SPSO decision report

Case: **202108765, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C's spouse (A) was provisionally diagnosed with torticollis (a condition in which the head becomes persistently turned to one side) by their GP resulting in a routine referral to orthopaedics (specialism in the treatment of diseases and injuries of the musculoskeletal system). A's symptoms continued to worsen and their referral was upgraded to urgent. A had a telephone call with an orthopaedic consultant and an MRI scan was organised. The pain continued to intensify despite strong medication. A presented to the out-of-hours service and also to A&E with worsening pain in their neck. A was referred to the hospital by their GP and advised that they were terminally ill with bladder cancer which had spread to the spine. A later died.

C complained to the board with concerns about A's initial referral to orthopaedics not being treated as urgent, for the delay for an MRI scan, for orthopaedics not being consulted by A&E and further testing not being arranged. C additionally complained about the lack of process for a patient to be moved up the list of clinical priority when presenting to A&E. The board's response indicated that no red flags were raised in the initial referral, that the orthopaedic consultant organised an MRI scan after speaking with A and that the out-of-hours assessments did not identify immediate orthopaedic review was required. The response also noted that A&E noted a plan was in place for further investigation, that there was no emergency issue which required immediate referral and that the GP was best placed to expedite further care with the orthopaedic team.

We took independent advice from a trauma and orthopaedic consultant, a GP and a consultant in emergency medicine. We found that it was reasonable for orthopaedics to treat the original referral as routine, but it was unreasonable that there is no evidence of a clinical summary of the orthopaedic consultation, and thereby no evidence that red flags were explored. We upheld this aspect of the complaint. We found that it was unreasonable that a more detailed history and clinical examination was not undertaken at the out-of-hours consultations, especially of red flags. We upheld this aspect of the complaint. We found that it was reasonable that A&E did not refer A urgently to another speciality or arrange further investigation or immediate assessment. We did not uphold this element of the complaint.

We also found that the board failed to identify that a Significant Adverse Event Review should have been carried out and that their complaint response did not clarify that it was a joint response with a second board, resulting in a lack of clarity and transparency.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Orthopaedic telephone consultations should be recorded, including evidence that any possible red flag symptoms have been explored and considered.
- Patients should be examined thoroughly and a clear history should be taken which considers the presence or absence of red flag symptoms.
- When a relevant adverse event occurs, the board should promptly carry out an SAER to investigate the cause and identify any potential learning.

In relation to complaints handling, we recommended:

- Relevant staff should be aware of the requirements of the complaints handling procedures, particularly with respect to dealing with complaints which span more than one NHS board.

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.