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: South of Scotland

Case ref: 202101928, A Medical Practice in the Ayrshire and Arran NHS Board area

Sector: Health

Subject: GP & GP Practices / Clinical treatment / diagnosis

Summary

The complainant (C) complained to my office about the care and treatment provided to their late parent (A) by their GP practice (the Practice) after A presented at the Practice in August 2019, with shortness of breath and chest pain. A was subsequently diagnosed with severe Chronic Obstructive Pulmonary Disease (COPD, a lung condition that causes breathing difficulties) and lung cancer. A very sadly died in late 2020.

C complained that the Practice failed to provide reasonable care and treatment to A when they presented with chest pain. In particular that the Practice did not perceive A's condition as being serious and urgent and the significant deterioration in A's health was not investigated.

In responding to the complaint, the Practice considered that A's symptoms were taken seriously and that appropriate investigations were undertaken including excluding cardiac causes for their symptoms.

I sought independent advice on this complaint from a GP (the Adviser).

I found that:

- The Scottish Referral Guidelines for Suspected Cancer (the Guidelines), in particular, the section relating to lung cancer, should have been taken into account by the clinicians at the Practice from the outset when treating A.

- There was a failure by the Practice to recognise the seriousness of the symptoms A presented and to refer them urgently as required under the Guidelines. I considered this was a significant failing in care.

- While a referral was made to the respiratory physicians, I was extremely critical that this was not made on an urgent basis.

- While the Practice subsequently conducted a Significant Event Analysis (SEA), it was limited and did not fully address what had occurred in A's case.

There was no mention of the Guidelines in the SEA report. I was particularly critical of this.

Taking account of the evidence and the advice received, I upheld the complaint. I also considered there was a failure by the Practice to provide C with a full and informed response in relation to certain aspects of their complaint and in particular to take into account the Guidelines.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Practice to do for C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	Under (a) we found: • There was a failure to recognise the significance of A's symptoms when they presented at the Practice between August 2019 and September 2020, to make an urgent referral. • The SEA conducted by the Practice was limited and did not fully address what occurred in A's case or take account of the relevant Scottish Referral Guidelines for Suspected Cancer. There was a failure by the Practice to fully address the issues raised when responding to C's complaint and evidence of a lack of learning from the complaint by the Practice as a whole.	Apologise to C 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: 26 June 2023

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

Complaint number	What we found	What should change	What we need to see
(a)	Under complaint (a) we found: • There was a failure to recognise the significance of A's symptoms when they presented at the Practice between August 2019 and September 2020, to make an urgent referral.	Patient symptoms should be appropriately identified and managed. Symptoms or features suggestive of cancer should result in the appropriate referral being made in line with relevant guidance.	Evidence that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails. Evidence that training needs in relation to the application of relevant guidance have been identified and addressed. Evidence of how the findings of this case have been used as a reflective training tool for relevant staff. By: 24 July 2023

Complaint number	What we found	What should change	What we need to see
	The SEA conducted by the Practice was limited and did not fully address what occurred in A's case or take account of the relevant Scottish Referral Guidelines for Suspected Cancer.	Local and Significant adverse event reviews should be reflective and learning processes that considers events against relevant standards and guidelines, to ensure failings are identified and any appropriate learning and practice improvements are made.	Evidence that the Practice have reviewed their systems and processes for reviewing significant events to ensure it is a fully reflective and learning process that supports the staff involved to identify learning and improvement. By: 24 August 2023

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	Under complaint (a) we found: • There was a failure by the Practice to fully address the issues raised when responding to C's complaint and evidence of a lack of learning from the complaint by the Practice as a whole. • The complaint response contained out of date contact details for the SPSO, including the address.	Complaint responses should consider and respond fully to the issues raised in accordance with The Model Complaints Handling Procedures | SPSO. They should take into account any relevant national or local guidance in both the investigation and response, and identify and action learning. Learning from complaints and the learning should be shared throughout the organisation so that actions and improvements can be implemented to prevent the same issues happening again.	Evidence that these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (e.g., a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Practice's complaint handling process is clearly signposted on its website and that information, including documentation (e.g., complaint leaflet and/ or template complaint response letter have been updated) in accordance with the model complaints handling procedure. Evidence that the website and documents properly signpost to the SPSO, including the current SPSO contact details. Evidence that relevant staff have or are scheduled to have appropriate complaint handling training. By: 24 July 2023

Feedback

Points to note

The Practice, when making an urgent cancer suspected referral, could have requested consideration of a CT scan. This would have allowed for A to be considered for a CT scan after their first chest x-ray was carried out. I encourage the Practice to share this and reflect on it for the future.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are 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. She normally considers complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial, and free. SPSO 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 role of the SPSO 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 complained to my office about the care and treatment provided to their late parent (A) by their GP practice (the Practice) after A presented in August 2019 with shortness of breath and chest pain. A was subsequently diagnosed with severe Chronic Obstructive Pulmonary Disease (COPD) and lung cancer. A very sadly died in 2020.

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

   (a) The Practice failed to provide reasonable care and treatment to A when they presented with chest pain in 2019 (*upheld*).

Investigation

3. In order to investigate C's complaint, I and my complaints reviewer requested information from the Practice and took independent advice from a General Practitioner (the Adviser). In considering the case, the Adviser had sight of A's relevant medical records and the Practice's complaint file.

4. I appreciate at the time of reporting, the NHS, continues to be under considerable pressure due to the ongoing impact of COVID-19 and winter, and other pressures. Like others, I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) has made, and continues to make. However, as much as I recognise this, I also recognise 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 for the future.

5. I have decided to issue a public report on C's complaint because of my concern about the significant failings identified in A's care and treatment; the significant personal injustice caused by the failings identified; and the potential for wider learning from the complaint.

6. 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. C and the Practice were given an opportunity to comment on a draft of this report.

7. Although the focus of the investigation of the Practice's actions is on events in 2019, I consider events subsequent to 2019, particularly from May 2020 when A reattended the Practice are directly relevant. Given this I have reviewed these events as part of this report.

Background and key events

8. In early August 2019, A attended at the Practice where they were seen by an Advanced Nurse Practitioner. A had a two to three month history of shortness of breath and a two-day history of rib pain. The possibility of A having COPD was discussed. A was prescribed antibiotics and an inhaler and referred for a chest x-ray.

9. Later in August 2019, A attended a follow-up appointment with a GP (GP 1) and bloods were taken. Blood results showed a borderline erythrocyte sedimentation rate (ESR, a blood test that can show inflammation in the body). The chest x-ray was reported as normal. A follow up ESR showed an improvement in the inflammatory markers.

10. On 1 October 2019, A attended a further appointment with a different GP (GP 2). A complained of pain in their right hip and continuing of shortness of breath on exertion. They also complained of an ache in their chest on exertion. A was referred to cardiology to exclude angina (chest pain caused by reduced blood flow to the heart). GP 2 requested that A attend the Practice for a follow up ESR in six to eight weeks. A did not attend for this.

11. The next GP consultation A had was on 28 May 2020, when A had a telephone consultation with another GP (GP 3) following making a prescription request for an inhaler.

12. On 10 August 2020, A had a telephone consultation with GP 3. A noted ongoing shortness of breath. On this occasion, A was referred to the respiratory physicians. A later contacted the Practice to ask for the referral to be marked as urgent. It was explained to A that in the absence of new symptoms, the referral would be re-triaged by the respiratory physicians as routine. The Practice said they had a responsibility to make referrals appropriate to the clinical circumstances.

13. On 2 September 2020, A contacted the Practice and requested that GP 3 make a referral for them to see a particular Respiratory Consultant on a private basis. GP 3 said they made the referral the same day.

14. On 13 October 2020, A attended a consultation with the said Respiratory Consultant.

15. Following further tests, A was diagnosed with severe COPD and lung cancer.

16. On 14 December 2020, A died. At the time of their death A was in their mid-seventies.

(a) The Practice failed to provide reasonable care and treatment to A when they presented with chest pain in 2019.

Concerns raised by C

17. C raised the following concerns:

a. The Practice did not perceive A's condition as being serious and urgent.

b. The Practice repeatedly referred to A's age as a reason for their symptoms.

c. A was not offered a further chest x-ray following raised indicators in their blood test results.

d. The significant deterioration in A's health was not investigated.

e. The Practice made a routine rather than an urgent referral to the respiratory physicians and then refused, when requested by A, to upgrade the referral to urgent.

f. A was treated without understanding, compassion or respect.

g. A was prescribed an inhaler and then told not to use it.

The Practice's response to C's complaint

18. The contents of the Practice's original response is known to both parties, and I have not repeated it in full here.

19. In summary they said:

20. At no point when A presented at the Practice did anyone suggest that they did not have a real illness.

21. They did not dismiss A's symptoms as being due to their age. It was part of a wider discussion, one possible reason for A's increasing shortness of breath on exertion.

22. A's chest x-ray was reported as normal and the inflammatory markers were improving, so a further x-ray was not appropriate.

23. A's symptoms were taken seriously and appropriate investigations were undertaken including excluding cardiac causes for their symptoms.

24. The referral to the respiratory physicians could not be upgraded to urgent without new symptoms to prompt this. At the time of A's presentation there were no features of particular concern which prompted an urgent referral. If the Practice had done this, it would have been de-escalated by the hospital.

25. As a long-standing practice, patient care is of paramount importance. There were no indications of the severity of A's condition at the time. When no additional symptoms were brought to their attention, they were unable to action A's health care plan in any different way.

26. A saw the private Respiratory Consultant at a later stage in their illness where they presented with new symptoms and new signs on examination. Therefore, the more urgent nature of a cancer diagnosis was clearer.

27. A and GP 3 agreed to a trial without an inhaler to get a clearer impression of its effectiveness. A was not sure of its benefit and they ensured that A had sufficient support and was able to restart it if required, and report back to the Practice.

28. A's case and the events prior to A's death were discussed at a Practice meeting. All GPs have reviewed the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidelines for suspected lung cancer.

29. The doctors involved in A's care offered to meet with the family.

The Practice's response to SPSO enquiries

30. In response to my enquiries, the Practice provided my office with copies of:

    a. The report of a Significant Event Analysis (SEA) meeting held by the Practice in March 2021.

    b. The Practice protocols for referrals of patients in place at the time of the complaint and the subsequent updated version setting out the three levels of referral priority.

Relevant policies, procedures

31. Scottish Referral Guidelines for Suspected Cancer (Lung Cancer) January 2019

Medical advice

32. The Adviser said:

33. The relevant Scottish guidelines covering referral of a patient with suspected lung cancer are the Scottish Referral Guidelines for Suspected Cancer (the Guidelines). These Guidelines contain guidance where lung cancer is suspected. Although there are Scottish Intercollegiate Guidelines Network (SIGN) guidelines for the management of lung cancer, there are no SIGN guidelines for lung cancer referral. While there are also NICE guidelines covering referral, in Scotland, the Guidelines take precedence.

34. The Guidelines list the following symptoms as grounds for an urgent chest x-ray if they have gone on for more than three weeks:

a. change in a cough or a new cough;

b. dyspnoea (i.e., shortness of breath);

c. chest/shoulder pain; loss of appetite;

d. weight loss;

e. chest signs;

f. hoarseness (if no other symptoms present to suggest lung cancer refer via Head & Neck pathway);

g. fatigue in a smoker aged over 40 years.

35. The Guidelines go on to state that an urgent cancer referral should be done for:

> 'Any unexplained symptoms or signs detailed above persisting for longer than six weeks despite a normal chest x-ray.'

36. The Guidelines also state that, as a good practice point, people

> 'with features suggestive of cancer including suspected metastatic disease, but no other signs to suggest the primary source, should consider CT chest, abdomen and pelvis in accordance with local guidelines about the investigation of an unknown primary cancer'.

37. The Adviser commented that the Guidelines are intended to help GPs, the wider primary care team, other clinicians and patients and carers to identify patients who

are most likely to have cancer. Accordingly, GPs carry the responsibility for patients under their care who are dealt with by them or members of their primary care team.

38. When A first presented at the Practice in August 2019, they had at least two of the above symptoms, chest wall pain against a background of new onset shortness of breath for more than six weeks. As A was a smoker, they were at an increased risk of lung cancer.

39. In accordance with the Guidelines, even though A's chest x-ray was normal, an urgent cancer suspected referral should have been made given A's initial presenting symptoms of more than six weeks duration and this should have been made no later than A's attendance at the Practice in October 2019. The Adviser explained that the guidelines are clear on this. The Practice, when commenting on a draft of this report, said that they are not able to refer patients for CT scans. The Adviser agreed that the decision would be for the Chest Clinic physician. However, the Practice, when making an urgent cancer suspected referral, could have requested consideration of a CT scan. This would have allowed for A to be considered for a CT scan after their first chest x-ray was carried out.

40. The Adviser also noted that the Practice complaint response, in relation to A's first presentation at the Practice in August 2019, said that COPD was considered and a chest x-ray was arranged. However, the response had not commented on the decision-making process or the relevant guidance and the Adviser felt that these were significant omissions. In their view, the Practice did not take A's presentation at this stage seriously enough.

41. When A attended the Practice in May 2020, the evidence shows that A was not convinced the inhaler they were prescribed was helping them. It was, therefore, reasonable for GP 3 to suggest withholding the inhaler for a short period to see if A noticed any difference. There is no value in taking medication which is not benefiting the patient. Accordingly, it is not unreasonable to see if there is a benefit to withholding medication briefly when there are doubts that taking it is of benefit.

42. When A attended again at the Practice in August 2020 this should have resulted in an urgent referral as, by then, A had had these symptoms for a year.

43. Notwithstanding the above, from the Adviser's review of the evidence, they considered there was nothing to suggest the Practice had dismissed A's symptoms as being due to their age.

44. The Adviser also reviewed the SEA conducted by the Practice in 2021. While they did not consider what was discussed was unreasonable, given the outcome in

A's case they would have expected a more extensive SEA discussion and reflection to have been carried out which would have included a review of the Guidelines and a clear record of their consideration as part of the SEA. In their view, the SEA only covered the absolute minimum of what had occurred in A's case.

45. They also noted the Practice's complaint response to C did not refer to the Guidelines. This led them to the view the Guidelines were not considered at all by the Practice.

(a) Decision

46. C has complained that the Practice failed to provide A with reasonable care and treatment when they attended at the Practice in 2019. I want firstly to offer my sincere condolences to C on the death of A. I appreciate the distress and upset the issues complained about have caused C and why they have questions about A's care and treatment. I also recognise that it took strength to pursue the complaint, which would have caused C to recollect a painful and difficult time.

47. In investigating C's concerns, I obtained professional advice from the Adviser (as outlined above), and I accept their advice.

48. The Adviser has told me that the Scottish Referral Guidelines for Suspected Cancer (the Guidelines), in particular, the section relating to lung cancer, were applicable in this case and should have been taken into account by the clinicians at the Practice from the outset when treating A.

49. A attended at the Practice in August 2019 with chest wall pain and a two to three month history of shortness of breath. As A was a smoker they were also at an increased risk of developing lung cancer. Although A's chest x-ray was normal, under the Guidelines an urgent cancer suspected referral should have been made as A's unexplained symptoms had been present for more than six weeks. In any event, an urgent referral should have been made by October 2019 at the latest when A re-presented at the Practice.

50. It is evident that there was a failure by the Practice to recognise the seriousness of the symptoms A presented with between August and October 2019 and to refer them urgently as required under the Guidelines. I consider this was a significant failing in care.

51. While a referral was made to the respiratory physicians in August 2020 when A attended the Practice with the same symptoms, I am extremely critical that this was not made on an urgent basis as, by then, A had had their symptoms for a year. I note that A contacted the Practice at this time asking that the referral be changed to

urgent and this was refused. Instead A had to request a referral to a Respiratory Consultant on a private basis. I consider the Practice's justification for not upgrading the referral to urgent was unreasonable. It is very clear that the referral to the respiratory physicians should have been made on an urgent basis and that A should not have had to ask for a private referral to be arranged. Unfortunately, it was only after this private referral that A's cancer was diagnosed.

52. I have no doubt that if the relevant guidelines for suspicion of cancer had been followed, A would have been referred much earlier than they were and would not have had to resort to a private referral. The repeated failure to follow the Guidelines was in my view a serious failing in A's care resulting in a significant injustice to A and their family.

53. C is clear in their view that A was treated without understanding, compassion or respect during their interactions with the Practice. It is always difficult for me to determine the manner in which someone was treated or the way in which they were spoken to from medical records alone. As this is the only contemporaneous evidence that is available to me, I am unable to reach a view on this although I recognise and respect that this is C's clear recollection. Notwithstanding this I have seen no evidence in the medical records that the Practice were dismissive of A's symptoms due to their age. I also consider it was reasonable to have suggested to A that they stop temporarily using their inhaler given A doubted the inhaler was benefiting them.

54. I acknowledge that an SEA was subsequently conducted by the Practice. The purpose of an SEA is to have an open and supportive discussion of a patient safety case or incident with the aim of improving patient care and learning from what has occurred. The advice I have taken into account when making my decision, is that the SEA that was conducted was limited and did not fully address what had occurred in A's case. It is also notable that there was no mention of the Guidelines in the SEA report. Nor were the Guidelines referred to in the complaint response. I am particularly critical of this. It is one of a number of missed opportunities for learning - during the SEA process, when the complaint was received and investigated by the Practice, and when the Practice responded to my own investigation. (I consider the Practice's complaint handling in more detail below).

55. In conclusion, I consider the actions of the Practice were unreasonable and I uphold the complaint.

56. My investigation has found serious failings that have not been acknowledged or addressed by the Practice. It is important that these are now fully and urgently addressed. I have, therefore, made a number of recommendations. I am pleased that the Practice have accepted the recommendations. My complaints reviewer and I will

follow up on these recommendations. I expect evidence to demonstrate that appropriate action has been taken before I can confirm that the recommendations have been met. In addition, I have also included feedback for the Practice which I urge them to consider carefully and, in particular, whether there is any further learning for Practice staff.

Complaint handling issues

57. Under section 16G of the SPSO Act 2002, I am required to monitor and promote best practice in relation to complaints handling.

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

59. While the Practice's complaint response noted A's presentation in August 2019 it provided no comment or view on the reasonableness of the consultation. Nor did it refer to the relevant guidance. These were significant omissions. Overall, I consider there was a failure by the Practice to provide C with a full and informed response in relation to certain aspects of their complaint and in particular to take into account the Guidelines.

60. I expect organisations to learn from complaints and that the learning is shared throughout the organisation. This learning should identify areas of concern so that appropriate action can be taken to avoid the same issues happening again. Of particular concern to me in this case was the apparent lack of learning from C's complaint by the Practice as a whole.

61. Given these issues, I consider the Practice's complaint handling was unreasonable. I also note that while the complaint response which the Practice issued to C signposted C to my office, the recommended wording in the current NHS Scotland Complaints Handling Procedure was not used, and out of date contact details for my office, including the address, were provided.

62. In making this finding, and my recommendation, I recognise and acknowledge that complaint handling can be challenging for GP practices as they often have an ongoing relationship with their patients, which may cover years (or even generations). Equally, making a complaint about their GP is often a last resort for many patients. I encourage the Practice to reflect on how they can use the opportunity presented by the complaint to be a positive method of engagement.

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 C

Complaint number	What we found	What the organisation should do	What we need to see
(a)	Under (a) we found: • There was a failure to recognise the significance of A's symptoms when they presented at the Practice between August 2019 and September 2020, to make an urgent referral. • The SEA conducted by the Practice was limited and did not fully address what occurred in A's case or take account of the relevant Scottish Referral Guidelines for Suspected Cancer. • There was a failure by the Practice to fully address the issues raised when responding to C's complaint and evidence of a lack of learning from the complaint by the Practice as a whole.	Apologise to C 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: 26 June 2023

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

Complaint number	What we found	What should change	What we need to see
(a)	Under complaint (a) we found: • There was a failure to recognise the significance of A's symptoms when they presented at the Practice between August 2019 and September 2020, to make an urgent referral.	Patient symptoms should be appropriately identified and managed. Symptoms or features suggestive of cancer should result in the appropriate referral being made in line with relevant guidance.	Evidence that this decision has been shared and discussed with relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails. Evidence that training needs in relation to the application of relevant guidance have been identified and addressed. Evidence of how the findings of this case have been used as a reflective training tool for relevant staff. By: 24 July 2023
	The SEA conducted by the Practice was limited and did not fully address what occurred in A's case or take account of the relevant Scottish Referral Guidelines for Suspected Cancer.	Local and Significant adverse event reviews should be reflective and learning processes that considers events against relevant standards and guidelines, to ensure failings are identified and any appropriate learning and practice improvements are made.	Evidence that the Practice have reviewed their systems and processes for reviewing significant events to ensure it is a fully reflective and learning process that supports the staff involved to identify learning and improvement. By: 24 August 2023

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	Under complaint (a) we found: • There was a failure by the Practice to fully address the issues raised when responding to C's complaint and evidence of a lack of learning from the complaint by the Practice as a whole. • The complaint response contained out of date contact details for the SPSO, including the address.	Complaint responses should consider and respond fully to the issues raised in accordance with The Model Complaints Handling Procedures | SPSO. They should take into account any relevant national or local guidance in both the investigation and response, and identify and action learning. Learning from complaints and the learning should be shared throughout the organisation so that actions and improvements can be implemented to prevent the same issues happening again.	Evidence that these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (e.g., a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Practice's complaint handling process is clearly signposted on its website and that information, including documentation (e.g., complaint leaflet and/ or template complaint response letter have been updated) in accordance with the model complaints handling procedure. Evidence that the website and documents properly signpost to the SPSO, including the current SPSO contact details. Evidence that relevant staff have or are scheduled to have appropriate complaint handling training. By: 24 July 2023

Feedback for the Practice

The Practice, when making an urgent cancer suspected referral, could have requested consideration of a CT scan. This would have allowed for A to be considered for a CT scan after their first chest x-ray was carried out. I encourage the Practice to share this and reflect on it for the future.

Terms used in the report **Annex 1**

A	the aggrieved, and the parent of C
C	the complainant
chronic obstructive pulmonary disease (COPD)	a lung condition that causes breathing difficulties
CT scan	computerised tomography scan: a scan which uses x-rays and a computer to create detailed images of the inside of the body
GP 1	a GP at the Practice
GP 2	a GP at the Practice
GP 3	a GP at the Practice
erythrocyte sedimentation rate (ESR)	a blood test that can show inflammation in the body
respiratory	the organs and tissues in the body that are involved in breathing
significant event analysis (SEA)	a way of formally analysing incidents that may have implications for patient care
the Adviser	a General Practitioner
the Practice	a medical practice in the NHS Ayrshire and Arran area
x-ray	a type of electromagnetic radiation that creates images of the inside of the body

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

Scottish Referral Guidelines for Suspected Cancer (Lung Cancer) published January 2019