SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: Glasgow

Case ref: 202100560, A Medical Practice in the Lanarkshire NHS Board area

Sector: Health

Subject: GP; GP Practices / Clinical treatment / diagnosis

Summary

The complainant (C), a representative of the Patient Advice and Support Service, complained to my office on behalf of A about the treatment A's spouse (B) received from their GP practice (the Practice) between July and October 2020. B developed cellulitis (a bacterial infection of the skin) on one of their legs. Although B was treated with multiple courses of antibiotics, the infection did not improve. Following an allergic reaction to the antibiotics, B chose not to receive further treatment. Sadly, B's condition deteriorated and B died.

C complained that the Practice prescribed five courses of antibiotics without seeing B and considered that a GP should have reviewed B face-to-face when the infection did not resolve. A complained that B was not told of the risks of refusing antibiotic treatment. A also considered that the Practice should have carried out blood and skin tests to ensure that an effective antibiotic was prescribed and that the Practice should have referred B to hospital for intravenous antibiotics when B's condition did not improve.

The Practice detailed the contact they had with B and said that skin conditions such as cellulitis are treated by their Advanced Nurse Practitioners (ANPs) and that they considered the treatment offered to B had been appropriate. The Practice said that they would not recommend the referral of B to hospital due to the COVID-19 restrictions in place at the time.

I sought independent advice from a GP (the Adviser). The Adviser told me B should have been closely monitored and specialist advice should have been sought early on in B's care pathway. The Adviser told me B should have been seen face-to-face at the first appointment and a doctor should have been involved after the first course of antibiotics failed to work and in line with NICE accredited guidelines, specialist input should have been sought after a second course of antibiotics failed to improve B's condition and admission for intravenous antibiotics considered.

The Adviser also told me there were no restrictions in place preventing patients from being admitted to hospital should their condition require this between July and

October 2020. The Adviser gave their view that the failings they had identified had contributed to B's death.

In light of the evidence I have seen and the advice I received, I found that: the Practice did not provide reasonable care and treatment to B between July and October 2020. As such, I upheld C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Practice to do for A:

Rec. number	What we found	Outcome needed	What we need to see
1.	Under (a) we found that the care and treatment provided by the Practice to B between July 2020 and October 2020 was unreasonable. In particular that: • B should have been seen face-to-face at their first appointment and by a GP after the first course of antibiotics failed to work. • Swabs should have been taken when there was no improvement. • Specialist input should have been sought after B's condition failed to improve. • A Significant Event Analysis or similar reflective review should have been carried out. • The Practice's complaint response was unreasonable.	Apologise to 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.	A copy or record of the apology. By: 21 June 2023

We are asking the Practice to improve the way they do things:

Rec. number	What we found	Outcome needed	What we need to see
2.	The care and treatment provided by the Practice to B between July 2020 and October 2020 was unreasonable.	Patients presenting with symptoms suggesting cellulitis should be appropriately assessed including a face-to-face assessment and being appropriately monitored. If their condition does not improve treatment should be escalated in line with relevant guidance.	Evidence that the Practice have: i. Critically reviewed their guidance and training needs on the management of cellulitis for all relevant staff to ensure achievement of the outcomes needed. ii. Ensured relevant guidelines are appropriately referred to and reflected. Confirmation should be provided of the review and the changes implemented as a result of this review; how the guidance has been updated and disseminated, and how the training needs of staff have been addressed. By: 16 August 2023, with a progress update by 5 July 2023.

Rec. number	What we found	Outcome needed	What we need to see
3.	A Significant Event Analysis or similar reflective review should have been held.	Where there has been a significant adverse event a reflective review should be considered, and either a clear reason recorded as to why it was not carried out, or held, ensuring that events are considered against relevant standards and guidelines and that failings, and good practice, are identified and any appropriate learning and practice improvements made.	Evidence that the Practice have systems and processes in place for reflective review of significant adverse events that support staff involved to identify learning and improvement By: 16 August 2023

We are asking the Practice to improve their complaints handling:

Rec no.	What we found	Outcome needed	What we need to see
4.	The Practice's complaint response was unreasonable. There is no evidence to support the Practice's recording that the complaint was acknowledged or that the complaint was responded to within 20 working days in line with the Model Complaints Handling Procedure. There was a failure to investigate and respond to all the concerns raised by C and provide an appropriate response that recognised the significance of the events for A and the impact of B's death. The response was undated.	The Practice's complaint handling monitoring and governance system should ensure that: i. Complaints are properly investigated and responded to in line with the NHS Scotland Model Complaints Handling Procedure. ii. Failings and good practice are identified, and learning from complaints is used to drive service development and improvement. iii. Complaint responses recognise and acknowledge the significance and human impact of the events complained about, particularly when a death has occurred. Complaint responses are clearly dated and records reflect when and how they are shared.	Evidence that the findings on the Practice's complaint handling have been fed back in a supportive manner to relevant staff and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion.) By: 19 July 2023

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. She is the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. SPSO's service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The SPSO's role is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. C, a representative of the Patient Advice and Support Service, complained on behalf of A about the treatment A's spouse (B) received from their GP practice (the Practice) between July and October 2020.

2. B developed cellulitis (a bacterial infection of the skin) on one of their legs. Although B was treated with multiple courses of antibiotics, the infection did not improve. Following an allergic reaction to the antibiotics, B chose not to receive further treatment. Sadly, B's condition deteriorated and B died.

3. C complained that the Practice prescribed five courses of antibiotics without seeing B and considered that a GP should have reviewed B face-to-face when the infection did not resolve. A complained that B was not told of the risks of refusing antibiotic treatment. A also considered that the Practice should have carried out blood and skin tests to ensure that an effective antibiotic was prescribed and that the Practice should have referred B to hospital for intravenous antibiotics when B's condition did not improve.

4. The complaint from C I have investigated is that:

   (a) The care and treatment provided by the Practice between July 2020 and October 2020 was unreasonable (*upheld).*

Investigation

5. In order to investigate C's complaint, I and my complaints reviewer considered the documentation provided by C in support of A's complaint and requested and considered information and documentation, including B's relevant medical records, from the Practice. We also took independent advice from an appropriately qualified adviser, a General Practitioner (the Adviser).

6. I appreciate that at the time the actions investigated took place, and at the time of reporting, the NHS was and continues to be under considerable pressure due to the impact of COVID-19 and other significant issues. Like others, I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) has made, and continues to make. However, much as I recognise this, I also recognise that patient safety, personal redress, and learning from complaints are as relevant as ever and it is important that collectively we do not miss opportunities to learn and improve for the future.

7. I have decided to issue a public report on C's complaint. This reflects my concern about the failings identified in B's care and treatment; the significant

personal injustice caused by the failings identified and the potential for wider learning from the complaint and the way it was handled.

8. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all of the information provided during the course of the investigation. Both C and A and the Practice were given an opportunity to comment on a draft of this report.

C's complaint

9. B had a history of Klinefelter Syndrome (a condition affecting those who are born with an extra chromosome) and several allergies, including an allergy to penicillin. In July 2020, B developed cellulitis on one of their legs. C said that B telephoned the Practice and received a call back from an Advanced Nurse Practitioner (ANP) who prescribed a course of antibiotics. Despite treatment with the antibiotics, B's cellulitis returned. C said that the infection persisted and B was treated with a further two courses of antibiotics.

10. C said that B's infection still did not improve; B was seen by an ANP and stronger antibiotics were prescribed. However, these also failed to improve B's infection. A further, fifth course, of stronger antibiotics was therefore prescribed by the ANP.

11. C explained that B had an allergic reaction to the stronger antibiotics and so had to use their epi pen. C said that this caused B significant stress and trauma. B subsequently telephoned the Practice and was given a telephone consultation with a GP (GP 1). C said that A reported hearing B saying that they did not want to take any more antibiotics. A commented that they believed B's statement was a reaction to the shock of the allergic reaction B had suffered. A said they believed that, with patience and follow-up, B could have been persuaded to receive further treatment. C said that A did not consider that the risks of the decision to stop antibiotic treatment were fully highlighted to B and, had B known that they could die as a result of their infection, B would have sought and accepted further treatment.

12. A considered that, well before the fifth course of antibiotics being prescribed, B should have been seen by a GP. A considered that B should have had blood and skin samples taken and tested to identify the bacteria that was causing the cellulitis so that an effective antibiotic could be prescribed. A also considered that, as the oral antibiotics prescribed by the Practice were not working, B should have been referred to hospital for intravenous antibiotics.

13. C noted that, following B's telephone consultation with the GP, no follow-up care was offered and no doctor or nurse called or saw B. Approximately three weeks later, on 13 October 2020, B reportedly became very tired and weak. Sadly, B died that night at home.

14. A said that, following B's death, the Practice initially declined to sign the death certificate due to B's underlying health conditions and the fact that no doctor from the Practice had seen B. However, later in the day, a different GP (GP 2) called to say that they had signed the death certificate and that the family could now arrange a funeral. A noted that no post-mortem was carried out and questioned how the Practice were able to determine B's cause of death when B had not been seen by a doctor during the four month period of their illness and no blood tests or other investigations had taken place.

15. C raised A's complaints and concerns with the Practice.

The Practice's response

16. In their response to C's formal complaint, the Practice commented that skin conditions such as cellulitis are treated by their ANPs and the prescription of antibiotics is appropriate treatment.

17. The Practice said that B was seen in the Practice on two occasions for a physical review: 29 July 2020 and 14 September 2020. They said blood tests were taken on 19 August 2020 and a further referral was submitted on 14 September 2020 after the face-to-face consultation that day. Information provided by the Practice indicates this was a referral for an echocardiogram (a scan used to look at the heart and nearby blood vessels).

18. With regard to A's view that B should have been referred to hospital, the Practice commented that they would not recommend this course of treatment due to the COVID-19 restrictions in place at the time. The Practice considered that the treatment offered to B was appropriate.

19. With regard to the choice of antibiotics that B had been prescribed, the Practice explained that they could not ascertain if a patient is allergic to a medication they have not previously been prescribed. However, it was subsequently noted on B's patient file that B was allergic to these antibiotics (Doxycycline) and that these should not be prescribed.

20. In response to A's concern that B received no follow-up care following the allergic reaction, the Practice advised that they had listened to a recording of the telephone consultation B had had with GP 1 on 15 September 2020. The Practice

noted that GP 1 had asked ‘Do you want to take a different antibiotic if we can get one?’ and that B had replied ‘No I think I will leave it’. The Practice said that GP 1 also advised B to get back in contact with the Practice if the redness on their leg started to spread and to call 999 should they experience any breathing difficulties.

21. In response to A’s comments regarding the Practice’s ability to determine B’s cause of death, the Practice commented that GP 2 reported B’s death to the Procurator Fiscal and stated the cause of death as cellulitis. They noted that the records stated that

> ‘The [Procurator Fiscal] advised that they were satisfied with the initial report of sudden death and as there are no suspicious circumstances we can go ahead and issue the death certificate’.

22. The Practice reiterated that B had been seen by an ANP on two separate occasions in the Practice and had had blood tests taken.

23. We asked the Practice what training and/ or guidance the Practice’s ANPs had received by July 2020 or had access to at that time in relation to when to direct a patient to a GP in relation to cellulitis or similar conditions.

24. In response the Practice stated that they had taken over the operation of the Practice in April 2020 and their focus for the first several months was to stabilise the team and clear the significant backlog of work that they had inherited from the previous operators. The Practice highlighted that this was in the midst of the early weeks of the COVID-19 pandemic and that this impacted on their plans. The Practice said that the ANPs involved in the care and treatment of B are no longer employed by the Practice, and their training would have been carried out by the previous operators. The Practice said they did not have any specific details of this training but that if an ANP needed clinical advice there would always be a GP available to offer this and to review the patient if needed.

Document review

25. My complaints reviewer and I examined B’s clinical records including the Practice’s patient notes. These detailed the contact and consultations that B had with the Practice, although they did not specify whether B spoke with an ANP or a GP. The Practice also provided written notes of their investigation of C’s complaints (the investigation notes) that recorded B’s contact being with ANPs on all consultations except the 15 September 2020 telephone consultation with GP 1.

26. The clinical records show that B first contacted the Practice by telephone on 22 July 2020 complaining of swelling and pain in their lower left leg. This was reportedly inflamed and hot to the touch. Cellulitis was suspected and the first course of antibiotics was prescribed.

27. B telephoned the Practice again on 28 July 2020 and a face-to-face review was scheduled with an ANP for the following day in light of the ongoing cellulitis. At the face-to-face consultation on 29 July 2020, B's leg was observed to be hot to the touch, with signs of pitting oedema (swelling) and cellulitis. A further course of antibiotics was prescribed along with frusemide (for the swelling) and a plan was made to review B after the antibiotics had run their course. It was noted that, if B's symptoms persisted, they may need a further course of frusemide, but that blood tests would be required first.

28. The clinical records note that B telephoned the Practice again on 17 August 2020. B reportedly explained that the cellulitis and oedema had flared up again over the preceding four days. B was given a month's course of frusemide and arrangements were made for B to have bloods taken at that time, with more to be taken one month later.

29. B telephoned the Practice again on 28 August 2020 regarding a further flare-up of the cellulitis, this time in the other (right) leg. It was noted that B was allergic to some antibiotics and that this complicated B's recovery. B was prescribed a course of doxycycline with a plan to review B if symptoms persisted or worsened.

30. Following a further telephone call to the Practice, B was seen for a face-to-face appointment on 14 September 2020. It was noted that B had had 'a few' courses of antibiotics and that these had improved the condition of B's legs only for the cellulitis to flare-up again after around three days. A further course of antibiotics and frusemide was prescribed, along with a cream.

31. On 15 September 2020, B telephoned the Practice to advise that they had had an allergic reaction to the antibiotics. It was noted that B had not taken any further antibiotics and did not want to try a different antibiotic. The investigation notes record that B spoke to GP 1 and was advised that their allergy would be noted and that they would be reviewed if their symptoms worsened.

Medical advice

32. We asked the Adviser whether or not they considered the care and treatment provided to B was reasonable or unreasonable. The Adviser's comments can be summarised as follows:

i. B should have been seen face-to-face at the first appointment and a doctor should have been involved by the time a second antibiotic was considered. The consultation entries do not identify the role of those who dealt with B, but the scribbled notes (the investigation notes) do seem to identify the member of the clinical team involved. (The investigation notes indicate, as noted above, that B was seen by ANPs apart from the telephone consultation on 15 September 2020 with GP 1.)

ii. If, on the first course of antibiotics, there had been no significant improvement after two to three days, then a swab should have been taken, and a swab should have been taken at the outset if the skin was broken.

iii. After the second antibiotic had failed to work, a discussion should have taken place with a hospital microbiologist and admission for intravenous antibiotics considered. There were no COVID-19 restrictions preventing the admission of people who needed to be admitted and the Practice's suggestion that there were, was disingenuous.

iv. It was not reasonable for B to have been prescribed five courses of antibiotics.

33. We asked the Adviser whether or not it was appropriate for B to be left without treatment after their allergic reaction to the final course of antibiotics. The Adviser's comments can be summarised as follows:

i. If a patient makes a genuine informed choice not to have any more treatment, and has capacity to make such a decision, then it is reasonable for doctors to go with that choice. With regard to B's telephone consultation with GP 1 on 15 September 2020, the Practice believed they were following B's wishes regarding the prescription of further antibiotics and appropriate 'safety netting' advice was given. This was reasonable.

ii. However, the Practice should have considered reviewing B in a day or two to ascertain whether the condition was declining or not. A refusal by a patient for a particular treatment does not mean a doctor should stop caring for them.

34. We also asked the Adviser whether they considered it appropriate for B's cause of death to be recorded as cellulitis, given that no post-mortem was carried out. The Adviser's comments can be summarised as follows:

i. This was reasonable. The Practice discussed B's death with the Procurator Fiscal who was happy with the decision to sign the death certificate and put cellulitis as the cause of death. The decision to sign the death certificate was reasonable given these circumstances and it would be for the Procurator Fiscal to decide whether or not a post-mortem was required.

35. In addition, the Adviser stated:

i. B's cellulitis was not managed appropriately and this undoubtedly contributed to B's death. To treat a case of cellulitis, a potentially fatal condition, with five different courses of antibiotic without any direct face-to-face GP involvement was poor practice. Guidance accredited by the National Institute for Care and Health Excellence (NICE)[1] advised seeking specialist advice or hospital admission if there has been no improvement after 14 days despite treatment.

ii. B should have had a face-to-face appointment with a GP after the first course of antibiotics proved ineffective and specialist advice and/ or hospital admission should have been considered when the second course of antibiotics failed to work. It was incorrect to suggest that hospital admission could not have been considered due to the restrictions put in place as a result of the COVID-19 pandemic.

iii. Given this was an unexpected death, some form of significant event analysis should have been considered by the Practice.

Decision

36. C complained to my office, on A's behalf, that the care and treatment the Practice provided to B between July and October 2020 was unreasonable. I recognise and acknowledge at the outset the devastating impact of these events for A and the importance of the issues raised for them.

37. In investigating A's concerns I have obtained professional advice from the Adviser as outlined above. I have carefully considered this advice, which I accept.

38. It is evident that B was suffering from a serious and potentially fatal condition. Given this they should have been closely monitored and specialist advice should have been sought early on in B's care pathway. Unfortunately, this did not happen

[1] Scenario: Management | Management | Cellulitis - acute | CKS | NICE

and my investigation has established that the Practice's management of B's cellulitis was unreasonable in a number of respects.

39. B should have been seen face-to-face at the first appointment and a doctor should have been involved after the first course of antibiotics failed to work.

40. While the Practice have told me that, if an ANP needed clinical advice there would always be a GP available to offer this and to review the patient, this did not happen in B's case, despite the seriousness of their condition. I consider it was a significant failing that this did not occur.

41. I accept the Adviser's view that a swab should have been taken when there had been no significant improvement two to three days after antibiotics were first prescribed and a swab should have been taken at the outset if the skin was broken. Furthermore, in line with NICE accredited guidelines, specialist input should have been sought after a second course of antibiotics failed to improve B's condition and admission for intravenous antibiotics considered.

42. I am especially concerned to note that there was no apparent escalation of B's treatment in line with the above. Each time B contacted the Practice to advise that the cellulitis had not resolved, B was given a further course of antibiotics and/ or frusemide to help with the swelling. It is clear that B should not have received five courses of antibiotics and their treatment should have been escalated after their first course of antibiotics didn't work.

43. Although blood tests were undertaken, I found nothing to suggest that swabs were taken at the appropriate time, a specialist opinion was sought, or admission for intravenous antibiotics considered after the second course of antibiotics failed. I am critical that none of this happened and consider these are serious failings.

44. I am also deeply troubled by the Practice's response, that they would not recommend referral to hospital due to the COVID-19 restrictions in place at the time. There were no restrictions in place preventing patients from being admitted to hospital should their condition require this. While I recognise that guidance issued during the pandemic was updated frequently, I consider it reasonable that the Practice should have been aware about there being no restrictions in relation to hospital admission where needed; and I do not consider their position on this to be acceptable.

45. I am satisfied that the Practice acted in line with B's wishes following B's decision not to take further antibiotics after the allergic reaction and that B was given

appropriate safety netting advice. In addition, I am satisfied that the Practice acted appropriately in relation to the signing of the death certificate.

46. However, as outlined above, I consider that B's treatment was not escalated as it should have been and they should have been referred for specialist treatment a considerable time before they suffered the allergic reaction which caused them significant distress and most unfortunately led to their decision not to take further antibiotics. I also accept the Adviser's view that the Practice should have considered reviewing B a day or two after this to ascertain whether their condition was declining or not.

47. I am mindful of the circumstances relating to the operation of the Practice in mid to late 2020 as detailed in the Practice's response to my investigation. It is unfortunate that the lack of available evidence regarding the training and guidance available to ANPs at this time means clearer identification of the causes of this lack of escalation is not now possible. I have also taken into account that these events were at a time when the NHS was having to deal with the early months of the COVID-19 pandemic. Notwithstanding this, my investigation has established serious and significant failings in B's care.

48. The advice I have received is clear, that these failings contributed to B's death. I am therefore deeply concerned that none of these failings have been accepted by the Practice and that they remain unaddressed.

49. Had a significant event analysis or similar reflective review been carried out by the Practice following B's death, there would have been an opportunity to reflect on and address fully the care provided to B. In a situation like this, involving the death of a patient, it is essential there is an appropriate review system in place that enables both failings and good care to be identified and that supports full reflection and learning by staff involved. It is concerning this did not happen.

50. Given all of the above, **I uphold this complaint**. It will undoubtedly be devastating for A to learn that, had B received better care, their death might have been prevented. They have my, my complaints reviewer's and my office's, utmost sympathy.

51. I have made a number of recommendations to address the issues identified and they are set out at the end of this report. My complaints reviewer and I will follow up on these recommendations. I expect evidence that appropriate action has been taken before I can confirm that the recommendations have been met.

Complaint handling

52. Under my Complaints Standards Authority powers, I can make recommendations on complaints handling issues without a specific complaint having been made by the complainant.

53. Every NHS organisation should have an appropriate complaints handling procedure in place in accordance with the NHS Scotland Model Complaints Handling Procedure (MCHP)[2].

54. C raised A's complaints and concerns with the Practice in a letter sent by email to the Practice on 24 February 2021. The investigation notes record that the complaint was acknowledged on 7 March 2021. However, no other evidence of the acknowledgement of the complaint has been provided. The investigation notes record that the investigation of the complaint was completed within 20 working days, in line with the MCHP. This position is questionable. The Practice's response letter is undated and the copy provided by C indicates that it was received on 19 April 2021 by the Patient Advice and Support Service which is outwith the 20 working day timescale under the MCHP. There is no evidence that an update was provided in line with the MCHP to explain the reasons for the delay and provide a revised timescale. I am therefore critical of the record-keeping; the apparent delay in providing C with a full response; and the failure to update.

55. While the Practice's response addressed a number of A's concerns, it did not clearly address A's concerns, stated in the complaint letter that; no follow-up care was offered, no doctor or nurse called or saw B following B's telephone consultation with the GP, and that the Practice initially declined to sign the death certificate. In addition, I am deeply concerned about the lack of empathy and tone of the response given the significance of the events being complained of and the death of B. There was no open recognition of the loss suffered by A or indication of regret expressed over B's passing. In my view, the response lacked humanity.

56. I accept that this was a difficult time for the NHS, particularly for GPs and their practice staff. I encourage the Practice to reflect on how their poor response may have impacted their staff, and perception of their staff, working under those difficult circumstances.

57. In the circumstances, I consider the Practice's complaint handling was unreasonable and I have made an additional complaint handling recommendation.

[2] https://www.spso.org.uk/sites/spso/files/csa/OriginalCHPs/NHSMCHPMarch2021.pdf

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints, and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Practice to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under (a) we found that the care and treatment provided by the Practice to B between July 2020 and October 2020 was unreasonable. In particular that: • B should have been seen face-to-face at their first appointment and by a GP after the first course of antibiotics failed to work. • Swabs should have been taken when there was no improvement. • Specialist input should have been sought after B's condition failed to improve. • A Significant Event Analysis or similar reflective review	Apologise to 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	A copy or record of the apology. By: 21 June 2023

Rec. number	What we found	What the organisation should do	What we need to see
	should have been carried out. • The Practice's complaint response was unreasonable.		

We are asking the Practice to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	The care and treatment provided by the Practice to B between July 2020 and October 2020 was unreasonable.	Patients presenting with symptoms suggesting cellulitis should be appropriately assessed including a face-to-face assessment and being appropriately monitored. If their condition does not improve treatment should be escalated in line with relevant guidance.	Evidence that the Practice have: i. Critically reviewed their guidance and training needs on the management of cellulitis for all relevant staff to ensure achievement of the outcomes needed. ii. Ensured relevant guidelines are appropriately referred to and reflected. Confirmation should be provided of the review and the changes implemented as a result of this review; how the guidance has been updated and disseminated, and how the training needs of staff have been addressed. By: 16 August 2023, with a progress update by 5 July 2023.

Rec. number	What we found	Outcome needed	What we need to see
3.	A Significant Event Analysis or similar reflective review should have been held.	Where there has been a significant adverse event a reflective review should be considered, and i. either a clear reason recorded as to why it was not carried out, or ii. held, ensuring that events are considered against relevant standards and guidelines and that failings, and good practice, are identified and any appropriate learning and practice improvements made.	Evidence that the Practice have systems and processes in place for reflective review of significant adverse events that support staff involved to identify learning and improvement. By: 16 August 2023

We are asking the Practice to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
4.	The Practice's complaint response was unreasonable. There is no evidence to support the Practice's recording that the complaint was acknowledged or that the complaint was responded to within 20 working days in line with the Model Complaints Handling Procedure. There was a failure to investigate and respond to all the concerns raised by C and provide an appropriate response that recognised the significance of the events for A and the impact of B's death. The response was undated.	The Practice's complaint handling monitoring and governance system should ensure that: i. Complaints are properly investigated and responded to in line with the NHS Scotland Model Complaints Handling Procedure. ii. Failings and good practice are identified, and learning from complaints is used to drive service development and improvement. iii. Complaint responses recognise and acknowledge the significance and human impact of the events complained about, particularly when a death has occurred. iv. Complaint responses are clearly dated and records reflect when and how they are shared.	Evidence that the findings on the Practice's complaint handling have been fed back in a supportive manner to relevant staff and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion.) By: 19 July 2023

Terms used in the report **Annex 1**

A	the aggrieved
ANP	Advanced Nurse Practitioner
B	the aggrieved's spouse
C	the complainant
cellulitis	a bacterial infection of the skin
doxycycline	an antibiotic
frusemide	a diuretic used to help reduce swelling
GP	General Practitioner
GP1	a GP at the Practice
GP2	a GP at the Practice
NICE	National Institute for Care and Health Excellence
oedema	swelling
the Adviser	a General Practitioner who provided independent advice on this case
the Practice	B's GP practice and the subject of the complaint

List of legislation and policies considered **Annex 2**

NICE (National Institute for Health and Care Excellence) accredited Clinical Knowledge Summary ‘Cellulitis – acute: Scenario: Management of acute cellulitis’