not currently anticipate that any of its recommendations will significantly disrupt this relatively consistent demand for clinical advice as a percentage of our overall health related casework.

The current process

To inform the work of the Review Team and to aid external understanding of how we commission and use clinical advice we have developed a set of process maps to set out how the clinical advice process currently works across four key stages of the casework process:

Assessment Stage

- Clinical advice may need to be obtained at this stage in order for a caseworker to make a decision as to whether to investigate.
- It is rare that a complex caseworker obtains clinical advice during the assessment stage, though it is important to note complex caseworkers have only just started routinely carrying out assessments.

Investigation Stage

- Clinical advice may need to be obtained at this stage in order for a caseworker to make their decision on a complaint.
- This is the most common stage at which clinical advice is commissioned and can involve multiple requests either for the same adviser or for an adviser of a different discipline (especially in a complex case). Advice can be captured in a variety of formats.
- Complex caseworkers follow a slightly different process, which is captured on the process map.

Comments received after sharing provisional view

- This captures where clinical advice might be used at the provisional view stage. After being shared with the complainant and organisation we investigate there could be criticism of the clinical advice from either of these parties. The clinical advice used may need to be reviewed, or a new piece of advice obtained.
- To commission a new piece of clinical advice at this stage is relatively uncommon.

Post-Final report (Review and Feedback Team)

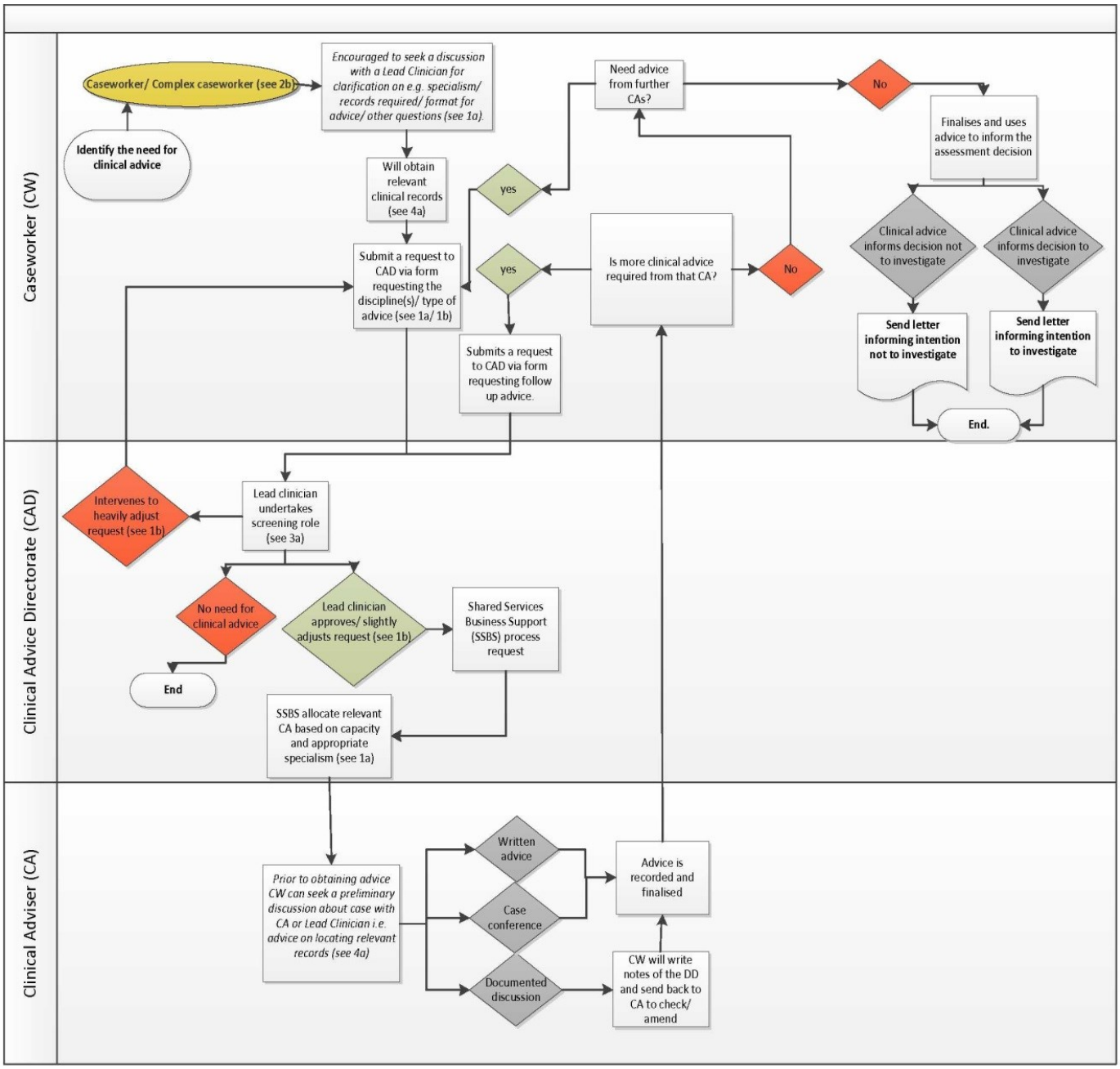
- This captures where clinical advice might be used once a final report has been published. The complainant may use our Review and Feedback team to request a review of the findings. This could involve that team commissioning a new piece of clinical advice.

- Again, commissioning a new piece of clinical advice at this stage is relatively uncommon.

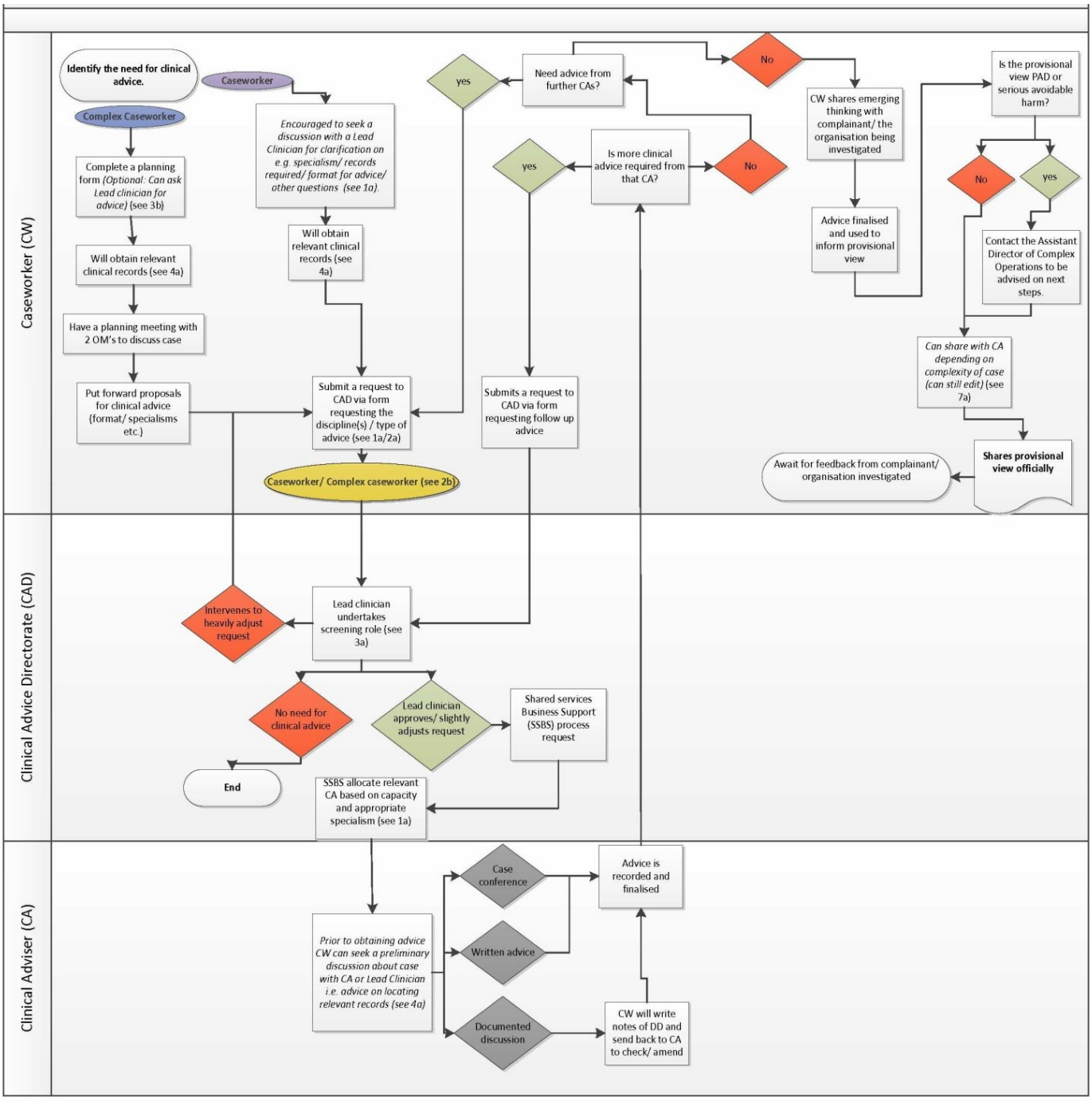
The maps for each stage are set out below. For a key and terminology, and further contextual information explaining points of detail, see Appendix A.

The maps do not cover the administrative functions that support the overall process, although the Review Team will be considering this as part of its wider work on the structure of the clinical advice function.

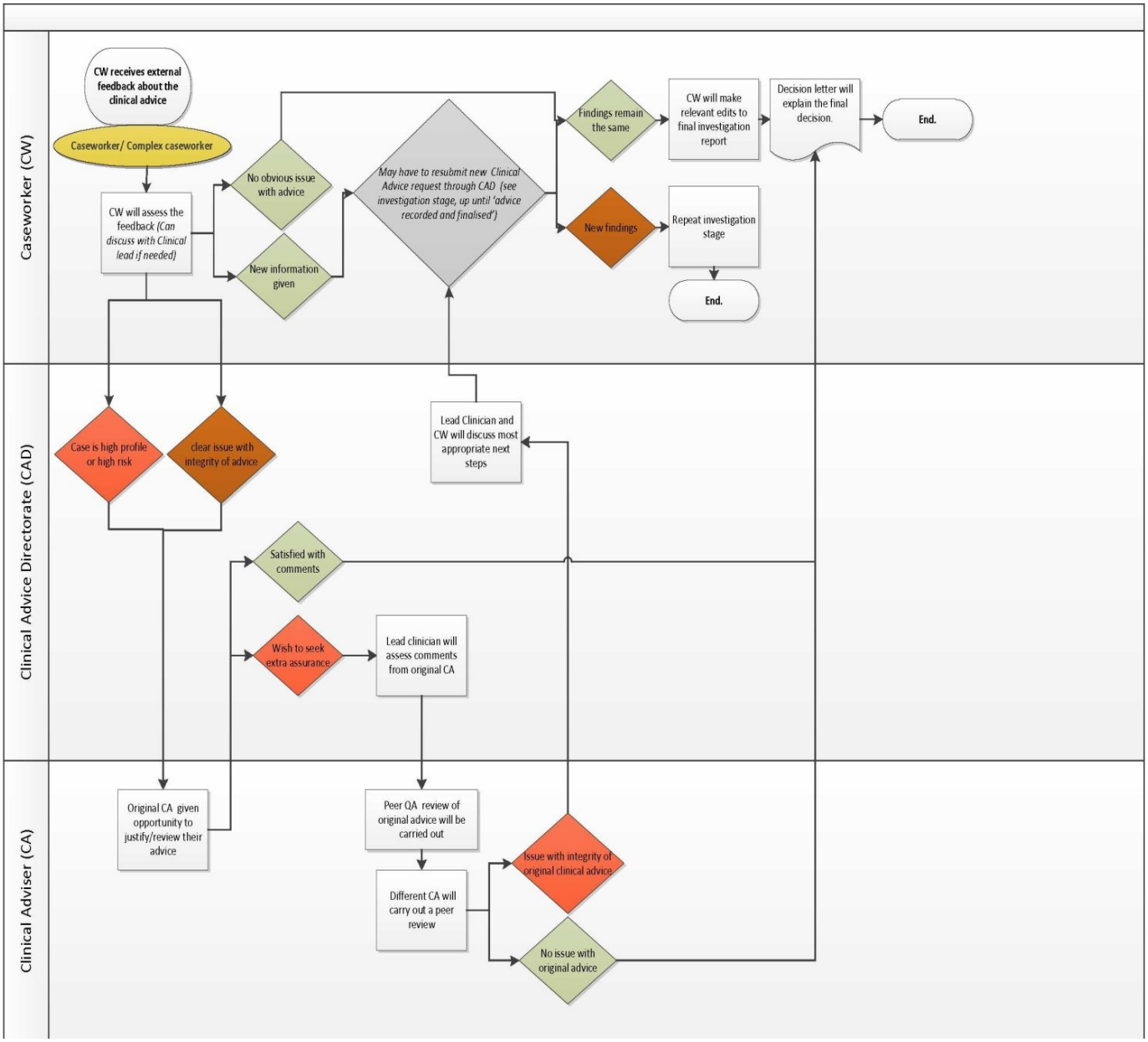
Assessment stage



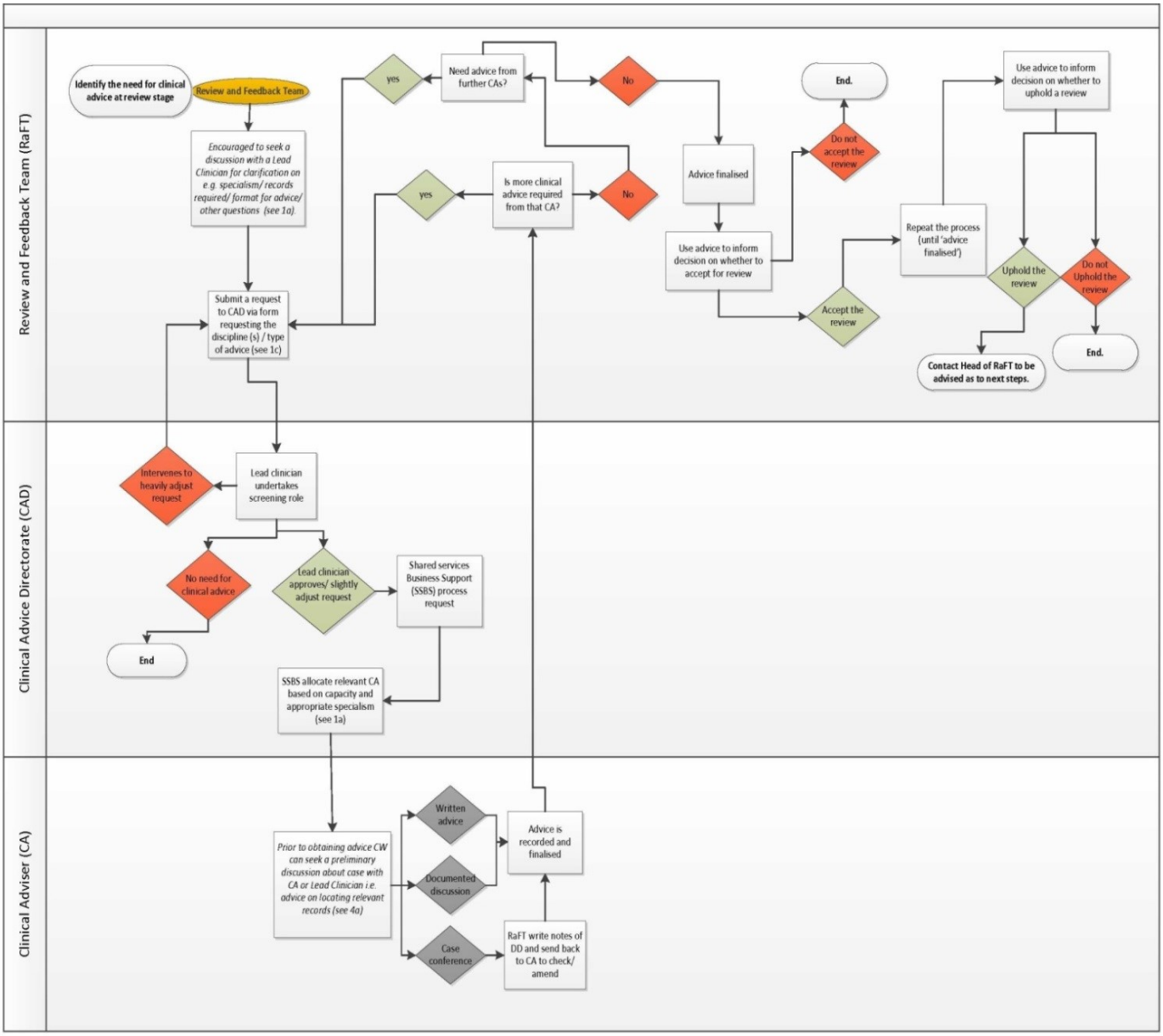
Investigation stage



Comments received after sharing provisional view



Post - final report - Review and Feedback Team (RaFT)



Following the consultation, **the Review Team has recommended that these process maps are updated and re-published** to reflect any necessary changes in light of the recommendations it has made once these are implemented.

The current principles

As set out in our consultation paper, to date we have used a set of core values and behaviours to underpin its approach to requesting and receiving clinical advice. These are that:

- Caseworkers and clinical advisers work in partnership
- Caseworkers and clinical advisers understand and have respect for each other's distinct role
- Caseworkers and clinical advisers will communicate effectively along the pathway of a case, which includes the request for, and provision of clinical advice
- Problems are anticipated and addressed proactively in order to learn from casework and avoid delays

There are also two core principles we currently expects our caseworkers and clinical advisers to incorporate into their approach. These are set out below.

Key Principle 1 - Requesting Clinical advice

'A good request for Clinical Advice is defined by the scope of the complaint and is clearly understandable for the adviser, in which the questions are focussed and specific to address the clinical aspects of the complaint'

Current features of Key Principle 1:

- A clear understanding and analysis of the evidence and scope of the complaint by the caseworker ensures that clinical advice is only requested on matters that require it.
- The investment of time to consider the need for, and type of advice, promotes timely and focussed clinical advice.
- Caseworkers seek opportunities for early discussion to inform appropriate requests for clinical advice for those cases that are not clear.
- Clear signposting is embedded within the questions posed by caseworkers

- Questions asked and documents provided are proportionate and relevant to the scope of the complaint and the type of advice requested

- Case files are prepared and presented with relevant, ordered and identifiable information

- Caseworker should request advice in discussion format unless explanations of complex issues or more in-depth analysis is required.

- Carefully considered initial questions reduces the need for further clinical advice at a later stage

Key Principle 2: Providing Clinical Advice

'Clinical advice enables caseworkers to understand the clinical issues and helps them to make findings about clinical matters'

Current features of Key Principle 2:

- Clinical advice is obtained from appropriately qualified and experienced healthcare professionals.

- Clinical advice – Written and Documented Discussion, meets the relevant Quality Assurance standards such that it is able to withstand challenge.

- Questions are answered in Plain English with clinical terms properly explained.

- Clinical advice is based on a clear understanding of the scope of the complaint and in response to the questions asked by the caseworker.

- Clinical Advice is based on evidence reviewed and is referenced within the body of the advice to recognisable, time-appropriate guidance and standards and in line with the Ombudsman's Clinical Standard.

- Clinical advice is objective and unambiguous, with no emotive language or reference to purely personal practice and or individual opinion

- Clinical Advisers avoid addressing matters outside the scope of the complaint put to them.

- The significance of any clinical failings are described to enable the caseworker to make a judgement about a case

The Independent Adviser to the Review Team is considering these principles in detail as part of his work and has invited feedback on improvements that can be made in the Review Team's consultation.

Quality

In addition to having strong underlying principles when using clinical advice, it is important that there is a clear understanding about how we assure ourselves of the quality of what we receive from our advisers and how this is applied. This is particularly important if both the complainant and the organisation we investigate are to have sufficient confidence in the way we have taken our decision, even if they do not agree with the conclusion we may have reached.

While we have robust processes in place already to check the quality of the clinical advice we receive, the Review Team have identified some gaps that they are recommending we address.

Our current process includes different elements depending on the types of adviser we use. We use a mix of clinicians of a similar if not the same clinical speciality, and other clinicians not of the same specialty but experienced in providing advice to conduct our quality assurance reviews so that we get a rounded view on what is being provided from different clinical backgrounds.

For our internal clinical advisers, meaning those we directly employ on a permanent part-time basis to provide regular advice, all new starters will have as a minimum their first six pieces of advice quality assured. Feedback is also obtained from caseworkers at this stage on the advice they have received. After these first six cases, the adviser will then either be signed off as providing advice at a sufficient standard or their advice will continue be monitored until they either reach this point or they leave the organisation. Once they have been assessed as meeting the necessary standard, all our internal advisers will usually have at least two pieces of advice quality assured each quarter, with feedback provided to their line manager on the outcome.

For our external advisers, meaning those we employ on an ad hoc basis to provide specialist advice in areas where we usually receive fewer complaints, the first three pieces of advice provided will be quality assured in the same way we do for internal advisers. Once an external adviser is signed off as providing advice of the appropriate standard, their advice will still be periodically reviewed, usually on a minimum bi-annual basis, depending on how much advice is provided over the course of a year.

In looking at our processes the Review Team has noted that caseworkers can refer the advice they have received for quality assurance if they have concerns. It has also noted, however, that there appears to be limited opportunity for clinical advisers to formally reciprocate and provide feedback on the quality of the requests for advice they receive, although this does happen on ad hoc basis.

Asking the right questions in the right format as early as possible in a case can have a real impact on how quickly it progresses. Ensuring that caseworkers are drafting clear and appropriate requests for advice is therefore crucial.

The Review Team has therefore recommended that a formal system be established as part of our processes to enable clinical advisers to provide structured feedback on the quality of requests for advice they receive.

In the course of its work the Review Team has seen work already developed by the clinical advice management team that identified this gap. Unfortunately, however, the online survey solution they had identified to fill it has consistently been delayed due to the wider change pressures faced by the organisation.

The Review Team recommends that this online survey should now be implemented as quickly as possible.

Similarly, as clinical advisers can be referred by caseworkers for specific quality assurance in relation to the advice they provide, *the Review Team has suggested that the reverse should also apply. This would mean that where clinical advisers have concerns about how their advice has been recorded, whether through a documented discussion, in a provisional views report, or a final investigation report they should have a formal mechanism for reporting this.*

The Review Team has noted, however, that at present advisers are not routinely asked to review how their advice has been translated into either the provisional views that are communicated or final investigation reports, although this does happen in some cases, particularly the most complex. It is the view of the Review Team that this ad hoc approach is not right and that a more robust process is needed to ensure not only the correct application of clinical advice but also that is communicated as clearly as possible.

This is supported from some of the evidence the Review Team has heard from advisers. For example they were told that, when advisers have been asked for their views on the feedback received from complainants and organisations we investigate on the provisional views that have been issued, this could often have been addressed by better explaining the clinical advice provided. Involving clinical advisers at this stage could therefore help reduce the amount of feedback received at the provisional view stage and increase understanding and confidence of how clinical advice has been used.

Although clinical advice is only one part of the evidence considered by the caseworker when reaching their views on a case, it can often be the most complex element. It is clearly essential that there is full confidence that the clinical advice provided has been fully understood and applied by the caseworker in relation to the case.

The Review Team has therefore proposed that it should become an established part of the process that clinical advisers are always given the opportunity to comment on the application of the advice they have provided in the provisional views and final investigation reports that are issued to ensure their advice has been accurately summarised.

The Review Team has also noted the importance of making sure that internal training programmes are updated to reflect this new approach prior to implementation.

Finally, the Review Team has noted that there is a wider ambition to develop a formal accreditation process for caseworkers as part of the new 3-year strategy.

The Review Team has recommended that once the new feedback process it proposes has been developed and implemented, consideration is given to how the information generated can be built into the new accreditation process.

The Service Charter

Our Service Charter makes commitments about the service we provide at different stages of our process. We use these commitments to measure how well we are delivering our service and understand where we need to improve. To measure our performance we use an independent research company to anonymously survey complainants that use our service at all stages of our process. We publish the data we receive through this survey on a quarterly basis. As outlined in the data section above, clinical advice is used in almost 75% of our health investigations, which in turn account for almost 9 in 10 of all our investigations. Despite this, however, we do not specifically ask complainant's views in our survey on whether the use of this advice and how it has informed our decision has been sufficiently clear. This is also true of the survey that we have recently launched seeking the views of the organisations we investigate on the service we provide.

The Review Team has proposed that once the new investigation report templates that are being developed are implemented, the views of complainants and organisations investigated should be sought on whether the use of clinical advice in relevant decisions has been sufficiently clear. This could be done either through existing surveys or other means.

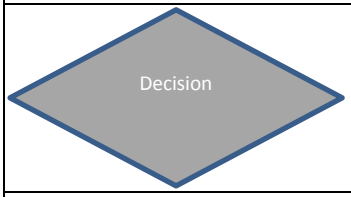
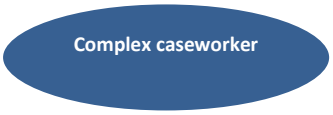
The Review Team's view is that this would increase understanding about whether some of the underlying issues that led to the review being established in the first place have been addressed or if more work may be needed.

To that end, **the Review Team has also recommended that if it is possible to collect any such data before the changes to the investigation report templates are implemented, this should be done.** This would provide baseline data to help measure the impact generated by the changes it proposed in this area.

Appendix A – process map, key and background

Key and terminology for Clinical Advice Process Maps

Italics – optional/ encouraged
QA – Quality Assurance
RAFT – Review and Feedback Team
CW – Caseworker
CCW- Complex Caseworker
SSBS- Shared Services Business Support
CA – Clinical Adviser
CAD – Clinical Advice Directorate
OM – Operations Manager

Shape	Meaning
	A step within the process.
	A decision has been made. Green captures 'Yes' and Red captures 'No'. Grey captures other decisions.
	This signifies the start or end of a process.
	A document has been shared i.e. a decision letter/ provisional view.
	The process that only a complex caseworker would follow.
	The process that only a caseworker would follow.
	The process that only Review and Feedback Team would follow when deciding whether to review a case.
	The process that both a caseworker and a complex caseworker would follow.

Question	(a) Clinical Lead	(b) Caseworker	(c) Review and Feedback Team (Post-final report)
(1) Submitting a request for clinical advice	Once the request has been received into Clinical advice directorate, the specialism is reviewed as part of the screening activity by a Lead Clinician. The request is then assigned by colleagues in Shared Services Business support who take into account individual adviser workload, availability, and applying their knowledge relating to sub specialisms and conflict of interest (having an oversight of adviser working patterns and NHS roles). This advice is sought in-house, but can also be sought from an external adviser if the specialism required does not exist internally, or where demand exceeds current capacity Caseworkers are encouraged to seek Lead Clinician advice regarding the specialism required before submitting their request if they are unsure. Type of queries may include the specialism/ records required/ format for advice. Clinical leads remain present throughout the process to give advice and guidance and appropriate next steps, as well as helping to deal with outlier cases.	*(CCW)* complete the same Dynamics clinical advice request as you would for any other case. *(CW)* If the advice request is not in line with standards, lead clinicians may come back to the caseworker and ask them to alter the request and/or provide additional information. This can be at both assessment and investigation. This can also happen when working with the adviser to deliver the advice. *Lead Clinicians will make a suggestion and ask the CW if they agree. They will not make a unilateral decision to change the format of the request.	In general they follow the same process as caseworkers doing assessments and investigations process up to 'Advice finalised'. Clinical advice is not always needed; it depends on the information in the review request. We will review a decision where we see information that suggests we got something wrong that could change the decision. So, often, clinical advice is obtained to see whether 'new' evidence received changes the original advice obtained during an assessment/investigation. We may also obtain clinical advice to help explain the reasons for investigation findings/decisions, and/or to help us understand the significance of information in a review request. The original adviser would be approached, unless there were concerns about the integrity of the advice or other reasons to request new advice from a different adviser, such as change in specialism, or the individual no longer works for the office.
(2) Difference between Assessment/ Investigation	The process is the same (regarding declarations, standards for the provision of clinical advice, for example) regardless of the stage at which it is required. A request is submitted to Clinical Advice and screened in the same way. The stage at which the advice is requested is defined on submission of the template.	*(CCW)*The complex team has only recently started doing assessments, so they have relatively little experience of requesting advice to help with the 'Should we investigate' decisions. Advice at this stage could be written or DD and could generate further questions, either for the adviser who has provided the advice or for an adviser with another specialism. (*CW*) The difference between advice at assessment/ investigation is that the clinical advice is likely to be more focused on a specific incident or focused to allow us to make the correct specific/general discretion tests.	

(3) Format of Clinical advice - how to decide what is most appropriate?	The format of the clinical advice is decided by the CW prior to submission of the request. CWs are encouraged to seek a discussion with a Lead Clinician if they are unsure as to the most appropriate format for the individual case. Upon screening, the Lead Clinician will contact the CW if the format requested is not the most appropriate, following which the request may be amended. Clinical advisers may also highlight concerns about the format of the request and ask if they can change from DD to written or vice versa. Clinicians are encouraged to discuss this with the caseworker prior to commencing the provision of advice, in particular where the complexity of the case, or the need for careful clinical explanation might be better presented in written format. In some cases, following a DD, there may be an agreement that the adviser writes up the advice writes up the advice due to the reasons above.	(*CCW*) Complex goes through a detailed planning stage for each investigation. They complete a planning form and have a planning meeting with two Operations Managers. At the planning meeting the Complex team SCW puts forward their proposals for clinical advice, including the specialisms they think are needed, the questions they plan to ask, and whether the advice is to be written or DD. Sometimes a Complex team SCW will ask a lead clinician for advice while completing the planning form to help them decide on the specialisms needed. In the advice request itself Complex team SCWs ask three basic questions: what should have happened; what did happen; and if there was a gap between what should have happened and what did happen, what was the impact on the person affected. We often append the advice in full and then reference it into our provisional view. (*CW)* In standard investigations narrower questions are asked and then the relevant advice is weaved into the provisional view.	

(4)When should relevant clinical records be asked for?	The CW should obtain the relevant clinical records prior to submission of the request, otherwise delays are encountered in clinical advice and the case may have to be returned awaiting arrival of the correct records. As with the format of the request and the specialism of the adviser, CWs are encouraged to seek a discussion with a Lead Clinician prior to submission of the request if they are unsure about the records required. After a request has been submitted, but before advice is obtained a discussion can be had with a Lead Clinician, a clinical adviser or with an internal only where it relates to signposting (specialism/records required/questions, etc). It is important to note that it is not intended nor appropriate that advice is sought which may be relied upon in making findings on a case. That would represent formal advice and would need to be requested as per process		We usually already have the relevant clinical records as these have already been obtained before the case comes to us (but not always) and we do not share provisional views.
(5) When should you ask for relevant standards from the organisation investigated?	This has not been a routine approach in casework, but it has now started to be applied in new cases following the outcomes of caseworker learning from the Miller & Howarth Judicial Review – This area relates to directly to caseworkers and not clinical advice. However advisers will be asked to apply the standard used by the organisation/ individual.	(CCW) Ahead of the planning meeting the Complex team SCW will also try to identify any standards and guidance that might be relevant. But sometimes it is simply not possible to identify the standards and guidance. Therefore, we nearly always ask our questions to clinical advisers about what should have happened starting with something along the lines 'with reference to relevant standards and guidance please tell us …'. This is also applicable to 'standard' caseworkers and senior caseworkers. The request for this information from the organisation will be from the caseworker.	

(6) Quality Assurance at Provisional stage	The usual approach when clinical advice is challenged is for the original adviser to have the opportunity to comment on the issues raised in order to either add more clarity/evidence to their original advice or to stand by it if no additions are required. It is not routine practice to seek fresh advice as that may suggest that we do not agree with the original advice which may not be the case. The exception may be where it is clear that the advice provided clearly cannot be used due to conflict of interest, evidence of bias, inappropriate language, for example. A discussion with a Lead Clinician should then take place to agree next steps. If concerns are not so significant that the original advice cannot be used, but we wish to seek assurance about the clinical correctness of the advice, and following discussion with a Lead Clinician agreed, an option is to obtain a peer Quality Assurance review of the original advice. This is not the same as new advice. If, after discussion and QA, concerns are maintained about the integrity of the original clinical advice, the last resort might be to seek fresh advice. Sometimes this is deemed necessary in cases where there are very limited guidance and standards upon which to reach findings. Fresh advice however, does not always result in clear-cut clinical views and must be taken within the context of the clinical events complained about where clinical care and treatment is not always black and white. This may lead to a wider discussion with line manager, clinician adviser, Lead Clinician and Assistant Director.	*(CCW)* Our first recourse would be to the clinical adviser who provided the original advice. Generally, we would only seek second advice if we had concerns that the advice we had received from the adviser might not be correct and we wanted the reassurance of a second opinion. Or if the case is high profile or high risk. Occasionally, in high profile, high risk cases, we have actually taken the decision at the outset to obtain more than one piece of clinical advice for each specialism. For example, in the anorexia case we published in December 2017, we decided at the planning stage to seek clinical advice from two psychiatrists and two psychologists.	N/A

(7) Sharing how the advice is captured with the Clinical Adviser	We do not routinely share provisional views with advisers.		We would not go back to the clinical adviser to share how the advice is captured because, generally, we do not share the review analysis externally. The clinical advice obtained during a review is used to seek assurance on the final decision being reviewed and is for our internal processes only although we do tell the complainant what the outcome of the review was and the reasons for it.
(8) Quality Assurance throughout entire process	We carry out Quality assurance of our clinical advice – this includes quarterly peer reviews for our internal advisers and scheduled QA of our external advisers. This could be identified directly by clinical advice support team, or the caseworker if they have concerns about the case and advice All co-ordination of this activity is managed and supported by the business support team. After which the Lead Clinicians access the reports to discuss at 1-2-1's. If any concerns are identified they are fed back to individual and there will be a discussion with the caseworker to identify any further actions required to ensure that they are able to work with the case.	*(CW)* QA for caseworkers and senior caseworkers in 'standard' would be to check whether the advice answers the questions and references appropriate standards/ guidance.	

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