TS0191_03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against

Ayrshire and Arran Primary Care NHS Trust[1]

Complaint as put to the Ombudsman

1. The account of the complaint provided by Mr C is that he has suffered from Chronic Fatigue Syndrome (CFS) for a number of years. He was admitted to Ayr Hospital (the Hospital) on 26 March 2002 because of worsening depression linked to the severity of his CFS. While in hospital his condition slowly improved, largely because he was able to rest adequately. This enabled him to start a graduated physical rehabilitation programme supervised by a Consultant in Rehabilitation Medicine (Consultant 1). Mr C also started to return home for two-day visits. He found these visits exhausting. However, he was able to maintain the overall gradual improvement in his condition as he was able to rest adequately when he returned to the hospital.

2. Mr C was keen to ensure that he continued to receive support and have opportunities to get adequate respite care after he was discharged, in order to maintain the improvement in his condition, which he stated had been recommended by a Consultant Psychiatrist at the hospital (Consultant 2). Referrals were also made for him to receive support after discharge from a Community Mental Health Team (the CMHT) and a Cognitive Behavioral Therapist (the Therapist).

---

1 Ayrshire and Arran Primary Care National Health Service Trust (the Trust) was established by The Ayrshire and Arran Primary Care National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The National Health Service Trusts (Dissolution)(Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to Ayrshire and Arran Health Board came into effect. To avoid confusion, this report continues to refer to the Trust when describing actions taken by, or on behalf of, the Trust. However, the recommendations within this report are directed towards the Board.

3. Mr C was discharged from the Hospital on 2 July 2002. On 15 July he was sent a letter from a Community Psychiatric Nurse (CPN) in the CMHT (Nurse 1) stating that while he was in hospital a decision had been made that it would be more beneficial for him to be seen by Consultant 1 and the Therapist and so the CMHT would not become involved in his care. Mr C contacted the CMHT and was subsequently assessed by a Consultant Psychiatrist from the CMHT (Consultant 3) on 5 August. This assessment confirmed that the CMHT would not take an active role in supporting and monitoring Mr C's mental health, although a referral could be made in the future if appropriate. Mr C continued to pursue the issue of respite care in discussions with the Therapist, his General Practitioner (GP) and with another CPN from the CMHT (Nurse 2). However, he was not provided with any respite care.

4. On 18 September Mr C complained to the Trust via his MSP. The Trust Chief Executive responded on 4 November. The Chief Executive apologised that Mr C had been told that he would be contacted by both the Therapist and the CMHT on discharge as this was an error and did not reflect the agreement that had been reached about his care. The Chief Executive said that this error came to light after Mr C contacted the CMHT. The Chief Executive also said that there was no evidence that respite care had been discussed with Mr C and this was not considered to be a clinically preferred treatment option.

5. On 9 December, Consultant 1 re-referred Mr C for a further psychiatric assessment. However, no appointment with a Consultant Psychiatrist was made for this assessment to take place and Mr C considered that he was being ignored by the Psychiatric Services.

6. Mr C requested an Independent Review Panel (IRP) to consider his complaint as he felt the explanations given to him were unsatisfactory and inaccurate. The Convener concluded that, while the information Mr C had been given on discharge did not reflect the agreement reached at the multi-disciplinary meeting prior to discharge, the Trust had apologised and adequately responded to this aspect of his complaint. However, she referred his complaint back to the Trust for further consideration regarding the provision of respite care. Mr C became increasingly dissatisfied with

the way his complaint was being handled and he was not satisfied with the Trust's further response on the issue of respite care. He complained to my office on 13 February 2003.

Matters subject to investigation

7. On 20 May 2003, I decided to investigate Mr C's complaint. The matters subject to investigation were specified as:

(a) The care provided to Mr C by the Trust was inadequate including, but not limited to:

failing to facilitate a co-ordinated management plan for his treatment; and

failing to ensure adequate co-ordination between staff at the Hospital and the CMHT during the planning of his discharge.

(b) The care provided to Mr C by the CMHT was inadequate including, but not limited to:

apparently deciding that they would not become involved in his ongoing care following his discharge before he had been assessed by a Consultant Psychiatrist from the CMHT; and

failing to provide clear and consistent reasons for their decision not to become actively involved in his ongoing care following his discharge.

(c) The Trust's response to Mr C's complaint has been inadequate including, but not limited to:

stating that the error in telling him that he would receive contact from both the Therapist and the CMHT following his discharge was identified after he contacted the CMHT, when the terms of Nurse 1's letter dated 15 July 2002 appears to show that the error was identified before this;

stating that an agreement had been made that he would not receive contact from the CMHT as well as the Therapist following discharge, without being able to clarify who made this agreement and when; and

initially stating there was no evidence that respite care had been discussed with him at any time, however then stating that this matter was fully considered by the clinical team involved in his care.

(d) The Convener's consideration of Mr C's complaint was inadequate including, but not limited to:

failing to take appropriate clinical advice.

8. However, during the initial part of this investigation, it became apparent that it was appropriate to also investigate Mr C's concerns about the apparent failure of staff to make timely arrangements for an appointment with a Consultant Psychiatrist following Consultant 1's referral on 9 December 2002. Accordingly, my Investigator wrote to the Trust on 27 January 2004 extending the scope of the investigation to include consideration of this issue.

Investigation procedure

9. I authorised one of my Complaints Investigators to conduct this investigation on my behalf. He obtained advice from two Independent Professional Assessors, a Consultant Psychiatrist and a Senior Registered Mental Health Nurse. Their explanation of the treatment given to Mr C is at paragraph 13 and their advice is in paragraph 50 of this report.

10. The Trust's comments and relevant papers, including Mr C's medical records, were obtained and examined. My Investigator interviewed Mr C and, along with the Assessors, interviewed a number of current or previous members of staff from the Trust. When the extent of my investigation was extended, further relevant papers and records were obtained and examined.

11. I have drawn on all of this material in the preparation of this report. I have not put into this report every detail investigated but I am satisfied that nothing of significance has been overlooked.

12. Mr C and the Trust have been given an opportunity to comment on the key facts contained within this report. Where appropriate, their comments have been reflected in the text.

Clinical Assessors' account of Mr C's treatment

13. My clinical Assessors have provided the following account of Mr C's treatment.

Basis of Account

(i) This account is based upon examination of the psychiatric and nursing records as they relate to Mr C's contact with Ayrshire Psychiatric Services between February 2002 and the start of 2003; and a series of interviews conducted with those members of clinical staff who appeared to us most directly involved in Mr C's care during that period.

Background

(ii) Mr C is a 45 year old former teacher. He is married with three young children.

(iii) He has suffered from CFS since 1993. His symptoms appear to have waxed and waned through the years but his physical condition is said to have deteriorated markedly through 2001 and there then emerged frank depressive symptoms for which his GP prescribed antidepressant treatment.

(iv) Mr C's first contact with the CMHT took place in February 2002. To Nurse 1, he described depressive and anxiety symptoms but he appeared to her interested only in being referred to a specialist in Chronic Fatigue. Nurse 1 established that Consultant 1 would be prepared to carry out an assessment if Mr C's GP was to refer and she wrote to the GP accordingly. She appears too to have

referred Mr C for a cognitive behavioural psychotherapy assessment at that time.

(v) On 14 March 2002 Mr C was seen at the Homeopathic Hospital in Glasgow by a Consultant Liaison Psychiatrist (Consultant 4). Consultant 4 concluded that Mr C 'clearly has a severe major depressive illness on top of his long standing chronic fatigue syndrome'.

(vi) Consultant 4 recommended no change to recently instituted antidepressant treatment (with Trazodone). He suggested that Mr C would be likely to benefit from a cognitive behavioural approach to his difficulties and arranged to review him the following week.

(vii) On 26 March 2002 Mr C was transferred from the Homeopathic Hospital to Park Ward, at the Hospital in Ayr. (The admission was to Ayr as there were no available beds in Crosshouse Hospital, Kilmarnock, which served the catchment area in which Mr C lives.) On admission to the Hospital Mr C again described symptoms of depression and anxiety and it was decided that his treatment would continue with the antidepressant Venlafaxine (a treatment apparently substituted in the days following his first contact with Consultant 4).

(viii) The admission to the Hospital extended over 10 weeks. During that period Mr C was referred again to Consultant 1 and to the Therapist. Consultant 1 arranged a graded exercise programme for Mr C, which appears to have started in May 2002 before Mr C was discharged from the Hospital. It was agreed that in due course the Therapist would see Mr C as an outpatient for cognitive behavioural therapy.

(ix) During the period Mr C was in the Hospital Nurse 1 contacted the Ward on four occasions by telephone to enquire about his progress. She explained to us that members of the CMHT covered different GP practice areas. If patients from their area were being treated in hospital, it was standard practice for members of the CMHT

to liaise with the ward about these patients as they might become involved in the patient's care after discharge.

(x) Mr C made slow progress but following a series of home passes he was discharged from the Hospital on 2 July 2002. The discharge letter prepared by the Registrar records the follow-up arrangements as involving contact with the CMHT, at the psychiatric outpatient clinic, with the Therapist and at the Douglas Grant Rehabilitation Centre, the latter referring to Consultant 1's care specifically in connection with the management of Mr C's Chronic Fatigue. The discharge letter is addressed to Mr C's GP but does not indicate whether it was copied more widely.

(xi) In fact the discharge plan was modified during a telephone discussion on 28 June 2002 between Nurse 1 and Nurse 3, Mr C's named nurse in Park Ward. Nurse 1 had concluded that there was no role for a CPN given that there was to be regular cognitive behaviour therapy and the arrangement for CMHT contact was thus cancelled. Nurse 3 explained to us he agreed to this change as he felt the CMHT would have a better understanding of community services. He did not record the change or communicate it to other members of the inpatient team or Mr C. He accepted that he should have done but recalled the conversation had been at the end of the day and thought this led to his error. It appears that because this change in arrangements was not recorded or communicated neither the discharge letter nor the written information given to Mr C on his discharge reflected the change.

(xii) Mr C first learned of the cancellation of the proposed CMHT contact in a letter from Nurse 1 dated 15 July 2002. Mr C contacted Nurse 1 to express his concern. In response, Nurse 2 met Mr C on 30 July 2002 jointly with the Therapist to assess the level of support he required. It is noted that Mr C would see Consultant 3, for further assessment and would continue to see the Therapist for cognitive behavioural therapy.

(xiii) Consultant 3 told to us that she arranged to review Mr C on 5 August 2002 in order to clarify the care plan although she also explained to us that her normal practice would be to see patients in circumstances similar to Mr C's on one or two occasions following discharge, establish that they were OK, and then arrange a Crisis Care Plan (CCP) which the patient could use to contact the CMHT if necessary. In the letter documenting her contact with Mr C, Consultant 3 indicated that she had not received a copy of the discharge letter and that she had therefore known of no expectation that she would see Mr C for outpatient review. She noted that since his discharge Mr C had suffered an exacerbation of his anxiety symptoms but she felt that that had been the consequence of domestic stressors. Consultant 3 could find no evidence of clinical depression. She concluded that the antidepressant medication should continue but that the mainstay of M C's management should be with cognitive behavioural therapy. She noted that the Therapist would be in a position to support Mr C, to monitor his mental state and to refer him back to the CMHT or to the psychiatric outpatient clinic should circumstances demand it.

(xiv) Mr C met Nurse 2 on 11 September 2002 when a CCP was prepared. Nurse 2 noted this meeting as having been difficult and that Mr C described his physical and mental health as deteriorating and that he felt the need for respite away from his family situation and that this had apparently been recommended by both his consultant physician (presumably Consultant 1) and his psychiatrist at the Hospital.

(xv) On 13 November 2002 Mr C's GP contacted the out of hours service after seeing Mr C that afternoon. He requested that Mr C be seen by a CPN the following day because of worsening depressive symptoms. Mr C's records show the referral was passed to the CMHT the following morning and that his case was discussed at a Team Meeting and separately with both Consultant 3 and the Therapist. The Therapist is described in the records as Mr C's key worker and both he and the CPN from the CMHT dealing with this referral

separately discussed it with the GP's partner, GP 2 who indicated that he felt a case conference would be helpful.

(xvi) The following day, on 15 November 2002, Mr C met two CPNs from the CMHT. The note of this meeting indicates Mr C described increased levels of pain which were having a direct negative impact upon his mood and motivation. The note also describes Mr C as being able to express himself clearly; at times becoming verbally hostile when he perceived that the content of the session was suggesting solutions he did not agree with; and appearing fixed on the issue of respite care. The outcome of this assessment is not specified in the records, but it appears to have been that there was no requirement for further CMHT involvement in Mr C's care at that time. The records note that the assessment was discussed by telephone with both GP 2 and the Therapist and they were both noted to be comfortable with the outcome.

(xvii) On 9th December 2002 Consultant 1 referred Mr C to another Psychiatrist at the Hospital. His referral letter included:

> *'… I think it has become increasingly apparent that [Mr C's] psychiatric problems significantly outweigh any underlying chronic fatigue syndrome that he may have.*
>
> *He was assessed by our own Neuropsychologist … who undertook some assessment using the hospital anxiety depression scale, this highlighted a psychiatric caseness for anxiety and depression.*
>
> *… he seemed to express the view that if someone would admit him to hospital and let him sleep for the majority of the day then he would be quite happy with that.*
>
> *My overwhelming impression is that this is a gentleman who has major anxiety and depression problems who is basically failing to cope with life …'*

The referral seems to have been forwarded to the CMHT at some point and an unsigned and undated annotation states 'has been seen about three weeks after discharge. Will not be seen again.'

(xviii) Consultant 3 told us she had not seen this referral. The Therapist explained to us that he was aware of Consultant 1's referral and had tried to follow it up because Mr C felt it was important, but he was not concerned that Mr C's mental health indicated a recurrence of his depressive illness.

(xix) Throughout the months that followed the Therapist maintained his contact with Mr C. Though this has proved a difficult and complex case the Therapist confirmed that he felt it appropriate to manage it himself. He reported to us that he has seen no evidence of a recurrence of major depression in Mr C and he has had no reason to believe that manipulation of Mr C's antidepressant treatment would improve matters. The Therapist has been aware throughout that he might arrange psychiatric review or call upon the resources of the CMHT at any time. He has felt no need to do so. As well as co-ordinating Mr C's care he has seen his role to contain Mr C's anxieties, his demands and his expectations of the service.

History of complaint

14. When the Trust's Chief Executive wrote to Mr C's MSP on 4 November 2002 (paragraph 4) his letter included:

> '… [Mr C] also has indicated the issue that he is being denied respite care. There is unfortunately, no supporting evidence to suggest that respite care was discussed at any time, either during his discharge arrangements at [the Hospital] or following discharge with the CMHT. I understand that, clinically, this is not a preferred option …'.

15. On 26 November 2002 the Trust's Patient Relations and Complaints Manager (Officer 1) received a 20 page letter from Mr C. Mr C seems to have written this letter on 27 October 2002, before the Chief Executive had responded to the MSP, and as a result Mr C's letter made no reference to the Chief Executive's response. I have not been able to establish the

reason(s) for the delay in receipt of this letter. Among other things, in this letter Mr C outlined the history and severity of his illness and explained why he felt he needed respite care. He also stated that, as part of the discharge process, both Consultant 2 and the Specialist Registrar at the Hospital (the Registrar) had indicated that respite would be appropriate for him and he implored the Trust to provide this care.

16. The Trust's records show that staff from the Patient Relations and Complaints Office contacted the Therapist to alert him to Mr C's comments about the severity of his illness and his need for additional support. Additionally, Officer 1 wrote to Mr C on 27 November 2002 suggesting that he discuss his request for further support with the Therapist and noting that the Chief Executive's letter dated 4 November 2002 had addressed other aspects of his concerns.

17. Mr C wrote to the Trust's Complaints Convener (the Convener) on 27 November 2002 in response to the Chief Executive's letter of 4 November 2002, but presumably before he had received Officer 1's letter of 27 November 2002. He stated he was 'very unhappy' with the way the Trust had handled his complaint and requested that an IRP look into his complaint. He outlined his key concerns in a document entitled Appendix 4 and enclosed a number of other documents which he felt demonstrated these concerns. Amongst other things, Mr C:

- referred to the agreement mentioned in Nurse 1's letter dated 15 July 2002 that the CMHT would not become involved in his care following his discharge and he stated that Consultant 1 and the Registrar had not been aware of any such agreement. He asked when and by whom this agreement had been made. He described it as a 'childish and blatantly obvious excuse' which he believed to be untrue.

- challenged the accuracy of the statement in the Chief Executive's letter dated 4 November 2002 that the error in the discharge information he had been given was only identified after he had contacted the CMHT. He described this as being 'simply untrue' and enclosed a copy of Nurse 1's letter dated 15 July 2002, which indicated

that the error had been identified before he contacted the CMHT on 24 July 2002.

- challenged the accuracy of the statement in the Chief Executive's letter dated 4 November 2002 that there was no evidence that respite care had been discussed with Mr C. He reiterated that Consultant 1 and the Registrar had been supportive of respite care and stated that the Therapist had made numerous attempts to identify both suitable respite care providers and funding for such respite care.

- asserted that each CPN he had met had been 'totally unaware' that he suffered from 'severe post-viral fatigue syndrome causing reactive depression' and further that they had insufficient understanding of this condition to make decisions about his care.

- indicated that in his view the real question was 'why did the CMHT … refuse to care for me?'

18. Mr C wrote to Officer 1 on 6 December 2002 acknowledging her sympathetic letter of 27 November 2002 but asking if this would result in action on the issues he raised. Mr C enclosed a copy of Appendix 4 with his letter.

19. The Convener wrote to Mr C on 20 December 2002 as follows:

> '… I am writing to inform you that I have decided not to grant your request for an IRP. I have made this decision following detailed consideration of your complaint and discussion with an Independent Lay Panel Chairman.
>
> I note from your lengthy letters dated 27 October 2002 and 9 December 2002 that there are two main issues in which you were requesting an IRP.
>
> … these may be summarised as follows:-

1. The Discharge Information from the Hospital was incorrect in that you were advised that you would be referred to [the Therapist] and to [Nurse 1]

2. And secondly that you are not being provided with sufficient respite care.

During my consideration of your complaint it was apparent that the Discharge Information which you received from the Hospital did not reflect what had been agreed at the multi-disciplinary Team Meeting prior to your discharge.

The Trust have written to you in this regard and have apologised for the confusion that arose. I am therefore satisfied that the Trust have correctly dealt with your complaint and have responded to you in a suitable manner …

Turning now to the second aspect of your complaint. It is clear from your detailed correspondence that your complaint is distressing and painful. The issues which I must consider revolve around whether your complaint has been correctly handled …

I am satisfied that the Trust has correctly dealt with your complaint. Both the Lay Chairman and myself are in agreement that there are no issues which require to be resolved by way of an IRP … However, I do feel that there are issues which would benefit from referral back to local resolution regarding the provision of respite care …'.

20. On 17 January 2003 the Chief Executive wrote to Mr C in response to the Convener's decision to refer his complaint back for further local resolution. The Chief Executive explained that his request for respite had again been addressed by Consultant 3 and the CMHT. He explained that while the CMHT had access to a 'support break flat' there were strict criteria for use and Mr C did not meet those at that time, however his care planning arrangements could be reviewed in the future.

21. Mr C became increasingly dissatisfied with the way his complaint was being handled and he complained to my office on 13 February 2003.

22. As part of my Investigator's initial consideration of Mr C's complaint, he asked the Trust to provide copies of relevant documentation and, specifically, details of how the agreement that it would not be appropriate for Mr C to be seen by both the Therapist and a CPN from the CMHT following his discharge had been reached. However, while the Trust provided copies of the relevant documentation, neither this documentation nor the Trust's reply clarified how this agreement had been reached.

23. On 11 May 2003, Mr C wrote to my Investigator pointing out that he had still not received an appointment with a Consultant Psychiatrist following Consultant 1's re-referral on 9 December 2002. At the time my Investigator considered this to be a new issue which Mr C should pursue directly through the Trust's complaints procedures.

24. As noted in paragraph 7, on 20 May 2003 I decided to formally investigate Mr C's complaint.

25. On 28 May 2003, the Trust replied to a further letter from Mr C's MSP. This letter stated:

> '… May I begin by offering my apologies to [Mr C], for what appears to have been some misunderstandings between the Community based staff and [Mr C] …
>
> … I am advised there may be some misunderstanding regarding the membership of the local [CMHT]. It may be helpful therefore to clarify that [the Therapist] is a member of the Multi Disciplinary Team that has provided aspects of Mr C]'s care, not a member of the CMHT. [The Therapist] and [Mr C] have had discussions and [the Therapist] has recorded them in his notes, as indicated by you, this is in his capacity as a member of the Multi Disciplinary Team …
>
> … [The Staff Nurse from Park Ward, at the Hospital (Nurse 3)] clearly recalls that an agreement was reached about [Mr C]'s discharge plan

prior to his discharge. Thereafter, further discussion took place between the ward staff and the CMHT on 9 July 2002 and a change was made in respect of the intervention. It is quite clear that [Mr C] was not informed timeously, but only learnt of the changes to the plan when he received the letter dated 15 July 2002, from [Nurse 1].

… [Nurse 1] was absent from work during the initial investigation into [Mr C]'s complaints and was therefore unavailable to assist in providing information regarding the action which had been agreed on 9 July 2002. This is regrettable, particularly in view of the clear misunderstanding where the Trust indicated in earlier correspondence that [Mr C] contacted the CMHT, prior to receiving [Nurse 1's] letter, which was not the case. … I can confirm that as part of the initial investigation, the Manager drew some of his information from a letter between the GP and [Consultant 3] dated 8 August 2002 … It has emerged that the Manager drew the wrong inference from that letter … I apologise unreservedly for the error on this occasion.

… [Nurse 2] has noted that she and [Mr C] referred to his need for respite, during an appointment on 11 September 2002 …

… I am aware this is considered to be evidence that a discussion did therefore take place between a member of the CMHT and [Mr C]. However, unfortunately, it remained that no service availability was identified …

I would like to offer apologies on behalf of the CMHT for the delays in conveying information timeously to [Mr C].'

26. On 9 June 2003 the Trust responded to my decision to investigate Mr C's complaint. Amongst other things, the Trust acknowledged there had been a breakdown in communication; that the decision that the CMHT would not be involved in Mr C's care following discharge was taken without the involvement of other clinical staff members; and that Mr C had not been involved in this decision. The Trust also gave other commitment relating to future practice and procedures in general. It concluded:

'… The Trust accepts the points raised in the complaint statement. However, we are inclined to emphasise that the issues highlighted are not entirely in keeping with our understanding of the original complaint, where the key factor was the availability of respite care.

That being said, the Trust will ensure:

- A patient has a full and clear copy of the proposed and agreed care planning arrangements both in hospital and in the community, through the Named Nurse and care planning process.

- Staff, where able, will secure a signed agreement from the patient in line with good practice, which will ensure the patient agrees with the treatment plan. Additionally, this will ensure an agreement has been reached.

- Where amendments are made to any care planning arrangements, staff will ensure full documentation is prepared and available to support the changes made.

- Patients will receive notification of any changes made and a record will be kept of those changes.

- Patients will be informed of the opportunity to contact a member of staff to discuss aspects of correspondence they receive, to ensure a full understanding is reached …'

27. On 7 September 2003 Mr C complained to the Trust about the failure to arrange an appointment with a Consultant Psychiatrist, following Consultant 1's referral in December 2002 and other issues. I have not been able to establish why Mr C delayed pursuing his complaint about this issue. In his letter, Mr C said that he felt he had been 'ignored, forgotten about and totally neglected by Ayrshire and Arran's Psychiatric Services' and that it was only after he contacted his GP in May 2003 that he finally received an appointment with a Consultant Psychiatrist and, even then, the appointment was not until 18 August 2003.

28. The Trust responded to Mr C on 9 October 2003 stating:

> '… I understand the referral letter was sent initially to the Hospital and unfortunately this caused some delay as the letter had to be redirected to the North Cunninghame CMHT. I apologise for this delay and can advise that Service Managers are taking the opportunity to improve the way information, as important as this, is transferred between Teams, to ensure a more timeous response, particularly to referrals. I am further advised that [Nurse 2], made arrangements to meet with yourself on 16 January 2003 to review your Crisis Care Plan … The CMHT felt, at the time, this was an appropriate way to review your health needs.'

29. The Trust also acknowledged that after Mr C had cancelled three appointments to meet Nurse 2 because of his poor physical health, the final one having been scheduled for 7 February 2003, the CMHT did not make further attempts to see him. The Trust apologised for this lack of follow up and acknowledged why Mr C might have felt ignored and neglected.

Mr C's comments to my Investigator

30. Mr C was very complimentary of the care he received while in the Hospital. He described being very involved in the discussions about his care after discharge, which had been largely led by the Registrar but were overseen by Consultant 2. The Registrar told him that he would benefit from respite care. By this he understood that he might be at home for approximately three days a week, with the remainder of the week being spent in some other care setting. He acknowledged that this was similar to the pattern of care he was receiving towards the end of his period in the Hospital but Mr C understood he was being discharged because (a) it was felt that his psychological condition had improved and (b) there was pressure for beds in the Hospital.

31. Mr C described being very upset when he received the letter stating that the CMHT would not be involved in his care and he questioned whether it was appropriate for Nurse 1 and Nurse 3 to agree by telephone this change to his proposed care arrangements. He complained that the CMHT's involvement in his care after discharge had effectively been limited

to the preparation of his CCP and even this only came about following his complaints. He also questioned whether the CMHT had sufficient expertise in the treatment of people with CFS, which he felt was essential as he understood his depression was a reaction to his poor physical health. Lastly, Mr C commented that he had considerable concerns about the accuracy of the Chief Executive's responses to his complaint.

Clinical Aspects of complaint: staff comments to my Investigator

32. Consultant 2 explained that in practice it was the Registrar who led the majority of Mr C's care, made the appropriate referrals and prepared his discharge summary. She felt Mr C had received 'gold standard' treatment while in the Hospital and she speculated that this may have led to him having unrealistic expectations about the care he might receive in the community.

33. Consultant 2 said that, while Mr C's diagnosis of severe depression had been confirmed on admission to the Hospital, it was complicated by his eight year history of CFS. She felt his depressive symptoms had largely resolved with the aid of anti-depressants during the course of his admission. He presented as being bright and reactive while in the Ward and Consultant 2 felt that by the time he was discharged there was very little evidence that he had a psychiatric illness and she viewed his care needs as predominantly relating to his CFS.

34. Consultant 2 explained that Mr C had been admitted to her care in the Hospital as an 'out of catchment patient' as normally patients from his area were admitted to Crosshouse Hospital under the care of Consultant 3 and within the CMHT area. However, such out of catchment admissions were not uncommon because of a shortage of beds at Crosshouse Hospital.

35. Consultant 2 explained that, while it was normal practice for a CPN from the CMHT to attend ward rounds at Crosshouse Hospital to facilitate discharge planning, they did not normally attend ward rounds at the Hospital except in cases considered to be complex and to carry significant risks when the process would be more formal. Instead, Consultant 2 commented that there was an expectation that the CMHT would accept the recommendations of hospital staff for the patient's care following discharge.

She had envisaged the role of the CMHT in Mr C's post discharge care arrangements as being largely to support the Therapist while he provided Mr C with treatment for his CFS. However, the CMHT had not initially appeared to accept this proposal. While this was unusual, Consultant 2 felt it might reflect pressures on the CMHT.

Consultant 2 felt that the care package initially arranged for Mr C following his discharge was very good. She doubted that either she or the Registrar would have recommended to Mr C that he use respite care following his discharge because there is no respite service in adult psychiatry. Consultant 2 accepted that she and the Registrar had reassured Mr C that if he needed to be re-admitted to hospital then this would be arranged. However, she would have only envisaged re-admitting Mr C if he became depressed again and not because of primarily physical problems relating to his CFS but she acknowledged that this may not have been clear to Mr C.

36. Nurse 3 felt that, in general, the discharge planning arrangements for out of catchment patients worked well. He explained that the relevant CMHT would contact the ward for regular updates on a patient's situation and would be invited to the pre-discharge meeting, although they did not necessarily attend. If no one from the CMHT had attended, they would be informed of the conclusions and notified by telephone of a patient's discharge and, if relevant, a referral sent.

37. Nurse 1 explained that the only time she had actually met Mr C was in February 2002 when she had carried out an assessment. At the time, she concluded that there was no requirement for the CMHT to become involved with his care but she had facilitated referrals to Consultant 1 and for cognitive behavioural therapy.

38. Nurse 1 said that, because Mr C was from the GP practice area she covered and she had been involved in facilitating his admission to the Hospital, she had liaised with ward staff about Mr C while he was in hospital. This was normal practice. Nurse 1 added that normally the relevant CPN from the CMHT would be invited by ward staff to the pre-discharge meeting to plan for a patient's discharge. CPNs would normally try to attend these but this was more difficult for patients in the

Hospital because of the time required to travel there but, if they could not, they would make their views known prior to the meeting.

39. Nurse 1 did not recall being invited to attend Mr-C's pre-discharge meeting. However, from the feedback she had received from ward staff during his admission she understood that his circumstances had improved and she felt that, by the time he was ready to be discharged, the follow-up arrangements from her assessment in February 2002 remained appropriate. As a result, she agreed with Nurse 3 that the CPNs from the CMHT would not become involved in Mr C's care although she continued to expect Consultant 3 to review Mr C following his discharge.

40. Nurse 1 wrote to Mr C on 15 July 2002 after she received the discharge information, as she realised that this did not reflect the agreement she had made with Nurse 3. Mr C had contacted her after he received her letter and it was agreed that a CPN from the CMHT would jointly assess Mr C along with the Therapist, in light of the confusion. Nurse 1 was not able to carry out this assessment as she was on holiday and she had no further contact with Mr C.

41. Consultant 3 explained that a CPN would regularly liaise with ward staff if a patient from the CMHT area was being treated in hospital. This system had been set up in part because of the recognised communication difficulties between CMHTs and ward staff, especially when patients were being treated on an out of catchment basis. Additionally, the CMHT would normally be notified of the pre-discharge meeting and someone would try to attend but this was not always practical.

42. Consultant 3 said that she would not necessarily maintain routine and ongoing follow-up of patients in Mr C's circumstances following their discharge. Her normal practice would be to see them on one or two occasions, establish that there was no cause for concern and then arrange for a CCP to be completed, which the patient could use to contact the CMHT if necessary.

43. Consultant 3 said that she saw Mr C's GP as co-ordinating his care and managing his medication, with advice from CPNs if required. She felt this

was appropriate, given that Mr C presented with a mixture of psychological and physical health problems. She saw the Therapist as having a role in monitoring Mr C's mental health. She was confident that the Therapist would have made further referrals if he had been concerned about Mr C.

44. Consultant 3 said that she had not previously seen Consultant 1's referral letter dated 9 December 2002. If she had, she would have suggested that either she or a CPN speak to the Therapist to assess whether he was concerned that Mr C was suffering from a psychiatric condition at that point. However, Consultant 3 also noted that Mr C had been seen by a range of staff from the mental health services. All their assessments appeared consistent and none of them appeared concerned that he was developing a psychiatric illness. She noted that Mr C's perception of his needs differed from the conclusions of the various specialists treating him. She felt Mr C sought to 'split' the people involved in his care and that there was a pattern developing of Mr C avoiding the key issues and seeking inappropriate intervention. Consultant 3 felt all the CMHT could do was to be clear and consistent in the message they gave to Mr C and they tried to achieve that by maintaining boundaries and restricting the number of people involved in his care.

45. The Therapist said that he had first met Mr C shortly before he was discharged from the Hospital. After his discharge, the Therapist had become involved in trying to obtain respite care for Mr C as this was Mr C's main focus during their sessions and he did not seem able to move on from this. However, the Therapist felt that the CMHT were justified in refusing Mr C's application for respite care as, in his view, Mr C's pursuit of this was an avoidance of his main issues.

46. The Therapist had been aware of Consultant 1's referral of Mr C for a psychiatric review in December 2002. The Therapist had taken steps to follow up this referral because Mr C had felt it was important rather than because he (the Therapist) was concerned that such a review was needed. In his view, Mr C's mental health did not indicate a recurrence of his depressive illness and he did not consider that closer management of Mr C's antidepressant therapy would have been beneficial.

47. Officer 2 managed both community based services and the CMHT. He did not manage inpatient services at the Hospital but he had discussed Mr C's complaint with Nurse 3 as he had investigated all aspects of this complaint.

48. Officer 2 acknowledged that when patients from the CMHT area were admitted to the Hospital they would be cared for by a different Consultant Psychiatrist and communication was more difficult. Officer 2 felt there was no reason why members of the CMHT could not participate in discharge planning meetings but he accepted that in practice this might depend upon the amount of notice given, as meetings could be difficult to accommodate at short notice. He also said that the degree and formality of discharge planning was generally related to the seriousness/complexity of the patient's needs and care package and he commented that Mr C's case and care package were not considered to be particularly complex.

49. Officer 2 acknowledged that the seemingly differing views as to whether or not the CMHT should be involved with Mr C's care following discharge might have been addressed earlier by better communication between the inpatient team and the CMHT. However, he considered the CMHT's decision not to become involved was sound and the fact that Nurse 3 felt able to agree to it indicated that he did not feel uncomfortable with it. More generally, Officer 2 commented that it was common for nurses to agree limited changes to discharge plan arrangements although the degree to which this happened might vary depending upon the relevant Consultant's approach.

Clinical Assessors' report

50. The report of the clinical Assessors is set out below.

> *Comments on the Actions of Clinical Staff*
>
> *(i) Mr C's first point of contact with the psychiatric service in Ayrshire was with Nurse 1. She concluded then that the CMHT had nothing to offer but identified that a service might be provided by Clinical Psychology and Neurological Rehabilitation. She appears to have disposed of the referral entirely appropriately.*

(ii) We see no reason to fault Mr C's care at the Hospital. The management of his depression was standard and he was referred appropriately for assessment and management of his chronic fatigue.

(iii) Mr C's admission to an 'out of catchment facility' was always likely to hamper communication and to make discharge planning more difficult. However, Nurse 1 maintained and documented her contact with the team at the Hospital during M r C's admission and we consider this was a high standard of practice.

(iv) The decision taken by Nurse 1 in discussion with Nurse 3 was that the CMHT (and by this was meant, we believe, the Community Psychiatric Nurses) would not be involved in follow-up was we think appropriate. The CMHT is required to marshal its resources and it is not clear that a CPN would have been able to do more than duplicate the work undertaken by the Therapist. Additionally, we consider it was appropriate for Nurse 1, as a CPN to have made this decision and Nurse 3, as Mr C's named Nurse to have agreed to it. We consider the majority of Psychiatrists would encourage nursing colleagues to exercise their judgement on such matters.

(v) It is unfortunate that this change in the follow-up arrangements was not communicated to Mr C or other members of the inpatient team. It is unfortunate too that the discharge letter detailing and communicating the follow-up arrangements to the relevant professionals seems not to have been copied to them. As a consequence Consultant 3 appears not to have been initially aware of Mr C's discharge and his outpatient review may have been delayed. It is not clear that he was otherwise disadvantaged.

(vi) Consultant 3 concluded that Mr C's depressive disorder was in remission when she saw him, that he should continue with antidepressant treatment and that his point of contact with mental health services should be with the Therapist. She made it explicit that the CMHT might become involved at the Therapist's request and that she would similarly be prepared to review the case. These arrangements appear appropriate.

(vii) At meetings with representatives of the CMHT on 11 September 2002 and again on the 15 November 2002 Mr C argued that he should be admitted to hospital for respite care. On neither occasion do the notes suggest evidence of psychiatric illness of sufficient severity to require psychiatric in-patient care. It seems clear that following the review on 15 November 2002 the professionals (in primary and secondary care) involved in Mr C's care were in broad agreement that his treatment package should continue without alteration and with the Therapist as keyworker.

(viii) On 9 December 2002 Consultant 1 requested a psychiatric review. The referral was appropriate. On the face of it, Mr C's mental state had deteriorated to the point where it had become difficult for Consultant 1's service to engage with him. At Consultant 1's request a senior neuro-psychologist had assessed him and had concluded that Mr C might be suffering from either an anxiety or a depressive disorder. The anonymous conclusion, that because Mr C had been 'seen about three weeks after discharge. [He] will not be seen again', was neither professionally courteous, nor, more importantly, safe. Depressive disorders are not stable over time and non-specific response to inpatient care with subsequent early relapse is common. We were not able to establish who made the decision to reject this request from a senior clinician for further psychiatric assessment or how this decision was made. However, it should only have been taken following discussion with the keyworker and correspondence with Consultant 1 should have followed. That Consultant 1 had responded to the initial referral of Mr C from the psychiatric service so promptly simply highlights the discourtesy.

(ix) The Therapist has been centrally involved and very active in Mr C's care since the admission to the hospital. He is an extremely experienced practitioner with a background in psychiatric nursing and CBT training. He seems to us to have done exceptionally well to keep Mr C in treatment over a prolonged period, not least when Mr C's agenda (for example in his single minded pursuit of respite care) and the Therapist's treatment goals must often have been at huge variance.

Conclusions

(x) Mr C has suffered from a CFS since 1993. On account of emerging and worsening depressive symptoms he was admitted to the hospital on 26 March 2002. Through a 10 week admission his condition slowly improved. It is not clear whether that improvement was a consequence of his drug treatment or a non-specific hospital effect.

(xi) There is no mention in Mr C's inpatient records that respite care was either offered or recommended by a Consultant Psychiatrist or any other member of staff at the Hospital. Consultant 2 recalled that she and the Registrar were asked by Mr C what would happen if he required readmission following discharge and she recalled too, reassuring him that that would be arranged. Implicit in this for Consultant 2 was that Mr C would be readmitted if necessary on account of depressive relapse. It appears that this may have been misconstrued by Mr C as an offer of future respite care.

(xii) Over the years psychiatric beds have been run down nation-wide. Respite admissions are now rare and we cannot imagine an acute psychiatric service in Scotland which would be in a position to offer respite to an individual suffering from Chronic Fatigue whether or not complicated by co-morbid depression.

(xiii) We note the Therapist's efforts to secure respite care for Mr C outside the NHS. We also agree with the Therapist's conclusion that respite would represent 'avoidance of (Mr C's) main difficulty which is successful self-management at home'.

(xiv) There is no doubt that information concerning the arrangements for Mr C's after care was not properly communicated either to Mr C or to those professionals who were being expected to provide it. The decision that no CPN would be involved in his follow-up should have been conveyed to Mr C. The discharge summary does not appear to have been copied appropriately. As a consequence of that M C's contact with Consultant 3 was delayed.

(xv) Despite these lapses in communication, it is the case that an entirely appropriate treatment package including Neurological Rehabilitation with graduated exercise, antidepressant treatment and cognitive behavioural therapy was arranged and in place at the time of Mr C's discharge from hospital. It is unlikely that such a comprehensive care package could have been offered so quickly across the country.

(xvi) The contacts between Mr C and the CMHT in September and November 2002 are well documented. There is nothing to suggest that during that period there was an indication for psychiatric admission. Appropriate liaison and unanimity of opinion between psychiatric and primary care services is clearly documented.

(xvii) Consultant 1's referral to the psychiatric service merited prompt attention which it did not receive. Whoever dismissed the referral for psychiatric re-evaluation was in error. There could be no safe assumption in the absence of discussion with the referring clinician (Consultant 1) and the key-worker (the Therapist) that psychiatric re-examination was required.

Findings: complaints (a) and (b)

51. Mr C was admitted to the Hospital on 26 March 2002 because of worsening depression linked to the severity of his CFS. His condition slowly improved and, after a number of home passes, he was discharged on 2 July 2002. While he was a patient, Mr C was referred to Consultant 1 who arranged and started a graded exercise programme in connection with his CFS. The discharge letter records that the follow up arrangements were for the CMHT to continue contact through the psychiatric clinic and for Mr C to attend the Therapist and Consultant 1 for CFS treatment. However, the discharge plan was amended following a telephone conversation between Nurse 1 and Nurse 3 on 28 June 2002, where it was decided that there would be no role for the psychiatric service in view of the regular contact from the Therapist. This change of plan was not communicated to Mr C and he first learned of it after discharge when Nurse 1 sent him a letter on 15 July 2002. Mr C wondered whether it had been appropriate for Nurse 1 and Nurse 3 to have made the decision to amend the discharge plan.

52. Consultant 2 thought that the CMHT's role after discharge would be to support the Therapist whilst he dealt with the CFS treatment. Consultant 2 doubted that either she or the Registrar would have recommended respite care to Mr C as there is no respite service in adult psychiatry. Consultant 2 had reassured Mr C that, should his depressive symptoms return and reach a level requiring hospital admission, then that would be arranged. However, she acknowledged that this might not have been made clear to Mr C.

53. Nurse 3 recalled his telephone conversation with Nurse 1 and agreed that Nurse 1's involvement in Mr C's care might deflect from the Therapist's treatment. However, he did not record the change in the care plan or discuss it with Mr C or other staff. Nurse 1 believed that Mr C's condition had improved in hospital and that the situation remained as before when she assessed Mr C in February 2002, that there was no requirement for the CMHT to become involved in his care and that referrals had been made to Consultant 1 and the Therapist. When Nurse 1 received the discharge information she realised that this did not reflect the agreement she had made with Nurse 3 and she wrote to Mr C to advise him of this.

54. Consultant 3 met Mr C on 5 August 2002 and he appeared to have been relatively well for the three weeks after discharge. Then he deteriorated. Consultant 3 questioned whether Mr C would gain anything from a CPN input as he was attending Consultant 1 and the Therapist. She was confident that the Therapist would have made further referrals if he had been concerned about Mr C and, in addition, Mr C's GP would be co-ordinating his care and managing his medication with advice from the CPNs if required.

55. The Therapist felt that it was reasonable for one person to coordinate Mr C's care and it was appropriate for him to do so. He would frequently work with the CMHT and would assume their role of monitoring the patient's mental health and making referrals to the GP or psychiatrists as required whereas the CMHT would only provide emergency care. He felt that it would be appropriate for the CMHT not to become involved in Mr C's care beyond developing and reviewing the CCP.

56. Officer 2 said that the differing views as to whether the CMHT should have been involved with Mr C after discharge might have been addressed by better communication between the inpatient team and CMHT. It was common for nurses to agree limited changes to discharge plan arrangements. He was comfortable that Nurse 1 and Nurse 3 had arrived at a decision that the CMHT were not to become involved in Mr C's care on discharge.

57. The advice I have received is that Mr C's initial contact with the CMHT in February 2002 was handled appropriately. Nurse 1 decided there was no role for the CMHT but identified a service could be provided by clinical Psychology and Neurological Rehabilitation. Mr C's depressive symptoms were appropriately managed and a referral was made to address his CFS symptoms. On discharge, it was appropriate for Nurse 1 and Nurse 3 to discuss, and agree, that CMHT involvement was not required as this would have been a duplication of the service provided by the Therapist. Consultant 3 had also reviewed Mr C after discharge and concluded that Mr C's depressive disorder was in remission and that a further review would be arranged should the Therapist identify a need. Further reviews took place on 11 September 2002 and 15 November 2002 which were well documented and the health professionals were in agreement that the situation regarding Mr C should remain as set out after discharge. The treatment package which Mr C received on discharge from hospital, including Neurological Rehabilitation with graduated exercise, anti-depressant treatment and cognitive behaviour therapy was comprehensive and quickly arranged.

58. I have taken into account the available evidence and I have concluded that Mr C received appropriate care and treatment from both the Trust and the CMHT. I therefore do not uphold heads (a) and (b) of Mr C's complaint to me. However, it is clear that there was a breakdown in communication and that information was not recorded in Mr C's clinical records about the change to the discharge arrangements or passed on to Mr C prior to discharge. I am also concerned that there is no mention in the clinical records that respite care was discussed with Mr C yet, evidently, it had been. I am pleased to note the action which has been taken by the Trust to address these concerns (see paragraph 26).

Additional clinical complaint

Failure to make timely arrangements for an appointment with a Consultant Psychiatrist following Consultant 1's referral on 9 December 2002

59. Consultant 3 said that she had not seen Consultant 1's letter of 9 December 2002 but if she had then she would have suggested that either she or a CPN speak to the Therapist to assess whether he was concerned that Mr C could be suffering from a psychiatric condition. However, Mr C had been seen by a range of staff from the Mental Health Services; all assessments had been consistent; and none, apart from Consultant 1, mentioned concerns about a developing psychiatric illness.

60. The Therapist was aware of Consultant 1's referral for a psychiatric review and had taken steps to follow it up as Mr C had felt it important, rather than because he felt a review was needed. In his view, there was no indication that Mr C's depressive illness had recurred and that closer management of the therapy was not required.

61. The Clinical Assessors have advised me that Consultant 1's request, dated 9 December 2002, for a psychiatric referral was appropriate, given that it appeared Mr C's mental health had deteriorated to a point where it was difficult to engage with him. At Consultant 1's request, a senior neuro-psychologist had assessed him and concluded that he might be suffering from either an anxiety or a depressive disorder. I share the Assessors' concern that the anonymous conclusion that because Mr C had been 'seen about three weeks after discharge [He] will not be seen again.' was neither professionally courteous, nor, more importantly, safe. The decision to reject the request should have been taken after discussion with the Therapist and a response issued to Consultant 1.

62. It has not been possible to establish who received or read Consultant 1's request before annotating and filing the letter. There was an initial delay, as the letter had been sent to the Hospital before being sent to the CMHT. Consultant 3 had not seen the letter but the Therapist had been aware that a review had been requested. I uphold this aspect of the complaint as I believe Mr C should have been reviewed by

Consultant 3, who would have decided on how best to progress matters and respond to Consultant 1.

Complaint (c): Trust's response to Mr C's complaint

63. Mr C complained that he had considerable concerns about the Chief Executive's responses to his complaint. In particular, he was concerned that the Chief Executive had said the error that Mr C would be contacted after discharge by the Therapist and CMHT had come to light after Mr C contacted the CMHT. Mr C had in fact learned of the error when he received the letter from Nurse 1 on 15 July 2002. Mr C contacted the CMHT on 24 July 2002. Mr C was also unhappy that the Chief Executive had stated that there was no evidence that respite care had been discussed with Mr C and this was not considered to be a clinically preferred treatment option. Mr C maintained that Consultant 1 and the Registrar had been supportive of respite care and stated that the Therapist had made attempts to identify suitable respite care providers and appropriate funding.

Staff comments to my Investigator

64. Officer 1 said all complaints that should be forwarded to the Patient Relations and Complaints Office where they were acknowledged and initially analysed. The complaint and the summary of the main issues are forwarded to an identified lead investigator (in this case, Officer 2), who is expected to investigate the complaint and complete a pro forma which (a) explains the outcome of investigation and (b) allows for drafting of a response from the Trust to the complainant. This draft response is revised in discussion with her and a relevant senior manager prior to being presented to the Chief Executive. In such a system, the lead investigator is mainly responsible for the drafting of the response to the complaint and this can result in difference of style in responses.

65. Officer 1 acknowledged that, in Mr C's case, the Chief Executive's response to Mr C's MSP dated 4 November 2002 contained comments about (a) when CMHT became aware of the error in discharge information and (b) that respite care had never been discussed with Mr C, which were subsequently shown not to be accurate. She understood these were based in part upon the lead investigator drawing the wrong inference from

Consultant 3's correspondence but she noted that these points were largely responded to in the Chief Executive's later letter dated 28 May 2003.

66. Officer 1 commented that Mr C had focused on details while pursuing his complaint. To her this highlighted the need for clarity in the Trust's responses. She felt terms like 'respite' and 'local resolution' were insufficiently clear to Mr C and were a source of confusion for him. She felt the Trust had a responsibility to try to be clearer.

67. Officer 2 said that he had investigated all aspects of Mr C's complaint. At least three relevant members of staff had been off work on long term sick leave during his investigation and this made establishing the sequence of events difficult. Officer 2 acknowledged that there had been some errors in his original understanding of events and, as a result, there had been errors in the Chief Executive's letter dated 4 November 2002.

68. Consultant 2 doubted that she or the Registrar would have recommended respite care, as this did not exist in adult psychiatry. The Therapist confirmed that he had become involved in trying to obtain respite care for Mr C.

Findings: complaint (c)

69. Officer 2 said that he had investigated Mr 's complaint and prepared a draft response, which was sent to his line manager for refinement prior to being sent to the Chief Executive for the final response. His investigation was hampered by three members of staff who were on long term sick leave, which made establishing the sequence of events difficult. He acknowledged that there had been some errors in his original understanding of events and, as a result, these were continued in the Chief Executive's letter of 4 November 2002. He had tried to establish whether the issue of respite care had been discussed as a real option for Mr C or simply if it had been raised during conversations.

70. Officer 1 acknowledged that the Chief Executive's response letter dated 4 November 2002, had comments about when CMHT were aware of the error in discharge information and respite care discussions, which were subsequently shown to be inaccurate. She understood these errors were

based on Officer 2 drawing the wrong conclusion from Consultant 3's correspondence but she noted the points were responded to in the Chief Executive's later letter dated 28 May 2003.

71. In this case, it is clear that the responses from the Chief Executive were inaccurate and I can fully understand the frustration which Mr C must have felt. I uphold this aspect of the complaint. I note that the Trust have fully admitted the errors and appropriate apologies have been provided. I recommend that staff are reminded of the need to fully investigate complaints and provide clear and accurate explanations in future.

Complaint (d): Convener's consideration of Mr C's complaint

72. The matter investigated here is whether the Convener sought appropriate clinical advice when considering Mr C's request for an Independent Review of his complaint.

73. At the time to which this complaint relates, the NHS Complaints procedure had two stages. The second stage involved consideration by Conveners of requests for Independent Review of unresolved complaints. Guidance on the NHS Complaints Procedure, revised in May 1999 and current at the time to which this complaint relates, stated that in considering requests for an Independent Review of a complaint relating to the exercise of clinical judgment, the Convener was to obtain appropriate clinical advice. The guidance also said that, in such cases, the letter conveying the Convener's decision should include reference to the fact that clinical advice had been sought.

74. Major changes to the NHS Complaints Procedure came into effect on 1 April 2005. The second stage of the procedure has been removed.

Evidence from Papers

75. The Trust's records indicate that, as part of her consideration of Mr C's request for an IRP, the Convener obtained additional comments and clarification of aspects of Mr C's complaint.

76. The Convener confirmed that she had sought clinical advice from the Medical Director on Mr C's complaint. It was not her practice to mention

this in her correspondence, as she felt this might give the complainant the impression that their personal circumstances were being inappropriately discussed within the Trust. The Convener accepted that the Guidance on the NHS Complaints Procedure indicated that Conveners should refer to the fact that clinical advice had been sought but she noted that this related to decisions not to take further action on a complaint and her decision had been to refer Mr C's complaint back for further local resolution.

77. The Convener explained that both she and the lay chair, in accordance with the guidance on the NHS Complaints Procedure, had consulted on Mr C's request and had concluded that the Trust had appropriately responded to his complaint and there was no case for an IRP. She accepted she might have simply decided to take no further action on the complaint in such circumstances but she wanted to be helpful and felt that it would be a shame to leave Mr C with no further opportunities for dialogue. For this reason, she decided to refer the issue of respite care back for further discussion but, with hindsight, she accepted it could have been more appropriate to simply decide to take no further action.

Findings: Complaint (d)

78. I am satisfied that the Convener gave Mr C's request full and correct consideration, including seeking appropriate clinical advice. I do not uphold this aspect of the complaint to me. I note, however, that the fact that the Convener's decision letter did not mention that clinical advice had been sought was not in accordance with the then guidance on the NHS Complaints Procedure.

Professor Alice Brown
Scottish Public Services Ombudsman

11 November 2005

ANNEX A

Key to names used

For legal reasons, all names used in this report have been changed. The names and abbreviations used are:

Mr C	The complainant
CFS	Chronic Fatigue Syndrome
The CMHT	Community Mental Health Team
Consultant 1	Consultant in Neurological Rehabilitation with Ayrshire and Arran Acute Hospitals NHS Trust, who primarily treated Mr C's CFS
Consultant 2	Consultant Psychiatrist responsible for Mr C's care while he was a patient in the Hospital
Consultant 3	Consultant Psychiatrist covering the CMHT area
Consultant 4	Consultant Psychiatrist at Homeopathic Hospital
GP	Mr C's GP
GP 2	GP 1's partner
Nurse 1	Community Psychiatric Nurse with the CMHT
Nurse 2	Community Psychiatric Nurse with the CMHT
Nurse 3	Staff Nurse from Park Ward, the Hospital, and Mr C's named nurse
Officer 1	Patient Relations and Complaints Manager
Officer 2	Patient Services Manager for Adult Mental Health Services
The Registrar	Specialist Registrar in Psychiatry who largely led Mr C's care in the hospital
The Therapist	Cognitive Behavioural Therapist and Clinical Nurse Specialist with the Consultant and Clinical Psychology Services, a part of the Trust