SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **201804428, Western Isles NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the mental health care and treatment provided by the board. They also complained about the board's communication in relation to their care and treatment.

C had been referred to psychiatry by their GP because of difficulties with anxiety and depression. C was seen by a psychiatrist who referred them for cognitive behavioural therapy (CBT) and discharged them from their clinic. C was re-referred to psychiatry urgently by their GP a few months later, following a deterioration in their mental health. C saw a psychiatrist three times and was referred for community psychiatric nurse (CPN) support because of the CBT waiting list and C's deteriorating mood state.

C saw a locum psychiatrist four times over a two-month period when C was experiencing a continued deterioration in their mental health. C then saw their original psychiatrist on another two occasions. C's mental health deteriorated further and they were admitted to a psychiatric unit.

We took independent advice from a mental health adviser, who noted from C's records that their clinical presentation was complex and multifaceted. We found that there had been a significant interruption in C's psychiatric out-patient care, with a period of 17 weeks elapsing between appointments. There was a further unplanned and unexplained gap of seven weeks between out-patient appointments. We considered these interruptions to be unreasonable, although we could not conclude with certainty that the interruption to continuity of out-patient care led to the deterioration in C's mental state and subsequent hospitalisation. Although we found that the care planning was reasonable, the significant unscheduled gaps between out-patient appointments were not reasonable, causing continuity of C's care to be disrupted. We therefore upheld this aspect of the complaint.

Overall, we considered that C had been appropriately enabled to participate in decision-making related to their care, but some failings in communication were noted. C did not receive an explanation for the issues with consultant cover which appear to have contributed to the gaps in their psychiatric out-patient care. On balance, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to clarify precisely when their CBT referral was withdrawn; for the significant unscheduled interruptions to their out-patient psychiatric care; for failing to provide an explanation for the issues with consultant cover which contributed to the gaps in their psychiatric out-patient care; and for the instances of ineffective communication between the psychiatrist and CPN, including that which resulted in a delay in referring C to another service. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- When there are unscheduled interruptions to patient care, the patient needs to be informed of this. There also needs to be clear communication between staff when decisions are made in relation to patient care, such as onward referrals or requests for intervention by other disciplines. The timescales for the action and the person responsible for the action should be made clear, and the request should be appropriately followed up to ensure the action is taken. The board should feed the above back to staff in a supportive 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.