SPSO decision report

Case: **201507775, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C was receiving care and treatment from one of the board's community mental health services. He complained that he was unhappy with aspects of his care and services provided by the board.

We took independent advice from a psychiatric adviser and a mental health nursing adviser. The psychiatric adviser found that Mr C's initial referral to the consultant psychiatrist had been lost, and we were critical of this. However, they were satisfied that Mr C received reasonable treatment from the psychiatrists he saw and considered that it was evident from the records that this treatment had resulted in an improvement in his condition. The mental health nursing adviser was satisfied that, for the period the community psychiatric nurse (CPN) was engaging with Mr C, the CPN's input was reasonable and of an appropriate standard. However, the mental health nursing adviser was critical that, following a referral to a practitioner of CBT (cognitive behavioural therapy), the CPN discharged Mr C from their caseload without waiting to see whether the CBT service would take on Mr C. The mental health nursing adviser considered that this had denied Mr C the opportunity to explore other support, and considered that Mr C's continuity of care had been interrupted and that this was unreasonable. We found that the CPN's clinical correspondence could have been better worded, and although the adviser did not consider that the CPN's actions could be considered to be a breach of professional conduct, they felt that this was a learning point. We therefore upheld this aspect of Mr C's complaint.

Mr C also complained that when the CPN was absent, the board did not provide him with a replacement CPN. We noted that the board had written to Mr C to ask him to call the service if he wanted a different counsellor in the absence of his CPN. The board said that if there was no response to this letter within two weeks, no follow-up letter would have been sent. The mental health nursing adviser considered that asking Mr C to maintain continuity of care was unreasonable, especially at a point when Mr C had not yet been seen by a psychiatrist. They noted that Mr C therefore had no CPN input for four months, which was unacceptable. We upheld this aspect of Mr C's complaint.

Mr C also complained about a weight-loss programme provided by the board. In particular, Mr C complained that he was not provided with recipes as part of the programme, and that the programme was not sufficiently holistic. We took independent advice on this aspect from a nursing adviser. They noted that recipes were not a specific aspect of the programme and considered that it was reasonable for the practitioner to recommend that Mr C use the library to find recipes. They also found that it would not have been appropriate for the practitioner to have supported Mr C with his other issues, including his mental health. We therefore did not uphold this complaint.

Mr C said that whilst the doctors and psychiatrists he saw considered that CBT would be useful for him, when he saw the CBT practitioner, they did not think that it would be suitable. Both the psychiatric and mental health nursing advisers agreed that the CBT practitioner had provided reasonable reasons for their decision that Mr C was not a suitable candidate for CBT. We did not uphold this complaint.

Mr C also complained that the board did not respond reasonably to his complaint. Although we considered that

many aspects of the board's complaints handling had been reasonable, we found that it had taken the board a disproportionate length of time to respond to Mr C's complaint. We therefore upheld this aspect of Mr C's complaint.

Recommendations

We recommended that the board:

- feed back the adviser's comments to the CPN involved so that the CPN reflects upon their style of report and letter writing;
- take steps to ensure that referrals within the community mental health team are received and appropriately processed;
- review the discharge procedures of the community mental health team, taking into account the adviser's comments;
- review the community mental health team's practice of writing to patients (in similar cases) and giving them two weeks to respond if they wish to have continued community mental health team input; and
- apologise to Mr C for the failings identified in this investigation.