SPSO decision report

Case: **202105940, A Medical Practice in the Grampian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the medical practice failed to provide reasonable care and treatment to their spouse (A) after they presented with a lump in their right breast.

We took independent advice from a GP. We found that the time taken to refer A to hospital when they first consulted the medical practice with the lump in their right breast was unreasonable. It was also unreasonable that the referral was not marked as urgent.

The medical practice had carried out a detailed review of A's care and had accepted that there was a complete systems failure in the care and treatment provided to A. They had made a number of changes which we welcomed and considered were appropriate. Nevertheless, we found that they had not fully acknowledged their specific role and responsibility in relation to the failings which had occurred given their responsibilities for the supervision, training and actions of their employed staff.

We also identified additional issues not addressed by the medical practice in their consideration and response to the complaint. In particular, that the medical practice should have a system in place to ensure any outstanding referrals were identified when a colleague is unexpectedly absent due to sickness or ill-health and that it was unreasonable that A was not contacted by the medical practice after the cancer diagnosis given the significance of the diagnosis and their delay in sending the referral and marking it as urgent. We also found that the medical practice did not appear to have considered their duty of candour responsibilities in this case. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A 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:

- Patients should receive appropriate assessment and referral in line with relevant guidelines. Patient referrals should be reviewed and actioned when the responsible member of staff is absent unexpectedly. Where appropriate, patients should be contacted after receiving a significant diagnosis. This should include when the practice become aware that harm has occurred as a result of an unintended incident in healthcare to take into account duty of candour responsibilities, individual roles and their role responsibilities in making sure this happens.

In relation to complaints handling, we recommended:

- The practice should ensure that, where failings have been identified during a complaint investigation, the investigation and response fully acknowledges and take responsibility for the failings and ensures there is appropriate learning across the practice.

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.