SPSO decision report

Case: **202001408, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received in relation to their mental health from the board over the course of just over a year. C was also concerned about the treatment that they received from a psychiatric consultant including consideration of referring C to a different health board and dealing with complexities in the case, such as C's parent being employed by the board. We took advice from an independent psychiatric nursing adviser. We found that the overall standard of treatment provided to C was reasonable and did not uphold this complaint.

C was also concerned that the board unreasonably delayed the organisation of community mental health care to them due to concerns over safety and risk. Although C was ultimately referred to the specific community mental health team outwith the area that they had requested from early in the process, we found that the board's regard for the potential risks of such an arrangement were reasonable and that, overall, there was no unreasonable delay due to the board's action and that the standard of care provided was reasonable. We did not uphold this complaint.

C was further concerned that the psychiatric consultant did not reasonably record their assessment and reasoning of decisions to hospitalise C, to prescribe medicine to C or to refer C to a psychologist. We found that record keeping over the relevant period had been reasonable and that, taking all of the available evidence, the psychiatric consultant had reasonably recorded their assessments and reasoning regarding C's treatment. We did not uphold this complaint.

C was concerned about delays in the board responding to complaints about their care and treatment, the board's inability to explain the reasons for those delays and the board's failure to provide a copy of a response to an elected representative as C had requested. While the board had accepted some of these failures during their consideration of the complaints submitted or while responding to our enquiries we also concluded that, contrary to the board's views, the reason for these delays were confusion within the board and a lack of clear responsibility for responding to the complaints. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Re-iterate their apologies to C for the unreasonable delays in responding to the complaints and their unreasonable failure to provide a copy of their response to their MSP as they had requested. Apologise to C that they did not provide reasonable explanations for the delays in responding to the complaints. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- Establish a clear hierarchy of responsibility for complaint responses and a system of escalation to senior management for circumstances where complaints have not been responded to within three times the length of a timescale in the Complaints Handling Procedure, or Complaints and Feedback Team follow up messages do not result in action to progress matters.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.