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EDITORIAL

The Independent Review Process

Complaints are now part of life in the NHS, no longer being the exception but perhaps not quite being the rule. The complaints system is currently under review by the NHS. One component, the Independent Review, has been an important part of the complaints system and, even though changes will take place, it is likely that in one form or another, the Independent Review will survive. This is because its very name embodies what everybody wishes when something goes wrong, i.e. an independent view of events. As a non-executive director of a busy general teaching hospital, I have been the complaints convenor for the last six years or so and have dealt with a number of Independent Reviews, none of them (because of my specialty) in psychiatry. Every trust has at least one non-executive director who deals with this part of the complaints system.

Any complainant has the ability to ask for an Independent Review. When that request is put down in writing, the trust responds, involves the complaints convenor, who consults with a lay chair nominated by the local NHS commissioners. These lay chairs have no medical knowledge, but are generally experienced in one sphere or another – either in business, local government, or one of the professions. The convenor will discuss the details of a particular complaint with the lay chair and agree on a course of action. The lay chair, at this stage, generally remains anonymous, but the convenor writes in person to the complainant and other interested parties. One of the reasons this part of the complaints system is under review is the lack of perceived independence of it. The convenor writes on trust notepaper, has all the administrative support paid for by the trust and, of course, receives an honorarium for being on the trust board. The convenor is always at pains to emphasise that he or she acts independently of the trust but, in the general public's mind, this sometimes does not seem to be the case. One can have a certain sympathy with an outside view that a person in such a position is not truly independent.

Generally, complainants ask for an Independent Review after a series of meetings with hospital staff have taken place and he or she is still unhappy with the outcome. One of the most common decisions made on first assessing a request for an Independent Review is that a further meeting or meetings should take place between the complainant and members of the hospital. This 'local resolution' has to be exhausted before an Independent Review can be formally considered. If complaints indicate they wish to involve a solicitor, or are thinking of suing the hospital, the Independent Review process ceases immediately.

If a meeting or meetings have taken place and it is clear that resolution is not going to be achieved, the complaints convenor and the lay chair will consider whether an Independent Review is appropriate or not. This is often a fine judgement. The aim of the process is to uncover a policy, process, or action which, if remedied, could improve the care of patients in general, largely in that particular trust, but of course it may have implications for other trusts. Where the complaints convenor and the lay chair feel that no further information will come to light as a result of having an Independent Review, then there is no justification for going ahead with one. For

example, if a patient was to complain that a member of staff did or did not do a particular thing, then it is unlikely that an Independent Review would be able to come to a decision as to what actually happened, so, if a patient complains that a member of staff has been rude to them, an investigation has taken place and an apology offered if appropriate, then an Independent Review is not needed as it will not uncover any additional information about the incident. Many complainants feel that an Independent Review is like a court of law and that a verdict will be given, but this is not the case. If there is an episode of care where perhaps more than one thing has gone wrong, and if independent scrutiny and consideration of all the facts of the case would lead to a judgement being made on the appropriateness of care, then an Independent Review is worthwhile. For example, if a patient was admitted and not operated on and then suffered harm as a result of that, it may be that an Independent Review would ask an expert or experts to judge whether the decision not to operate was appropriate or not.

If it is decided to proceed with an Independent Review, an Independent Review panel is set up. This consists of the lay chair, the complaints convenor, and one other non-clinical person nominated by the Health Commission in whose area the trust lies. One of the most important things for the convenor to do is to establish the terms of reference. These can be a series of three of four questions which are addressed by the panel. For example, it may be a broad questions such as ‘Was the treatment that Mrs H received in the trust of an acceptable standard?’ or it may be a particular question such as ‘Should a blood test have been taken on admission, and would the results of that blood test have influenced the outcome?’ These terms of reference have to be agreed in writing by the complainant. They are useful because it sets clear parameters by which the review panel acts.

The panel is advised by at least two independent advisors. These are experts in a particular field from outside the geographical Region who come along, for a modest daily stipend, and review the notes and interview the main parties involved. They advise the panel, but it is clear that it is the panel’s and particularly the chairman’s report. In a small specialty, it is likely that the advisors will be known to some of the medical staff against whom the complaint is made, and it is important that that is stated upfront.

The panel convenes, usually, for a full day, and a number of people are seen. Usually, the complainants and/or their representatives are seen first, and then members of staff are interviewed, including medical staff, nursing staff, and managers. Occasionally, the chief executive is interviewed if there is a particular point of policy.

A report is then put together by the lay chair. The background to the incident or incidents is given, with a summary of what happened on the day, and the terms of reference are specifically addressed, followed by a number of conclusions and recommendations. All three panel members have to agree the report. The advisor’s comments are usually put in as an appendix.

If the complainant is still unhappy with the outcome, then they have the ability to refer to case to the Ombudsman. The Ombudsman can decide whether the panel conducted its business appropriately or not. These judgements are usually made on

the process involved and not on the panel's decision on an individual term of reference, although if the panel has come to an outlandish decision, this will be usually obvious.

Although not meaning to be an adversarial process, the procedure inevitably may appear so. Some panel members can be quite forceful, and some staff members inevitably quite defensive. The process is particularly stressful on more junior nurses who are as likely to be called as senior clinicians. One of the roles of the convenor is to act as support for hospital staff before and after the panel.

Independent Reviews can be a good thing in that they give the complainant a chance to discuss complex issues of the case in front of an independent group. This can often resolve their own concerns about treatment and care, which is of benefit to everybody if handled correctly; and if clinicians see the process in a non-adversarial way, it may help by examining one's own processes and practice. I am probably unique in that I have had an Independent Review following a complaint about me of a patient under my care, I have acted as convenor in a number of reviews, and have been an expert assessor on one. While Independent Reviews will probably be consigned to history in their present form, some of the beneficial aspects will hopefully live on.

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ARTICLE

Camberwell Assessment of Needs for the Elderly (CANE)

Interest in the assessment of needs on an individual basis came about in the 1990s after increased focus on care in the community. Various research initiatives showed the number of needs an individual had and in particular, the number of unmet needs, was strongly related to an individual's health-related outcomes and other important outcomes, such as quality of life (UK 700 Group, 1999). 'Needs-based' assessment and care planning have since received much attention in the literature and instruments have been developed to assess the met and unmet needs of individual patients. Care-plans based on unmet needs have many benefits for individuals and health care professionals, involving users in their care and establishing meaningful outcomes for people. The CANE was developed as a comprehensive and holistic needs assessment instrument for use with older people. The instrument was based on the Camberwell Assessment of Needs (CAN), which was developed for assessing needs in adults with mental health problems (Slade *et al*., 1999). The CANE used a similar format as the CAN but adapted items to look at the particular needs of older people. The draft instrument was then tested using a Delphi process and psychometric testing of the final instrument demonstrated that it had good validity and reliability (Reynolds *et al*., 2000). Since publication of these initial trials the instrument has been translated into various languages and similar psychometric properties have been tested in these countries (Orrell & Hancock, 2004).

Within the UK, the CANE has been used in a wide variety of contexts, such as long-term care, community groups, primary care, sheltered housing, and day-hospital care. The CANE uses an open question format to guide the interviewer through 24 areas of need (see Table 1).

Table 1: Areas of need assessed by the CANE.

1. Accommodation	2. Household Activities
3. Food	4. Self-Care
5. Caring for Another	6. Daytime Activities
7. Memory	8. Communication
9. Mobility/Falls	10. Continence
11. Physical Health	12. Drugs
13. Psychotic Symptoms	14. Psychological Distress
15. Information	16. Safety (deliberate self-harm)
17. Safety (accidental self-harm)	18. Abuse/Neglect
19. Behaviour	20. Alcohol
21. Company	22. Intimate Relationships
23. Money	24. Benefits
A. Carer's Need for Information	B. Carer's Psychological Distress

The two additional areas concerning needs of carers are not added to an individual's total needs score, but were included to acknowledge the important role that carers have in many older people's lives. The administrator largely controls the nature of the interview and therefore can adapt their approach for the individual and the setting. This interview style is 'person-led', which means that when a person has few needs the interview will take a shorter period of time (10-20 minutes). When there are many or complex needs the interviewer can respond and the CANE collects more information concerning the details of the individual's situation. An unmet need is defined as a significant problem for which there is an available intervention, which could possibly alleviate the person's need. The CANE therefore requires the administrator to have sufficient knowledge of needs commonly encountered by the elderly and of local resources which could potentially be used to help. On the other hand, use of the CANE can also encourage the development of clinical skills through liaison with other professionals and agencies.

Various parties involved in caring for the older person can be interviewed using the CANE and there is space provided to record their responses independently of each other, this includes the individual, staff member, family carer and the researcher. The CANE documents met and unmet needs in each area, such that the results of the assessment show clearly where the needs are for the individual, what services are being currently provided to meet the person's needs or where more assistance may be needed to meet the unmet needs identified. As such, the CANE summary can give immediate direction as to how to meet unmet needs, given the interviewer's knowledge of local services or the information can be used to highlight risk factors or gaps in current service provision (e.g., need for a day-care service). Where there may be discrepancies between parties involved, the information collected using the CANE can be a starting point for discussion of differing perspectives, prioritising interventions, and maximising positive outcomes for the older person (e.g., a

discrepancy between local staff and the patient, may highlight need for patient education about local services). The CANE has also been used to measure outcomes of services in meeting individual needs over time (see Ashaye, 2003).

Overall, the body of work on the CANE has shown that unmet needs are prevalent in various samples of older people, in both community and institutionalised settings and that many of these needs go undetected. This work has also highlighted that these needs are related to other important variables, such as, social networks, psychological distress, satisfaction with services and quality of life. In addition, this work has indicated that older people from many different settings and situations can be successfully prompted about how they view their needs and that this information can inform local services to improve individual care packages and outcomes. Common unmet needs in most of these studies cluster around social (company, stimulating activities) and psychological (depression, anxiety) needs and it is to providing suitable (available and acceptable) interventions for these types of unmet needs that we must now turn. A list of interventions was compiled for each item on the CANE, to show the actions taken to meet the unmet needs identified. These needs were based on current best practice guidelines, but also allowed for the use of clinical judgement, dependent on the needs of the individual and their situation. Logging the actions taken meet unmet need means the efficacy of the interventions can be evaluated and the log used as a reference guide for future care-planning.

Over the past two years the CANE instrument has been through a process of further refinement and is presently being published into a book on needs of the elderly. Administrators will be able to use and freely photocopy the CANE instrument with the purchase of the book. The book also contains extensive information on the application of the CANE in various settings based on previous research, including its use abroad. In addition, the book contains a training pack and overheads for larger 'trainer-led' sessions. Ongoing study using the CANE continues to take place in residential care, sheltered housing, in primary care with the development of the Short-CANE, and overseas in Brazil, Germany, Norway, and Spain.

Further information on the CANE book can be obtained at www.rcpsych.ac.uk/publications or email: g.hancock@ucl.ac.uk

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CURRENT KEY ISSUES

The cognitive benefits of galantamine are sustained for at least 36 months

Raskind, M. *et al*. (2004) *The cognitive benefits of galantamine are sustained for at least 36 months*. Archives of Neurology 61, pp. 252- 256.

The objective of this study was to report the long-term cognitive effects of galantamine in patients with Alzheimer's disease over 36 months. 194 patients in the USA with mild to moderate Alzheimer's disease who had been randomised to continuous treatment in two double-blind, placebo-controlled trials and who subsequently received open-label treatment for up to 36 months were studied. The main outcome measures were cognitive decline in the galantamine-treated subjects compared to those in a clinically similar historical control sample of people with Alzheimer's disease who had received placebo for 12 months and with the mathematically predicted decline of untreated patients over 36 months. The main results were that patients treated continuously with galantamine for 36 months had a mean increase of ten points on the Alzheimer's Disease Assessment Scale 11-item cognitive subscale, a smaller cognitive decline (approximately 50%) than that predicted for untreated patients. Almost 80% of people who received galantamine continuously for up to 36 months seemed to demonstrate cognitive benefits compared with those predicted for untreated patients. The conclusion of the study was that cognitive decline over 36 months with continuous galantamine treatment was less than the predicted cognitive decline of untreated patients with mild to moderate dementia, and suggests that this anticholinesterase could slow down the clinical progression of Alzheimer's disease.

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Anger and depression management: psychoeducational skill training interventions for women caregivers of a relative with dementia

Coon *et al*. (2003) Anger and depression management: psychoeducational skill training interventions for women caregivers of a relative with dementia**.** *The Gerontologist* 43(5), pp. 678-89.

This study examined the short-term impact of two psychoeducational small group interventions with distressed caregivers, examining the role of a specific moderator and mediating variables on caregiver outcomes. 169 women aged 50 and older caring for a person with dementia living in the community were randomly assigned to one of three treatment interventions - anger management, depression management, or a waiting list control group. The primary outcomes were anger or hostile mood, depressed mood, frequency of use of positive and negative coping strategies, and perceived caregiving self efficacy measured as a result of the interventions which took place over a three- to four- month period. The main effects were found in the expected direction for most of the measures. Significant reductions in levels of anger or hostility and depression occurred in the active groups, compared to the waiting list control group, but use of positive cognitive coping strategies increased in the anger management group alone. Self efficacy was greater in both the interventions groups, but was also found to be an independent mediator of the intervention effects. The results support a growing body of evidence which supports the effectiveness of skills training in small groups to improve the psychological state and type of coping strategies used by caregivers and underscores the need to evaluate key pretreatment variables in order to determine what particular form of treatment should be given, i.e. interventions should be tailored towards the need of an individual caregiver.

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BOOK REVIEW

Partnerships in Family Care: Understanding the care giving career

Mike Nolan, Ulla Lundh, Gordon Grant and John Keady (Eds) (2003*), Partnerships in Family Care: Understanding the care giving career* Open University Press,333 Pages, ISBN 0 33521261 1

Although not a second edition of Understanding Family Care (Nolan *et al*., 1996), this book builds on the concepts outlined previously. Through a range of conditions, including dementia, it charts the partnership between carers, those who are cared for and professionals in a variety of contexts, critically examining the nature of carer support. It explores how partnerships change over time and addresses the question of what is required to ensure partnerships are successful.

Section 1 focuses on the early stages of caring and draws on studies of early intervention in dementia and the experience of becoming a carer in the case of

stroke. Section 2 highlights the partnership issues involved with caring in the longer term with examples from both dementia and from parents caring for children with disabilities. The third and final section addresses partnership in periods of transition where there are several chapters concerned with both dementia and nursing homes.

Despite the broad spectrum of caring scenarios the underlying themes are particularly relevant to those concerned with older people's mental health and the central messages set out a strong challenge to professionals. Models of carer support provided by 'helping systems' are considered and frequently found to be too reliant on the concept of burden and in danger of pathologising caring. It is argued that this contributes to the dissatisfaction felt by carers who often perceive these services as poor quality or irrelevant.

In addition the case is put forward that despite decades of research there is still limited evidence of what is most useful in terms of carer support. The authors suggest that striving for more robust measures and attempting to enhance research evidence through trials is unhelpful. This stance will not resonate with everyone, but there is a coherent argument that the nature of caring is complex and temporal and thus unsuitable for 'closed end' methods.

So what is the alternative? Briefly, it is proposed that utilising a model of social validity, where processes and outcomes are those that are deemed important by carers and those who are cared for, would be more appropriate. The 'senses framework', designed to capture the subjective and perceptual dimensions of caring relationships, coupled with symmetry and synchronicity, is put forward as a means of re-focusing on the triad relationship. Furthermore there is a call for the impact of interventions to be assessed by what makes a 'real difference' rather than research outcomes.

Well written with a logical structure the book provides stimulating theoretical concepts for readers to wrestle with. The international case examples supply an array of scenarios to illustrate the arguments, some of which make uncomfortable reading. This is certainly an important and thought provoking contribution to the literature on caring.

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WEBSITE REVIEW

Free journals on the web (4)

Clinical Psychiatry News

A **full-text** newspaper that provides news and commentary about clinical developments and health care policy for the practising psychiatrist. Published monthly by International Medical News Group. Access to the journal is free, but requires registration.

http://www.eclinicalpsychiatrynews.com/scripts/om.dll/serve?action=searchDB&searchDBfor=home&id=qc

Neuroscience-Net

A Scholarly Journal Devoted to Publishing Research in Basic and Clinical Neuroscience is a new journal published in electronic-only format on the World Wide Web. **Full-text** access to the journal is freely available. Articles are indexed in the following sections: anatomy, pharmacology, molecular biology, physiology, psychiatry/psychology, theoretical neuroscience.

http://www.neuroscience.com/

eBMJ

The **British Medical Journal** is freely available, in **full**, online from the eBMJ Web site. eBMJ also offers additional services such as customised @lerts, which will e-mail you when articles in your chosen topic are published.

http://www.bmj.com/

Ageing & Society :The Journal of The Centre for Policy on Ageing and The British Society of Gerontology

Ageing and Society is an interdisciplinary journal focusing on human ageing, published by Cambridge University Press, and made available on the web by Cambridge Journals Online. Tables of contents are freely available from Volume 17 (6), November 1997 to the present, and full-text articles are available to subscribers.

http://journals.cambridge.org/bin/bladerunner?30REQEVENT=&REQAUTH=0&500002REQSUB=&REQSTR1=ageingandsociety

American Journal of Geriatric Psychiatry

This is the official journal of the American Association for Geriatric Psychiatry and is published by the America Psychiatric Press, Inc. The journal contains original research articles, brief reports, clinical and research reports and letters. Topics covered include dementia, Alzheimer's, depression, disability, diagnosis and classification of psychiatric disorders, epidemiology and biologic correlates of mental

health problems, psychopharmacology and treatment strategies for the elderly. The tables of contents and abstracts can be accessed for free online from 1997onwards and subscribers can access the full-text of articles from 1998 onwards.

http://intl-ajgp.psychiatryonline.org/

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YOUR PROBLEM ANSWERED

Question:
It is generally acknowledged that the mental health input our Trust provides for older people on general hospital wards is poor, with tired community-based consultants often squeezing in their hospital assessments at the end of a busy day. We are thus trying to develop a business case for the establishment of a dedicated multidisciplinary liaison team. Is there any research we could cite to support this?

Answer:
Thank you for your question. Unfortunately the situation you describe is not unusual. A recent UK survey (Holmes *et al*., 2003) found that approaching 75% of mental health services for older people provided a generic, sector-based consultation service for older people on general hospital wards, whilst nearly 90% of respondents were unhappy with the care they offered. A slow response time was seen as a particular weakness of the consultation model, with hospital referrals competing for time with those from the community.

The same survey reported that the vast majority of consultants aspire to providing dedicated, hospital-based, multidisciplinary models and such a view is in keeping with the recommendations of a joint report by the Royal College of Physicians and Royal College of Psychiatrists (1995). Certainly teams moving towards such a service have reported improvements in their response times and increased numbers of appropriate referrals (Collinson & Benbow, 1998; Scott *et al*., 1988; Mujic *et al*., 2004).

As of yet there have been very few controlled trials of the relative effectiveness of the different service models however, and the overall results in terms of psychiatric outcomes are best described as modest (Draper, 2000). The most encouraging findings come from a large American consultant liaison study by Strain *et al*. (1991) in which the successful detection and appropriate management of depression in elderly hip fracture patients produced a significant reduction in their length of stay, and hence hospital costs. A further study in the Netherlands (Slaets *et al*., 1997) found that integrating the psychiatric and geriatric teams also resulted in shorter length of stay and better physical functioning, whilst a smaller Canadian trial (Cole *et al*., 1991) reported that a consultation service had a small positive (if non-significant) effect on psychiatric symptoms and functional status.

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