SPSO decision report

Case: **202410949, Highland NHS Board**
Sector: Health
Subject: Clinical treatment
Decision: upheld, recommendations

Summary

C complained about the mental health care provided by a locum psychiatrist and the handling of a request to change psychiatrist. C said that consultations were rushed, concerns about medication were not properly addressed, a referral was delayed, and a diagnosis was not communicated. C also said the request to change psychiatrist was handled poorly and led to a prolonged period without care; and that they were discharged from the Community Psychiatric Nurse (CPN) service as a result of this request. The board's first complaint response did not address all of C's points of complaint so we asked them to provide a fuller response. C remained dissatisfied and brought their complaint back to the SPSO.

We received independent advice from a consultant psychiatrist. We found insufficient evidence of unprofessional behaviour on the part of the psychiatrist, or of any unreasonable failure to change C's medication. However, we found failings in how the consultations were conducted overall. Specifically the failure to inform C of a diagnosis, and a significant delay in authorising a CPN referral. Therefore, we upheld this part of C's complaint. The board had acknowledged and apologised for these failings, and taken appropriate steps to feed back to staff, however, we did not consider the learning action was sufficiently robust or clearly linked to the issues arising in the complaint.

We also found that there were shortcomings in how the board handled C's request for a change in psychiatrist. We considered that the board's approach was not sufficiently supportive and did not adequately recognise C's preference. C was left for a prolonged period without an allocated clinician. We found no evidence, however, to support that C was discharged from the CPN service as a result of this request. We considered that the board's overall handling of C's request for a change of psychiatrist was unreasonable and, on balance, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for leaving them without psychiatric care for a prolonged period, and the unsupportive handling of C's request for a change in psychiatrist. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Attempts to restore the therapeutic relationship should consider the patient's needs and explore appropriate support.
- Locums should be supported and engaged with the local governance processes.
- Patients under the care of secondary mental health services, should have a responsible medical officer throughout their care.
- The board should meet its standards for timeframes for clinic letters.

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.