SPSO decision report

Case: **202311785, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the delay in the practice diagnosing their parent (A)'s cancer. C said that A was seen by a GP with recurring chest infections but was sent away with antibiotics and their initial requests for a chest x-ray were denied. When the x-ray was arranged and the results received by the practice, the GP did not contact A directly to discuss the results. Instead, A received a copy of the report from the reception staff, which was not easy to understand. C said the communication issues regarding the x-ray also led to a delay in an urgent prescription for antibiotics being passed to a pharmacy. C said that the delays in diagnosis limited the treatment options available to A.

C complained that the practice failed to reasonably investigate A’s respiratory symptoms. We took independent advice from a GP. We found that while the majority of the care provided to A was reasonable, there was a missed opportunity to refer A for an x-ray, given their symptoms and the lack of success with previous treatments. Therefore, we upheld this part of C's complaint.

C also complained that the practice failed to inform A of the results of the x-ray in a reasonable manner. We found that the x-ray report should not have been provided to A by reception staff and the findings should have been shared in person or over the phone with the GP, including all relevant information. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failing to consider a referral for a chest x-ray sooner and for failing to provide the findings from the x-ray in a reasonable manner. 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:

- Clinical staff should communicate with patients in line with GMC guidance in relation to sharing the findings of investigations.
- Patients are referred for further investigations in a timely manner, in line with NICE guidance on suspected cancer: recognition and referral.

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.