SPSO decision report

Case: **201906634, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board failed to provide them with reasonable care and treatment. C experienced a sudden loss of sensation in their left leg. C initially contacted their GP and after sypmtoms did not improve, they were referred to orthopaedics (specialists in the treatment of diseases and injuries of the musculoskeletal system) and reviewed by the on-call orthopaedic service at Royal Alexandra Hospital. C was examined by a junior doctor.

C told us they were concerned that their back was not examined; that they did not received a scan, that they were not reviewed by a senior orthopaedic doctor or a neurosurgeon, that there was a failure to contact them after a multi-disciplinary team discussion was held, that there was a delay in receiving a scan as an out-patient, that there was a significant delay between the reporting of the scan and C (and their GP) being made aware of the results and that there was a delay in receiving an out-patient appointment.

The board acknowledged that the examination C received was not in keeping with usual process, however, they considered that the junior doctor appropriately discussed C's condition with a registrar and received advice from the neurosurgery team.

We took independent advice from a consultant orthopaedic surgeon. We found that the initial assessment was reasonable and that it was reasonable for a scan to be completed as an out-patient. We considered that it was appropriate for the board to discuss C's case with the on-call neurosurgeon and that the treatment plan agreed was reasonable. However, we found that the delay in acting on the scan report was unreasonable, given that it contained significant findings.

In light of this, on balance, we upheld C's complaint.

Recommendations

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

- The board should take steps to ensure outcomes of multi-disciplinary team meetings are documented, and it is clear whose responsibility it is to contact the patient to communicate the outcome.
- The board should take steps to ensure that the results of urgent scans are managed reasonably, and that the referring clinician is made aware when significant findings are flagged up on a scan.

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.