2017 Report to the Investigating Committee from the Independent Complaints Moderator for BAcC
July 2018

This report is my sixth one as Independent Moderator of complaints for the British Acupuncture Council (BAcC). It covers the period 1 January – 31 December 2017 under the following headings:

1. Background

The BAcC is a membership body and a professional regulator accredited by the Professional Standards Authority for Health and Social Care under its Accredited Register scheme.

All BAcC member practitioners are bound by a Code of Professional Conduct (revised January 2015), a Code of Disciplinary Procedures (revised January 2018) and a Code of Safe Practice (November 2016; currently undergoing consultation). The January 2018 Code of Disciplinary Procedures substantially changed the processes for handling complaints about practitioners. The relevant codes and guidance under which complaints are considered are the ones in force at the time of the alleged incident that is the subject of the complaint.

The Codes are enforced by the BAcC's three Ethics Committees: Investigating Panel (IP), Professional Conduct and Competence Panel (PCCP) and Health Committee (HC). [Note: The names of the panels are those now used under the current Code of Disciplinary Procedures; previous reports referred to the Investigating Committee, as it was known before the Code changes.] The panels/committees are supported and administered by the Ethics Department of the BAcC and its Professional Conduct Officer (PCO).

Complaints about a practitioner who is a member of the BAcC can be made by a member of the general public, professional regulator, patient, fellow practitioner or member of any committee or employee of the BAcC. The PCO considers if a complaint falls within within the scope of the BAcC's Code of Professional Conduct and/or the Code of Safe Practice; if it does, then the PCO will notify the practitioner and progress the complaint, including referring it to the IP. The IP considers if there is a *prima facie* breach of the BAcC Codes; in other words, if there is a case to answer. The powers of the IP are explained in the BAcC Code of Disciplinary Procedures (January 2018).

The IP itself has no power to sanction a member through fines or disciplinary action. It can, however, refer a case to the PCCP, and it can recommend that the seriousness of the issues warrants temporary removal of the practitioner from the register (suspension) pending consideration of the case by the IP, PCCP or Health Committee. The IP can also decide there is no case to answer. Since 2008, the IP has been able to exercise its discretion not to refer a complaint to the PCCP where it identifies minor breaches of the Codes. In some cases, the IP will provide feedback to the practitioner and/or make recommendations for service

improvements. These are not binding on the practitioner, although the Ethics Department reports back to the IP as to whether the practitioner has complied with the recommendations, and this can be followed up if necessary.

The IP is made up of 3 members (one lay person, one acupuncturist and one person who is either lay or an acupuncturist), and is managed and supported by the BAcC's PCO.

2. Moderator role

My role as Moderator is set out in the BAcC Code of Disciplinary Procedures, Section 12 (Jan 2018 version). I have been appointed to review complaints made to the BAcC which the PCO decided not to refer to the IP and complaints that were referred to the IP but in which the IP found no case to answer.

My role is to review those complaints, describe how they were handled, and comment on the way they were handled in terms of communication and consistency. Where appropriate, I can make recommendations for improvements in the way complaints are handled by the IP. I also attend at least one meeting of the IP each year.

3. The BAcC complaints procedure

The complaints procedure sets out the steps in the complaints process, from the statement and supporting documents submitted by complainants through to the IP's decision. Practitioners complained of are required to provide a written response within 14 days of the BAcC requesting this, including copies of relevant patient notes. The IP then discusses the case at its next meeting, usually within one month.

The IP is entitled to ask for further information, including the complainant's comments on the practitioner's response, further relevant practitioner's notes and records, and a report from an independent Technical Assessor. The IP is also entitled to seek information and evidence from third parties and to seek advice from a lawyer or doctor. The IP then reviews any further information at its next scheduled meeting.

The IP must decide, following its consideration, whether there is a realistic prospect of a finding of impairment in relation to any allegation. Complainants are to be informed of the IP's decision within 14 days of the meeting at which the decision was made, although in practice this is usually done within 7 days of the decision meeting.

A guide to its complaints procedure (Information for Complainants), which clearly explains the role of the IP, the procedure, and what is required to submit a complaint, is sent to complainants and is also available on the BAcC website.

Under the 2018 Code of Disciplinary Procedures, both the complainant and the practitioner can appeal against a decision (including a decision not to refer a complaint to the PCCP or HC) made by the IP within 28 days of that decision (section 10).

4. Complaints this year: observations

In 2017, the IC found no case to answer in one of the complaints made to it, and this complaint was referred to me for consideration. I refer to the case by the numbering system used by the IC. I provide a brief description of the issues only, and do not include any names of the complainant (referred to as 'C') or the practitioner ('P'), in order to protect the anonymity of individuals involved.

Decisions of the IP are now recorded on a Decision Sheet, and the case information is contained within a Case Bundle.

Case 2/2017
Issues: adverse effects of treatment; unsafe practice; inadequate and lack of response to complaint

C complained to the BAcC of adverse effects resulting from treatment received from P. She was concerned that the area being treated had not been swabbed before needling and that as a result the site had become infected and developed an ulcer. She was also concerned about what she considered to be an inadequate response to her complaint when C showed P her leg following treatment, and about the lack of response when she later contacted P by phone and left a phone message to which P did not reply. C explained that she had had to stop work and was unable to walk very far because of the pain. She sent supporting evidence in the form of a letter from her employer, a letter from her GP and two letters from friends.

P's response to the complaint was sent from her solicitor and explained that she had not swabbed the site because the site was clean and there was no swelling, and no blood was drawn. The response explained that P followed the Code of Safe Practice on swabbing and also the guidance from the College of Integrated Chinese Medicine, which advises against swabbing unless the site is dirty. The response also stated that when P examined C after being informed of her concerns, she noted that the ulcer was in a slightly different location to the needling site. Regarding the allegation of an inadequate response to the complaint, the response explained that P had agreed to see C to examine her leg when requested, at no charge, and had advised C to return to her GP if any further problems. P had not responded to the subsequent phone message left by C because she was concerned at the tone of the message and therefore had sought advice. While seeking advice, P suffered a bereavement and had to travel abroad, which delayed her response to the phone message.

The IP considered the allegations and all the evidence submitted by both C and P, including supporting testimonials and P's treatment notes. The IP decided that there was no case to answer on the basis that:

- there was no definitive evidence-based rationale to support routine swabbing, noting there is considerable professional disagreement about this;
- there was insufficient evidence that the ulcer appeared as a result of the treatment;
- P acted appropriately in response to the concerns raised, although the IP noted that there was no follow-up by P after she examined C's leg and that P should have followed up after advising C to seek medical advice; and
- P's lack of response to C's phone message was understandable given the circumstances (the tone of the message and the bereavement).

Observations:
The IP's Decision Sheet and Decision Letters to P and C explain the reasoning for the decision and set out the evidence considered. It is clear that the evidence was carefully considered, not

only the evidence submitted by both parties but additional articles on swabbing technique. The IP considered the choice of needling point chosen by P and concluded that this was a conventional needling point that was appropriate for C's symptoms. It can be difficult to determine whether there is a causal connection between a problem experienced by a patient following treatment and the treatment itself, and it was not unreasonable for the IP to decide that there was insufficient evidence for such a causal connection in this case and that P had not committed a breach of the Codes.

Whether or not to swab before needling is generally left to the discretion and professional judgement of practitioners; the Guide to Safe Practice notes that there is professional disagreement as to the need for swabbing before needling. However, the Code states that practitioners must thoroughly clean any skin that has been treated with creams or oils before needling. It also requires practitioners to note the location of needles inserted during treatment.

I understand that the recording of IP decision-making has changed, and there are no longer any minutes recording the IP's deliberations; instead the Decision Sheet sets out the IP's reasoning for its decisions. I have therefore not seen any notes of the IP's deliberations. I have requested, and received, recollections from members of the IP that provide some further clarification of deliberations.

It is not possible to determine if the IP considered asking P specific questions about her practice, which might have helped the IP to determine if good practice had been followed. Among the questions that I think could usefully have been asked are:

- Is the needling site recorded on P's treatment notes? This might help to address the factual disagreement about the location of the ulcer at the needling site. I was unable to identify if the needling site was recorded in the notes.
- Did P open the needle in front of C? This is good practice under the Code of Safe Practice and also provides reassurance to patients.
- Did P ask C if cream had been applied to the needling site? This is a question to be asked when considering if swabbing is necessary before needling.
- Were GP details recorded on the treatment notes? This is a requirement of the Code of Professional Conduct.
- Was an Adverse Incident Report completed?

I believe the IP should have asked these further questions of P before forming a view as to whether any breach of the Codes had occurred or there was any lack of compliance with best practice. I am unable to determine with certainty whether or not the IP discussed asking further questions of P, nor can I determine if these issues were discussed in the panel's deliberations, although members' recollections suggest that the issue of GP details and needling site were discussed.

My other concern is that the IP noted a shortfall in P's service but did not feed this back to either P or C in its decision letters. In its Decision Sheet, the IP noted *'... the lack of follow-up by the practitioner to find out whether she had attended her GP and what advice was provided. The Committee considers that the Practitioner should have followed up with the patient subsequent to her seeking medical advice from the GP, although this would not have made any difference to the development of the leg ulcer.'* I would have expected this to have been fed back to both parties.

The decision letters are very thorough but also very formal. Given that this is an issue that has been highlighted in the past, I think it would be useful for the IP and the PCO to consider reviewing the tone and format of the decision letters, particularly in replying to C. For example, the expression of sympathy appears only at the end of the long letter to C explaining the IP's decision. This wording might be brought forward to earlier in the letter, followed by the detailed explanation of the IP's determinations.

5. Conclusions

I have noted two concerns about the complaint I considered from 2017: that the IP should have made further enquiries of P about her treatment and practice, and that the IP did not feed back to either party the issue about P following up with C after examining the affected leg. I have also suggested that the BAcC consider the format of its letters to complainants.

One of the questions that could have been asked in this case related to Adverse Incident Reporting, a point also highlighted in my report last year. I noted last year that the guidance on this was not consistent or clear. I have not yet seen the revised Guide to Safe Practice, but I understand that it contains an entire section on reporting adverse incidents, and also that a new policy on this has been developed. This is a welcome development. I suggest that this advice and guidance should be taken into account by the IP when considering complaints alleging adverse incidents, and where necessary practitioners who are the subject of such complaints should be reminded of their duties in relation to reporting and after care.

I noted last year that I am concerned that not all IP members have access to the members' section of the BAcC website, as this hampers their ability to consider complaints against all best practice guidance and advice for practitioners; it also hampers their ability to check that my recommendations have been actioned.

The Checklist that was introduced two years ago does not appear to have been used last year, and I suggest that this be reinstated. It included a note of parties' details, a conflict of interest check, a brief record of the outcome and follow-up actions. I would like to see this continue and for the checklist to be completed in each case.

Correspondence appears to have been completed within the timescales, and there was no delay in the IP’s consideration of the complaint I reviewed.

New recommendations:

- Consider whether further questions should have been asked of P in this case.
- Ensure feedback on any shortfalls in service identified (those not identified as a breach of the Codes) are fed back to both C and P.
- Consider the format of decision letters.
- Take account of the new guidance on adverse incident reporting.
- Reinstate the file checklist.

Previous recommendations:

- *Ensure all IP members have access to the members' section of the BAcC website*. I understand this is being actioned.

- *Consider clarifying the relationship between Action Plans and recommendations and the IP's role in following up recommendations and informing complainants of recommendations made in their complaints*.
- *Produce guidance on making meaningful apologies*. A useful template letter has been produced for practitioners to use in responding to a complaint, as well as valuable guidance for members on complaint handling (available on the members' section of the BAcC website). I understand that these were produced in response to my recommendation that guidance be produced on making meaningful apologies.
- *Consider whether the BAcC should produce a reminder to practitioners and a model patient note template containing the entry for GP details*. A podcast was made for Facebook, but it is not clear how much this is accessed by practitioners. Given that this is an ongoing issue arising in complaints, I suggest consideration should be given to what further reminders can be given to practitioners.
- *Set out in writing what follow-up the IP undertakes, including confirmation to complainants that the IC's recommendations have been implemented.* My view is that this should be explained in the information on the complaints procedure.

I would like to acknowledge the continued support and cooperation of the IP members and Teresa Williamson, the BAcC Professional Conduct Officer during this period and Caroline Jones, who returned to the BAcC as PCO at the start of this year.

Thank you for the opportunity to consider the work of the IP in 2017.

Margaret Doyle
Moderator, BAcC
July 2018