SPSO decision report

Case: **201606495, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr and Ms C complained about the care and treatment that their daughter (Miss A) received from the board's Child and Adult Mental Health Services (CAMHS) and other agencies, which they believed to be inadequate and ineffective in terms of assisting her recovery from bipolar disorder. Specifically, the issues related to the provision of psychiatric treatment; the provision of adequate specialist services; a delay in a referral to another clinical specialist; delays in the board preparing a detailed care plan and delays in conducting a case review.

We took independent advice from a consultant psychiatrist and from a registered nurse. We considered that Miss A was provided with appropriate psychiatric care and had been offered therapies and interventions in line with national guidance. There was also evidence to show that efforts had been made to address difficulties that were the result of changes to staff and therapeutic approaches. We did not uphold the complaint about the provision of psychiatric treatment.

We noted that the board had accepted that the approach of outreach interventions in combination with clinic appointments had not resulted in a more consistent delivery of treatment options or an improved outcome. As a result of this, they had recommended a review of Miss A's care along with compiling a detailed written care plan. We found that there had been a lack of consistency, frequency and attendance at certain appointments. We upheld Mr and Ms C's complaint about the provision of specialist services.

In terms of the referral to another clinical specialist, we did not identify any unreasonable delay in this taking place because an appointment was offered within the national waiting time target. We did not uphold this aspect of the complaint.

Although the board had agreed to review Miss A's care and compile a written care plan, we upheld these aspects of the complaint and made further recommendations because we found that there had been an unreasonable delay in the board completing these to ensure the same issues do not happen again.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr and Mrs C and Miss A for the delay in compiling a written plan and conducting a formal review. The apology should meet the standards set out in the SPSO guidelines on apology available at https:www.spso.org.uk/leafletsand-guidance.

What we said should change to put things right in future:

- In similar cases there should be a written care plan and agreed action, such as conducting a formal review, undertaken in a timely manner.

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.