SPSO decision report

Case: **201905182, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about a number of different aspects of the board's communication with them. Firstly, C complained about how the outcomes of two magnetic resonance imaging (MRI) scans were communicated to them. In respect of one scan, a consultant neurologist (specialist in the diagnosis and treatment of disorders of the nervous system) advised there had been “no change”. A later scan was then described as “unchanged over time”. After C obtained their medical records, they concluded that there were changes identified in both of the MRI scans.

We took independent advice from a consultant neurologist. We found that it was reasonable to describe the results as unchanged. We noted that most clinicians would, on receiving a report which described changes in a lesion which were of no clinical significance, report to the patient that there was no change. We understood why C may consider the information passed to them to be inaccurate compared to the more detailed records they obtained through a subject access request. However, we concluded that the results of the MRI scans were communicated to C in an acceptable manner and the board did not fail to carry out any follow-up actions that they should have. Therefore, we did not uphold this complaint.

C also complained about the board's communication with them following a consultation with a consultant ear, nose, throat and skull base surgeon. C had been referred by another consultant for a second opinion. Following the consultation, the consultant wrote to the referring consultant and copied in C's GP. However, C did not receive any communication about the outcomes of the consultation and their GP advised them that it is not a GP's responsibility to share results of tests initiated by a secondary care doctor with patients. In C's view, the board should have communicated the outcome of the consultation to them directly.

We found that local policies and procedures may affect how outcomes of consultations are communicated to patients. We were satisfied that the board appeared to agree that it is not a GP's responsibility to relay such outcomes to their patients. However, we would expect the patient to be copied into documentation unless there is a specific reason not to. We considered it unreasonable that the outcomes of the consultation were not communicated directly to C in some form. As such, we upheld this complaint.

Finally, C complained that the board failed to respond reasonably to their complaint. In C's view, the board's stage 2 response did not address several important points of their complaint and contained inaccuracies. We considered the board's stage 2 response to be a broadly reasonable and good faith attempt to address C's concerns. However, we concluded that there were specific aspects of the board's stage 2 response that undermined their efforts to address C's concerns. Firstly, a poorly worded statement caused it to be fundamentally inaccurate and confusing. Secondly, in some instances, the board failed to provide direct responses that tied clearly into C's complaint points. Given these shortcomings, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide a reasonable response to certain aspects of their complaint and for failing to communicate the outcome of their ear, nose and throat consultation directly to them. 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:

- The board should ensure that the outcomes of consultations carried out by secondary care clinicians are communicated to the patient in an appropriate and recognised method. It should not be assumed that the patient's GP will forward any correspondence to them.

In relation to complaints handling, we recommended:

- In line with the Model Complaint Handling Procedure, stage 2 complaint responses should be clear and easy to understand, and address all the issues raised and demonstrate that each element has been fully and fairly investigated.

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.