Case 200500942: Forth Valley NHS Board

Introduction

1. On 5 July 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) about the service she had received in 2002 and 2003 from the Department of Dynamic Psychotherapy of Forth Valley NHS Board's Primary Care Operating Division (previously known as Forth Valley Primary Care NHS Trust) and about the Division's handling of her complaint.

2. The complaints from Mrs C which I have investigated concerned:

(a) breach of confidentiality;

(b) termination of therapy before the end;

(c) inaccurate clinical records;

(d) complaint handling.

Following the investigation of all aspects of this complaint I did not uphold it (*see paragraphs 27 to 29*).

3. In summary, I am satisfied that the complaint had been thoroughly investigated by the Division and that appropriate remedies had already been made. This included remedy where there had been no shortcomings and also where shortcomings could not be proven. And I am satisfied that my own investigation has not revealed any shortcoming which the Division had not already acknowledged.

Investigation and findings of fact

4. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant psychiatrist. His role was to explain, and give an opinion on, the clinical aspects of the complaint. We examined the papers provided by Mrs C,

the Division's correspondence file and the clinical records of the Department of Dynamic Psychotherapy (which I shall refer to as the Department). To identify any gaps and discrepancies in the evidence, the content of relevant information was checked against other papers on file and was also compared with my own and the adviser's knowledge of the issues concerned. No interviews have been conducted, partly because memories about events which took place several years ago could not be considered to be reliable and partly because the file contains an exceptional quantity of detail. The standard by which the events were judged (in line with the practice of this office) was whether those events were reasonable, in the circumstances at the time in question.

5. Mrs C and the Division have commented on a draft of this report.

6. I turn now to the complaint. Mrs C expressed her complaint to the Ombudsman as being about four issues: failure in a service; failure to provide a service which had been agreed as being required by Mrs C; administrative failure in a service; and administrative failure in the NHS complaints process. Her complaint to the Division developed over time into many issues, with some letters from the Division prompting further disagreements. Part of my role as a Complaints Investigator is to identify and focus on the essence of a complaint. I have, therefore, confined my investigation to the points I have listed at paragraph 2 as I consider these to reflect the most important complaints covered by Mrs C's four issues.

7. A reminder of the abbreviations used in this report is at Annex 1.

(a) Breach of confidentiality

8. In late 2002 and early 2003 Mrs C attended the Department for a course of 12 therapy sessions run by a senior house officer (doctor) in psychiatry, whom I shall refer to as the SHO. The SHO was under the supervision of the Department's head, a consultant psychotherapist, whom I shall call Consultant 1. Mrs C had met Consultant 1 for two initial assessment sessions earlier in 2002. Other health professionals closely involved with Mrs C were her GP (the GP) and a consultant psychiatrist (Consultant 2) who worked in the Community Mental Health Team of a different Division of Forth Valley NHS Board.

9. The Department's patient-information leaflet said that information from therapy sessions might be passed on to avoid a risk to the public or a child and that this would normally be discussed first with the patient. Because Mrs C's situation did not meet those criteria, she understood the content of the 12 therapy sessions to be confidential. The leaflet also said:

> 'Everything you say during therapy will be respected as private and confidential, and therefore it would be very unusual for us to discuss your treatment with members of your family, or professionals outside of the department.'

As part of the Division's investigation, the SHO said that Mrs C had asked about confidentiality several times at the first session and possibly at two or three others. The SHO said that she had told Mrs C that information shared would only cover main issues, such as whether the therapy was successful and whether it had ended, and that information about the content would be expressed in 'concise' terms only, for example that a patient had low self-esteem.

10. In March 2003, during the last of the 12 sessions, Mrs C revealed to the SHO some particularly distressing events from her life, which I shall call the Events. She had found it hard to discuss other issues at the sessions. But the Events were a particularly difficult and sensitive subject for her and she had never told anyone about them.

11. Mrs C learned that Consultant 1 had written three letters which she considered breached confidentiality. Two of the three letters were written to Mrs C's GP in September 2002, reporting on her two initial assessment sessions with Mrs C. (It was the GP who had referred Mrs C to the Department for therapy.) For the most part, Consultant 1 wrote of her own feelings, rather than those of Mrs C, and wrote in generalities, such as:

> '… we had a chance to go through something of her home and family life' and,
> 'She [began] to tell me some of her traumatic experiences in trying to get help with [other people's] difficulties. She was talking to me in a great deal of detail.'

In other words, for the most part, the specifics of Mrs C's experiences were not stated in these two letters to the GP in September 2002. There were some specifics, in particular a sentence about some of Ms C's feelings at school, several decades previously. However, the adviser does not consider that inappropriate information was passed on in these two letters.

12. The third letter from Consultant 1 was written to Consultant 2 in June 2003, reporting on a pre-planned three-month review meeting between Mrs C, Consultant 1 and the SHO earlier that day. It said that Consultant 1 felt that Mrs C's distress at the review was connected to the feelings that had been stirred up by having spoken of the Events at the 12th therapy session in March 2003. Consultant 1 made an explicit (although brief and undetailed) reference to the Events. Consultant 1 also said in the third letter that she was pleased that Mrs C was under Consultant 2's care because she could need psychiatric support and that she had discussed that in a telephone call to Consultant 2 earlier that day, following the review meeting.

13. Mrs C was appalled that information which she had given during sessions, which she had believed would be treated confidentially, had been passed outside the Department in these three letters. She was particularly upset to find that the Events, which had cost her a great deal to speak of at all in the therapy session, had been clearly referred to in a letter. To make matters even worse, because Consultant 2 was not aware of the confidentiality issue, he inadvertently (and explicitly) referred to the Events at a consultation with Mrs C, which was attended as usual by a close family member – who until then had not known of the Events.

14. The relevant part of the Department's confidentiality policy was detailed in the Division's investigation report to Mrs C. As Mrs C has seen this, and the subject was covered in detail during the Division's investigation, I need not repeat the detail here. Briefly, it states that when confidential information from a patient is shared with certain people, those people are subject to a duty of confidentiality and that a patient's objections to this will be respected, except in a few (specified) cases. Consultant 1 and the SHO both considered that they had not acted outside that policy in the explanations which were given to Mrs C about confidentiality arrangements. After investigating the complaint, the Division concluded that the

information in the three letters was appropriate because there would be little value in clinicians involved in Mrs C's care receiving only information that was stripped of anything significant. However, they also concluded that the Department's patient-information leaflet was misleading in giving Mrs C false assurances about confidentiality. In other words, they said that the sharing of the information had been appropriate but that they had given Mrs C false assurances about information sharing. They considered that the complaint had revealed deficiencies in the Department and they made a number of changes, which I summarise below:

(a) the Department's patients now received an amended patient-information leaflet;

(b) therapists now discussed confidentiality at the initial consultation (whether or not raised by the patient) and they now confirmed in the clinical records that they had done so and that the patient had been appropriately informed, and recorded the extent of any restrictions which the patient had placed on the sharing of information outside the Department;

(c) a confidentiality action plan had been drawn up. (Amongst other things this introduced arrangements to safeguard patients' notes when taken off the premises by a clinician. This was done because part of Mrs C's complaint referred to the possible loss of notes by the SHO when she (the SHO) was on duty at different premises);

(d) the NHS Code of Practice on Protecting Patient Confidentiality had now been issued to all the Division's staff.

15. The adviser has said that because sensitive matters are often discussed in psychiatric work, confidentiality is a special concern; however, it is accepted in this field of work that other clinicians may need, and should be given, sufficient information for their own purposes. He considers that information was not shared inappropriately but agrees with the Department that their patient-information leaflet did not accurately reflect their confidentiality policy and could give patients a false sense of security about information which they revealed, for example in therapy sessions.

(b) Termination of therapy before the end

16. As indicated above, Mrs C attended her planned review with Consultant 1 and the SHO on 26 June 2003, three months after the 12 therapy sessions. The case notes contain no record of this review meeting. However, Consultant 1 reported it that day in her letter (described above) to Consultant 2. She explained that at the review meeting she arranged to meet Mrs C again to discuss further therapy and that she would envisage a short (around ten sessions) period of therapy on certain aspects, conducted by herself (as the SHO was leaving). She said she felt that Mrs C had seemed very angry because it would probably be at least three months before such therapy could start.

17. The meeting to discuss this possible further therapy was arranged for 1 September 2003. But in the meantime Mrs C learned of Consultant 1's disclosure of the Events in that consultant's letter of 26 June 2003 to Consultant 2 (see paragraph 12). Mrs C wrote a letter to Consultant 1 on 11 August 2003. In it she described her feelings about the disclosure, requested a copy of the letter (as she had not had the opportunity to read it, having only briefly seen it) and asked for its removal from the records of the Department, Consultant 2 and the GP (to whom it had been copied).

18. The case notes contain no record of the 1 September 2003 meeting, but Consultant 1 reported on it that day in a letter to Consultant 2. She said she had told Mrs C that she would not be able to offer further treatment because the essential trust needed for their professional relationship had broken down. She added that it was clear to her that the exploratory therapy (that is, the 12 sessions) had not helped Mrs C: she had hoped that Mrs C would benefit from the chance to discuss some of her difficulties but that this had not been the case, and she considered that further exploratory therapy would probably stir up Mrs C's feelings in an unhelpful way even further. She added that Mrs C was angry that not only would she (Consultant 1) not be providing therapy but that she would not be arranging for anyone else to provide it.

19. In their investigation of the complaint, the Division concluded that Mrs C had been led to believe that she would receive ten sessions of therapy from Consultant 1. They felt it was understandable that Mrs C had interpreted Consultant 1's decision as having been driven by resentment because of

Mrs C's letter of 11 August 2003 rather than by consideration of Mrs C's clinical needs. On the other hand, they also considered that no effective therapeutic bond could be maintained between the two parties. In resolving the complaint the Division, therefore, tried to help Mrs C by arranging, and funding, therapy from another health board.

(c) Inaccurate clinical records

20. Mrs C made a number of complaints about the clinical records. I consider that in their investigation report and earlier letters, the Division covered these aspects satisfactorily and in detail and that nothing can usefully be added by this office. However, I will cover here the most serious of these complaints, which was that Mrs C's records were incomplete.

21. The clinical records do not include any notes for the 11th therapy session. At first the SHO explained (as part of the Division's complaint investigation) that she could not write up the record as soon as the session ended because the session over-ran its allowed time, which meant that, when it ended, she had to go to a hospital for another shift. However, she had no time at the hospital to write them up and later could not find them, despite searching. She also said that there was no information in them which could identify Mrs C if anyone found them. Later, she said she believed that, in fact, she had not written any notes for that session. She had previously also explained that because she wrote up her notes immediately a session ended, she did not always take notes during a session. Mrs C said that the SHO had, in fact, taken notes at the 11th session. Mrs C also felt it was unacceptable that Consultant 1 had not realised that some of the SHO's notes were missing.

22. During their investigation the Division explained to Mrs C that although Consultant 1 held weekly review sessions with the SHO, she did not read the SHO's session notes and so would not have known that any were missing. The adviser agrees that Consultant 1 would not have been expected to know this. The Division also explained to Mrs C that the SHO's failure to produce notes for that session was unacceptable, that the SHO had been counselled in respect of that failure and that the Department had taken steps to improve not only note preparation but also the safe-keeping of notes. In other words, they had identified shortcomings and taken action to remedy them.

23. Mrs C also felt that the lack of a note about her meetings with Consultant 1 on 26 June and 1 September 2003 was unsatisfactory. The adviser considers that lack to be acceptable because information about the sessions was included in Consultant 1's letters to Consultant 2 about them. In other words, those letters form an appropriate clinical record of those meetings.

24. Finally, when the records were copied for Mrs C, she said that a drawing by herself was missing. The Division told her that it did appear in their own copy of the records - in other words, that it had not been lost. I can confirm that the drawing was present in the records sent to me by the Division: it comprises a drawing of two people, with one written word.

(d) Complaint handling

25. Having met the Division's Medical Director on 4 September 2003 to discuss her original concerns, Mrs C made her formal complaint on 10 October 2003. The Division made their formal reply on 2 April 2004, enclosing a 21-page investigation report plus attachments. Between those dates the Division sent many letters to Mrs C. (An indication of the work put into the complaint can be seen by the fact that the complaint file of the Division (and the independent review panel convener who also considered the complaint) comprises 161 pages.) In their letters the Division attempted to take account of Mrs C's expressions of concern and disagreement as the complaint escalated into a far greater number of issues. They also sought comments from those who had been involved, such as Consultant 1 and the SHO. As the complaint escalated, some of those people had to be approached again for comments on the new points.

26. Although complaint handling is not a clinical issue, the adviser has commented on the Division's unusually close scrutiny of the complaint and the unusually high quality of their investigation report.

Conclusions and recommendations

27. As explained at paragraph 5, I am satisfied that the evidence in this case has been adequately tested.

28. Mrs C's concerns developed during the Division's investigation of her original

complaints. From my reading of their exceptionally large complaint file, I am satisfied that the Division not only addressed the issues in detail but also made very significant efforts to give detailed explanations to Mrs C. There were a number of issues which could not be proven one way or the other, yet the Division took action on them in their efforts to resolve the complaints. For example, the Division could not prove whether the SHO had made notes of Mrs C's 11th session and taken them out of the building to write up. Yet they took action to help ensure the recording of sessions and the safe-keeping of clinical notes for future cases. This indicates an objective scrutiny and open minds. And the unusually close involvement of the Chief Executive and Medical Director are further indications of a genuine desire to deal with, and resolve, the complaints. I note that the Medical Director even allowed Mrs C to edit a referral letter which he planned to send to try and obtain therapy for Mrs C in another health board's area. In her complaint to the Ombudsman, Mrs C said she felt the Division had not taken her complaint seriously. The evidence on file points clearly to a genuine commitment by the Chief Executive, Medical Director and complaints team to take the complaint particularly seriously.

29. In relation to the other issues which I investigated, I am satisfied that the Division conducted a thorough investigation and took appropriate action to change procedures etc, even where they had not been at fault and where fault could not be proven. There is nothing more I feel I can usefully add nothing more to the extensive detail already given to Mrs C by the Division, particularly in their lengthy investigation report.

30. In short, I confirm that I do not uphold Mrs C's complaints (a) to (c) because they had already been appropriately dealt with by the Division, with appropriate remedies made. Complaint (d) was not investigated by the Division as it was not the subject of Mrs C's complaint to them. I do not uphold that complaint because I am satisfied with the Division's handling of the complaint.

27 June 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Division	Forth Valley NHS Board's Primary Care Operating Division
The Department	The Division's Department of Dynamic Psychotherapy
Consultant 1	The Department's head, a consultant psychotherapist
The SHO	A senior house officer (doctor) in psychiatry, working for Consultant 1 and acting as Mrs C's therapist at the Department
Consultant 2	Mrs C's consultant psychiatrist at NHS Forth Valley's Community Mental Health Team
The GP	Mrs C's general practitioner
The Events	Certain events about Mrs C's life which were disclosed to others.