SPSO decision report

Case: **202206891, A Medical Practice in the Tayside NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that they received from the practice prior to their diagnosis of an abdominal cyst, which was surgically removed some years after C first attended the practice with symptoms. C complained that they did not receive a referral for an ultrasound scan until many months after first attending the practice with symptoms. C also complained that four different doctors were involved in their care and that the practice's complaint handling was unreasonable.

We took independent GP advice. C's case was complex and challenging due to the nature of C's cyst, C's other diagnoses and the timing of C's consultations during the COVID-19 pandemic. Nevertheless, we found that there was a missed opportunity for the practice to refer C to the colorectal service based on the positive result of a qFIT test (a test to detect blood in the stool) when C first attended the practice with symptoms, based on the National Institute for Health and Care Excellence (NICE) guidance. We found that there was a further missed opportunity for the practice to consider referring C to secondary care based on C's subsequent positive qFIT test result, which was taken many months after the first positive qFIT test. We also found that there were delays in the practice contacting C after receiving the result of the subsequent qFIT test and when the practice received the result of C's ultrasound. We found that, given the state of NHS services at the time C attended the practice, there was not likely a significant delay in C receiving a diagnosis or surgery for their cyst. On balance, we upheld C's complaint about their care and treatment from the practice.

We found that the practice's complaints handling was unreasonable, because the first complaint response did not address the issues C raised as a complaint. We upheld C's complaint about the practice's complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to action the results of qFIT tests, for the delays and for the unreasonable complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Administrative systems at the practice should support timely actioning of abnormal results.
- Clinical staff should be knowledgeable about the indication and interpretation of qFIT tests, as per NICE guidance.

In relation to complaints handling, we recommended:

- Complaints should be appropriately acknowledged in line with the Model Complaints Handling Procedure for NHS Scotland, and the complaint response should fully address the substantive issues raised in a

complaint.

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.