SPSO decision report

Case: **202102429, A Medical Practice in the Lanarkshire NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their spouse (A) received from the practice. Following a routine smear test, A was advised to see a gynaecologist (specialist in the female reproductive system) as soon as possible and they attended a private appointment the same day. Investigations confirmed A had stage four endometriosis (a severe case of tissue similar to that found in the uterus growing outside of the uterus). The private gynaecologist advised A that they should ask their GP to refer them to the Endometriosis Speciality Clinic.

C complained that there was an unreasonable delay to A's referral for a specialist review. They noted that, when a referral was issued, it was sent to the local gynaecology department, rather than the endometriosis specialists.

We took independent advice from a GP. We found that an urgent gynaecology referral was created promptly following the smear test. We noted that the NHS appointment was cancelled by A while they pursued private investigations. Following a telephone consultation between A and the practice, during which they discussed the findings of the investigations and the recommendation that they be referred to the Endometriosis Speciality Clinic, we found there was an unreasonable delay in the practice sending a referral back to gynaecology. We noted the referral was not marked as urgent and A later had to ask for this to be prioritised.

We found that A was appropriately referred to local gynaecology services but we were concerned by the communication around their desired referral to the Endometriosis Specialty Clinic. There was a lack of clarity regarding what referral had been made, and why. Therefore, we upheld this part C's complaint.

C also complained about the practice's handling of A's complaint. We found that there were delays in the handling of A's complaint and that communication with A regarding the complaints procedure was lacking. We also found that the complaint response did not address some of the key aspects of A's complaint. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for the issues highlighted in this decision. 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 practice should reflect on A's experience of merging private and NHS care with a view to identifying any ways that communication and onward referral could have been better managed.
- The practice should review their procedure for processing and authorising referrals to ensure that referrals are tracked right through to the point where they are sent.
- The practice should take steps to ensure all staff, including temporary or locum staff, are trained to

understand and operate the referral system so that they can identify any potential delays to a referral being issued.

In relation to complaints handling, we recommended:

- The practice should review their complaints handling procedure and make sure that it is in line with the NHS Model Complaints Handling Procedure.

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.