SPSO decision report

Case: **202303446, A GP Practice in the Lanarkshire NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the practice failed to provide them with reasonable care and treatment. C was involved in a road traffic accident after they momentarily lost consciousness while driving. C had a phone and then a face-to-face consultation with a physician associate (PA, a healthcare professional who support doctors in the diagnosis and management of patients) who referred them to respiratory medicine to investigate possible sleep apnoea caused by hypersomnia (excessive daytime sleepiness). Another telephone consultation was held, during which the PA indicated their intention to refer C to the DVLA due to concerns that C was continuing to drive despite their advice to stop.

C was unhappy with their level of care. C disputed having been told that they must not drive, and complained that the referral was made on the basis of a suspected rather than confirmed diagnosis. They also said that they had not received fair warning of the consequences. C complained that it had not been made apparent that they were being seen by a PA rather than a GP. Lastly, C complained about the practice's complaints handling, and the accuracy of their responses.

We took independent advice from a GP. We found that the questionnaire used to assess hypersomnia had been incorrectly completed by the PA which provided misleading results. C's prescribed medication had not been followed up as a contributing factor in the accident and C's significantly low pulse rate had not been identified or acted upon. We found that the PA appeared to have been acting without sufficient supervision from a GP, particularly once the complex nature of C's situation became apparent. It would have been reasonable for C's case to be transferred to a GP.

We also found that the referral to the DVLA had not been made in line with either DVLA or GMC guidance. Furthermore, the practice had failed to take appropriate steps to ensure that it was clear to C that they were receiving care from a PA and not a GP. Lastly, we found that there had been a failure to proactively update C on the progress of their complaint and that there were inaccuracies in the complaint responses. Therefore, we upheld C's complaints.

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:

- A PA should be working within a defined scope of practice as determined by their employer. There should also be appropriate supervision and oversight from GPs when care and treatment is being provided by a PA. Supervision needs to take place in a timely fashion to ensure that complex cases are identified.

- The practice should ensure that all paperwork and IT systems are set up to allow for staff members to appropriately identify their job role.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the NHS complaints handling procedure and all efforts should be made to ensure the accuracy of complaints responses. Complainants should be kept updated on their complaints and clearly signposted to the SPSO in all stage 2 complaints responses.

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.