Scottish Parliament Region: Lothian

Case 200901866: Lothian NHS Board

Summary of Investigation

Category

Health/Hospital – Psychology; appointments; admissions (delay, cancellation, waiting lists)

Overview

The complainant (Mr C) raised a number of concerns about delay in him accessing appropriate care from NHS Lothian's Primary Care Mental Health Services. He also complained that there was a delay in reporting child protection issues and in responding to his complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in Mr C receiving appropriate care following his initial assessment *(not upheld)*;

(b) child protection issues were not reported for a two week period, contrary to guidance, and that Mr C was not offered appropriate support *(upheld)*; and

(c) there was a delay in responding to Mr C's complaint *(not upheld)*.

Redress and recommendation

The Ombudsman recommends that the Board:	*Completion date*
(i) write to Mr C acknowledging that the Community Mental Health Nurse Therapist should have acted sooner on the issue of child protection and apologising to him for the delay in doing so.	23 July 2010

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. The complainant (Mr C) has had episodic contact with Lothian NHS Board (the Board)'s Primary Care Mental Health Services and Psychotherapy services over the past few years for problems related to low mood and relationships. Mr C was in approximately monthly contact with the South East Primary Care Mental Health Team (PCMHT) from August 2006 until April 2007. In January 2008 Mr C was re-referred by his GP but this was not acted upon and it was not until after a second referral by a locum GP on 20 June 2008 that an appointment was arranged for Mr C to see a therapist.

2. Mr C saw the Community Mental Health Nurse Therapist (the Therapist) on 9 July 2008. The Therapist was the same person who had seen Mr C during 2006 and 2007. During a session with the Therapist on 1 August 2008, Mr C stated that he believed both he and his sister had been abused by their father and also raised a concern that his father had had access to his nephew. Mr C alleged that the Therapist did not pass on, or act on, these concerns in line with the Board's guidance.

3. In October 2008 the Therapist referred Mr C to the Edinburgh Psychotherapy Department at the Royal Edinburgh Hospital (the Hospital). Mr C was assessed in January 2009 at the Hospital but complained that there was a delay in him accessing psychotherapy, specifically a long-term evening group.

4. The complaints from Mr C which I have investigated are that:

(a) there was a delay in Mr C receiving appropriate care following his initial assessment;

(b) child protection issues were not reported for a two week period, contrary to guidance, and that Mr C was not offered appropriate support; and

(c) there was a delay in responding to Mr C's complaint.

5. In making his complaint to the Ombudsman's office Mr C also complained that he was, at that time, still waiting for appropriate therapy. In considering Mr C's complaint my complaints reviewer ascertained that he was now in receipt of appropriate care and for that reason my complaints reviewer informed Mr C that he would not be considering this aspect of his complaint. My complaints

reviewer did explain, however, that the general matter of delay following him having received his initial assessment would be considered.

Investigation

6. In investigating Mr C's complaint, my complaints reviewer wrote to the Board and requested a copy of the clinical records and complaints correspondence relevant to the complaint. He then sought the advice of the Ombudsman's independent mental health adviser (the Adviser).

7. The Adviser noted that the Board's response to Mr C had stated that, in their view, the Therapist's response to being told of Mr C's child protection concerns over his family member were in line with the Board's policies. It was the Adviser's view that that was not the case. For that reason, and out of line with the SPSO's standard investigation procedures, my complaints reviewer contacted the Board to highlight the Adviser's concerns. He did so to ensure that if procedures were not being followed appropriately by the Therapist or other Board members of staff, this was raised at the earliest opportunity and that any discrepancies were identified as early as possible to prevent a possible recurrence. Having done so, and later receiving the Board's final response, my complaints reviewer then sought the view of the Adviser on the appropriateness of the Board's actions.

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) There was a delay in Mr C receiving appropriate care following his initial assessment

9. Mr C complained that there was a delay in him receiving psychotherapy after his initial assessment at the Hospital.

10. Mr C had been referred to the Hospital by the Therapist on 28 October 2008. A letter was sent by the Psychotherapy Department (the Department) at the Hospital on 3 December 2008, advising that Mr C would be sent an appointment in due course and advising the Therapist that the waiting list was approximately one month.

11. On 14 and 21 January 2009 Mr C was assessed by an Adult Psychotherapist (the Psychotherapist). On 23 January 2009 the Psychotherapist wrote to the Therapist advising him of Mr C's progress. She wrote that Mr C was highly motivated to undertake longer term therapy but was limited in this regard due to work commitments and travel issues. She indicated that Mr C was keen on the idea of joining a long-term evening therapy group.

12. As part of the process of the Board formulating their response to Mr C's complaint, the Consultant Psychotherapist (the Consultant) explained that the Psychotherapist asked the Department's Specialist Registrar if he had a vacancy in his therapy group. The Specialist Registrar wrote to Mr C indicating that there was not a vacancy in the group but that he would meet with him in approximately six weeks time.

13. The Adviser told my complaints reviewer that it is not unusual for there not to be an immediate vacancy in such a group. He explained that some types of group are limited in their uppermost numbers and that groups can also be 'closed', in that once they commence they have a set membership and run for a specified time, during which the introduction of new members can be disruptive to the therapeutic aims of the group.

14. In their response to this aspect of Mr C's complaint, the Board stated that Mr C was offered appointments on 6 May 2009 and 13 May 2009 but that he received them with little notice and so was unable to attend. The letter stated that he then received another appointment for 20 May 2009. The Board acknowledged that there had been a breakdown in communication and that not enough notice was given for the appointments. The Board's Director of Operations and the Consultant apologised to Mr C and the Board indicated that the Consultant would review the Department's systems to ensure that such an occurrence did not happen again.

(a) Conclusion

15. Having been assessed by the Psychotherapist in mid-January 2009, it was agreed that Mr C's care should be in the form of him joining a long-term evening therapy group. By the time Mr C made his complaint to the Board he was still not in receipt of therapy but when the complaint came to the Ombudsman's office my complaints reviewer clarified with him that he was now receiving care and he indicated that this was the case (see paragraph 5).

16. The Adviser told my complaints reviewer that it is not unusual for there to not be an immediate vacancy in a therapy group such as Mr C was looking for and that a subsequent delay is not unusual. The Board have accepted that their communication with Mr C was not good and subsequently apologised and have reviewed their processes.

17. I am content that the Board have apologised and accept the view of the Adviser that delays in accessing therapy groups, as was required by Mr C, are not uncommon across boards and that there are good reasons why groups, once they are operating, do not take on new members for therapy. I accept this advice and, therefore, while noting that there undoubtedly was a delay, I am not of the view that it would be appropriate to criticise the Board. I, therefore, do not uphold the complaint. I also accept that the Board have already apologised for their failings in communication with Mr C and have reviewed their processes in an attempt to prevent a recurrence.

(b) Child protection issues were not reported for a two week period, contrary to guidance, and Mr C was not offered appropriate support

18. This element of Mr C's complaint stems from a meeting he had with the Therapist, having been referred by his GP (see paragraph 2) on 1 August 2008. During this session the clinical records recorded the following:

> 'Initial Meeting. Reported reflecting on our previous meetings and his relationships with his Father. He believes now that his Father sexually abused him as a teenager. He advised me that he discussed this with his sister and reported that he and his sister fell out for 9 months – he voiced his concern to his sister that his nephew/her son visiting their Father. Now he and his sister are communicating his sister also now believes she was a victim of childhood sexual abuse and she and her husband have stopped their son visiting. [Mr C] is contemplating discussing this with the police …'

19. The subsequent clinical records made by the Therapist did not indicate any action regarding Mr C's concerns until 17 September 2008, following a further consultation between Mr C and the Therapist where Mr C repeated a comment his nephew had made to him, which indicated that the boy may have been sexually abused by his grandfather.

20. At this point the Therapist notified the Board's Child Protection Team, who responded the next day and advised him to contact the Family Protection Team.

21. The clinical notes did not record that the Therapist did so but rather that, on meeting with Mr C on 18 September 2008, he advised Mr C to contact the police himself.

22. The Adviser told my complaints reviewer that he believed there was an undue delay of a month and a half between Mr C expressing his initial concerns and the Therapist seeking specialist Child Protection advice. The Adviser continued that, on receipt of that advice, the Therapist failed to act in accordance with it by not contacting the Family Protection Unit personally. The Adviser also stated his view that the Therapist's record-keeping in relation to these allegations was ineffective, in that it lacked detail regarding any concerns that the Therapist might have had; it did not record any discussion on this issue that the Therapist might have had with his line manager or supervision group; and it did not record that Mr C had contacted the police.

23. On receiving the Adviser's comments, my complaints reviewer contacted the Board to make them aware of his concerns. He did so because he was concerned that if a member of Board staff was not following their child protection procedures then the Board should be made aware of this immediately, so that they could take action to investigate and, if necessary, remedy the situation. My complaints reviewer wrote to the Board on 21 October 2009 telling them of the Adviser's view.

24. On 30 November 2009 the Board's Nurse Director (the Nurse Director) wrote to my complaints reviewer with the Board's response. She advised that the child protection guidance followed by the Therapist was different to that which the Board had provided to my complaints reviewer and which the Adviser had consequently considered but accepted that the guidance did include a reference to 'Making a referral without delay'. She told my complaints reviewer that the Board's guidance had now been sent to all team bases as a controlled document.

25. The Nurse Director advised that, following the 1 August 2008 meeting, the Therapist did not consider any person to be at risk, as Mr C's nephew was not then visiting his grandfather. In concluding her comments to the Ombudsman's office the Nurse Director wrote:

> 'On investigation of this complaint it is clear that the records [the Therapist] made in [Mr C]'s case do not conform to the standards laid down by the

Nursing and Midwifery Council for each entry. There are gaps in the notes relating to significant conversations and judgements on the risks presented.'

26. She continued that:

'… it appears that [the Therapist] made a judgement that there was no immediate concern and that no person was at on-going risk from [Mr C]'s father but this was not explicit in [Mr C]'s notes. When it became clear to [the Therapist] that [Mr C]'s nephew may have in fact been a victim, I am assured that [the Therapist] did act on this information within 24 hours. I do accept, however, that more concise record-keeping would have aided [the Therapist]'s accountability throughout this process and provided clear evidence of decisions taken and judgements made.'

27. The Nurse Director told me that as a result of Mr C's complaint, the Board had put in place the following actions:

- The Therapist was booked on to Child Protection training on 21 December 2009.
- NHS Lothian Child Protection guidelines were distributed to all team bases as a controlled document.
- Mental Health Nurse managers within Edinburgh Community Health Partnership will reinforce the message that Child Protection Training is essential for all practitioners.
- Clinical Nurse Managers will ensure that all staff undertake mandatory training every 18 months using NHS Lothian's Employee Management system – Empower - to monitor that this is taking place and take early remedial action.
- Clinical Nurse Managers for Mental Health will write to all nursing staff to remind them personally of the importance of adhering to the Nursing and Midwifery Council standards for record-keeping - and that this was done by the end of December 2009.
- An audit of Community Mental Health Nursing records was undertaken and carried out by the end of February 2010 to identify good practice and ensure corrective action where standards are poor. A standard format for progress notes will be developed incorporating NMC Guidelines. This will form part of standards measured as part of a rolling audit of nursing records.

- The anonymised details of Mr C's complaint were used as an example for Nurse Team Leaders to ensure that lessons were learnt.

28. On receipt of the Nurse Director's response, my complaints reviewer asked the Adviser for his view on the response. He stated that he felt the Nurse Director's response and the seven actions identified above addressed the issues raised with due diligence and an appropriate sense of urgency. He noted that the Nurse Director had also given a personal commitment to ensure that the actions stated were followed through.

(b) Conclusion

29. Mr C complained that there was an undue delay of two weeks and that he was not offered appropriate support. The Adviser told my complaints reviewer that he was of the view that there was a more substantial delay, ranging from 1 August 2008 until 17 September 2008, a period of some six weeks.

30. The Board's response to this was to indicate that the Therapist did not regard that what he was told at the 1 August 2008 consultation necessitated him taking any action as he did not regard that any individual was, at that point, at risk. Unfortunately, the Therapist did not detail in the records his thinking on this matter.

31. In essence, the variance of view between the Therapist and the Adviser is whether a healthcare professional being informed by an individual that they believe they were, as a child, sexually abused by their father and that their father had until recently, but not currently, had access to a grandchild, had a duty to act. The Therapist thought not and the Adviser felt that this should have resulted in the healthcare professional seeking advice.

32. Having been informed of the Adviser's comments the Board indicated that, as a result, they have put in place early actions on being informed of the Adviser's concerns to ensure that the Therapist undergoes updated Child Protection training and that the need for training and guidance is disseminated appropriately in the Board.

33. With regard to the Board's actions, the Adviser found them to be appropriate in terms of the actions and the urgency with which they were to be carried out.

34. I accept the advice received from the Adviser on what the appropriate action was following the 1 August 2008 consultation and that there was, therefore, subsequent delay. I, therefore, uphold this complaint. By not taking action, having been informed by Mr C of his concern, I am also of the view that he was not offered appropriate support with regards to the allegation.

(b) Recommendation

35. As the Board have taken appropriate actions at an early stage, I have no procedural recommendation to make.

36. I do, however, recommend that the Board:	*Completion date*
(i) write to Mr C acknowledging that the Therapist should have acted sooner on the issue of child protection and apologising to him for the delay in doing so.	23 July 2010

(c) There was a delay in responding to Mr C's complaint

37. In making his complaint to the Ombudsman's office, Mr C stated that there had been a delay by the Board in responding to his complaint.

38. Mr C's partner wrote, on Mr C's behalf, to the Board with his complaint on 16 June 2009. The letter of complaint was date-stamped as having been received by the Board on 22 June 2009. The Board acknowledged the complaint on 22 June 2009 and a full response to the complaint was sent on 21 July 2009.

39. NHS guidance on timescales for complaints indicate that a complainant should expect to receive an acknowledgement of their complaint within three working days of receiving the complaint and the Board should issue a full response to the complaint within 20 working days.

(c) Conclusion

40. Mr C complained that there was a delay in the Board responding to his complaint. NHS guidance states that a complaint should be acknowledged within three days of it being received. In Mr C's case, the Board acknowledged the complaint the same day that they received it.

41. NHS guidance also states that a full response should be sent within 20 working days. In Mr C's case, the response was sent on the 22nd working

day after receiving the letter of complaint. While this is outwith the 20 days referred to in the guidance, it does not represent a significant delay. The Board's letter of 22 June 2009 indicated that if the Board found themselves unable to respond to the complaint within 20 working days, they would write to Mr C again informing him of the reasons for the delay. In the instance of Mr C's complaint, and a delay of two working days, this would have been an impractical step for them to have taken and, in my view, the Board were correct to hold off and send the substantive response, albeit two days outwith the timescale identified in the guidance. I, therefore, do not uphold this aspect of Mr C's complaint.

42. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify him when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Lothian NHS Board
PCMHT	South East Primary Care Mental Health Team
The Therapist	The Community Mental Health Nurse therapist
The Hospital	Royal Edinburgh Hospital
The Adviser	The Ombudsman's independent mental health adviser
The Department	The Psychotherapy Department
The Psychotherapist	Adult Psychotherapist
The Consultant	The Consultant Psychotherapist
The Nurse Director	The Board's Nurse Director