Investigation of a complaint against a GP Practice

Report Reference: 202004152

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Appendix 1 – The Principles of Good Administration

Case Reference: 202004152

Listed Authority: GP Practice

SUMMARY

I received a complaint about the care and treatment a GP Practice provided to the complainant's father (the patient). The complainant raised concerns about the Practice's decision to conduct telephone consultations with the patient instead of face to face consultations from June 2020 until November 2021. She was also concerned the Practice did not take appropriate action following receipt of her father's CT report in March 2022.

The investigation acknowledged the consultations took place during a period where there were varying restrictions in place because of the COVID-19 pandemic. However, it established a failure in care and treatment regarding the Practice's decision to conduct telephone consultations instead of face to face consultations for this particular patient due to his presenting symptoms and medical history. It established it was clinically necessary for the Practice to offer in-person appointments to the patient at that time. In terms of the CT report, however, the investigation established the Practice's actions were appropriate and in line with relevant standards.

I therefore partially upheld the complaint.

I recommended the Practice provides the complainant with a written apology within one month of the date of the final report. I made three further recommendations for the Practice to address to instigate service improvement and to prevent future reoccurrence of the failing identified. I asked the Practice to provide this Office with evidence of steps taken within six months of the date of the final report. I also made observations I encourage the Practice to consider in its practice going forward.

I appreciate this was an incredibly difficult time for the complainant and all the family and hope this report provides some reassurance that the Practice will improve their process.

THE COMPLAINT

1. This complaint is about the care and treatment the Practice provided to the complainant's late father from June 2020 to March 2022. The complainant was concerned the Practice did not arrange face to face appointments for the patient during this period. She was also concerned the Practice did not act on the patient's cancer diagnosis in March 2022.

Background

2. The patient was a 71 year old gentleman who had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD[1]) in January 2020.

3. In June 2020 the patient contacted the Practice about a chesty cough with green sputum. [2]The Practice triaged the patient by telephone and prescribed an antibiotic. The patient subsequently contacted the Practice in October 2020, April 2021 and June 2021 with the same symptoms. On each occasion the Practice prescribed an antibiotic following a telephone triage.

4. In August 2021 the patient contacted the Practice again, this time about a chesty cough with grey sputum. He had recently quit smoking. The Practice asked him to produce a sputum sample and recommended he may require a chest x-ray. The Practice did not arrange the x-ray at this time and did not prescribe any medication.

5. In November 2021 the patient again contacted the Practice about a chesty cough with green sputum. The Practice prescribed an antibiotic following a telephone triage and advised him to ring back if it did not settle.

6. In January 2022 the patient contacted the Practice about a cough with white sputum. The Practice requested a full blood count [3] following a telephone triage. Following blood results in February 2022 the Practice requested urgent repeat bloods as the patient did not drink alcohol but the results showed a deteriorating sodium level. The Practice made an emergency same day referral

[1] COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum).

[2] Sputum-A mixture of saliva and mucus produced by the lungs as a result of viral or bacterial infections.

[3] A full blood count measures the number and size of red blood cells, white blood cells and platelets in your blood. It can help diagnose infections, anaemia and other diseases.

for the Urgent Care Centre (UCC) for further bloods, investigation and a chest x-ray as it had concerns about lung cancer given the patient's history of smoking.

7. In March 2022 the patient underwent a CT scan. The patient attended South West Acute Hospital on two further occasions in July 2022 complaining of chest pain, confusion and reduced mobility. A second CT scan then found "*suspicion of tiny lytic lesions [4]in the ribs bilaterally. Appearances might be in keeping with myeloma[5]. Clinical correlation essential*". The patient was subsequently diagnosed with Myeloma.

Issue of complaint

8. I accepted the following issue of complaint for investigation:
   - **Whether the GP Practice provided appropriate care and treatment to the patient between June 2020 and March 2022.**

   In particular, the investigation will consider:

     - the six telephone appointments the GP Practice provided to the patient between June 2020 and November 2021; and
     - action the GP Practice took after obtaining a CT report for the patient on 23 March 2022.

INVESTIGATION METHODOLOGY

9. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Practice's complaints process.

[4] Lytic lesions are areas of bone damage that result from cancer cells breaking down old bone tissue. They can cause fractures, pain, and high calcium levels in the blood.

[5] Myeloma is a blood cancer arising from plasma cells that affects the bone marrow and causes symptoms such as bone pain**,** infection and kidney damage.

Independent Professional Advice Sought

10. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - **General Practitioner (GP),** MRCGP – with experience in treating patients in a clinical practice in primary care.

    I enclose the clinical advice received at Appendix two to this report.

11. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

12. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[6]:

    - The Principles of Good Administration

13. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

14. The specific standards and guidance relevant to this complaint are:

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[6] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- National Institute for Health and Care Excellence (NICE) Guideline 115: Chronic Obstructive Pulmonary Disease in Over 16s – Diagnosis and Management, updated July 2019 (NICE 115);
- National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary: Bronchiectasis[7], revised March 2024 (Bronchiectasis CKS);
- National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary: How Should I Assess a Person with a Cough, revised August 2023 (Cough Assessment CKS);
- National Institute for Health and Care Excellence (NICE) British National Formulary[8] Extract on Respiratory System Infections, Anti-bacterial therapy – (BNF Extract); and
- The General Medical Council's (GMC) Good Medical Practice, updated April 2019 (the GMC Guidance); and
- NI Management of Infection Guidelines for Primary Care Antimicrobial Guidelines: Lower respiratory tract infections (Management of Infection Guidelines) published February 2019.

I will examine relevant sections of the guidance in my analysis section in this report.

15. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

16. A draft copy of this report was shared with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations.

[7] A condition in which airways of the lungs remain permanently damaged and widened due to persistent infection. This causes accumulation of excess mucus and bacteria resulting in frequent infections and breathing problems.

[8] UK pharmaceutical reference book containing a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service (NHS).

THE INVESTIGATION

Whether the GP Practice provided appropriate care and treatment to the patient between June 2020 and March 2022.

In particular, the investigation will consider:

- **the six telephone appointments the GP Practice provided to the patient between June 2020 and November 2021; and**
- **action the GP Practice took after obtaining a CT report for the patient on 23 March 2022.**

Detail of Complaint

Six telephone appointments

17. The complainant said the patient developed six separate chest infections during the relevant period. She explained that Practice handled each infection by prescribing antibiotics following a telephone triage only. The complainant considered the Practice should have seen the patient face-to-face on these occasions, given his presenting symptoms and medical history. She said if the Practice had done so, they would have observed a deterioration in his health over this time.

CT report in March 2022

18. The complainant said the practice were informed of the patient's asbestos related cancer in March 2022 but did nothing for the patient until he was subsequently diagnosed with another type of cancer in July 2022.

Evidence Considered

Legislation/Policies/Guidance

19. I refer to the following policies and guidance which I considered as part of investigation enquiries:

    - NICE 115;
    - Bronchiectasis CKS;

- Cough Assessment CKS;
- BNF Extract;
- Management of Infection Guidelines; and
- The GMC Guidance.

The Practice's response to investigation enquiries

Six telephone appointments

20. The Practice acknowledged the patient had COPD. The Practice stated the patient had '*2 chest infections in 2020'* and *'3 chest infections 2021'.* It explained that in August 2021 the patient also had a consultation to discuss side effects from stopping smoking. The Practice acknowledged it conducted a telephone consultation with the patient on each of these occasions, and that it prescribed an antibiotic on five of those occasions. It did not prescribe an antibiotic in August 2021 because it determined the patient did not have a chest infection on that occasion. The Practice explained COPD patients require '*early antibiotic treatment*' when they '*develop a chest infection*'. It stated that on each occasion it advised the patient to contact the Practice if there was '*no improvement*'.

21. The Practice stated during the covid-19 pandemic it triaged all patients by telephone first, followed by photo triage. It explained that if the patient showed no improvement following these steps, and it considered the patient '*required*' a '*physical examination*', then it offered '*one of the limited number of face to face appointments' it 'could provide each day*'. It accepted it did not offer or conduct a face to face consultation with the patient on any of the six relevant occasions.

22. The Practice acknowledged it had been '*unable to function as normal*' during the pandemic. It stated it '*understood'* patients' '*frustration*' about the impact the pandemic had on the availability of face to face appointments. It stated, however, that it provided '*appropriate*' treatment to the patient in '*the circumstances*'.

CT report in March 2022

23. The Practice acknowledged it received the patient's CT report on 23 March 2022. It stated the report showed a '*deteriorating sodium level*' and that there were "*calcified pleural plaques and lower lobe bronchiectasis but no evidence of malignancy*".

24. The Practice denied there was a finding of asbestos-related cancer in the CT report received and stated the patient had "*a CXR and a CT scan of his chest and was referred urgently to a Respitatory consultant*". He was prescribed treatment to help with secretions and a delayed antibiotic to start if the sputum became coloured.

Relevant Independent Professional Advice

25. I enclose the IPA's advice at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Six telephone appointments

26. I note the complainant's concern that the Practice only conducted telephone consultations with the patient on the six relevant occasions, instead of face to face consultations. I also note the Practice's confirmation that these took place by telephone, and its position that it was appropriate to have done so, given the COVID-19 restrictions in place at the time.

27. The IPA advised that during the pandemic, government guidance '*instructed*' GP Practices to '*triage all patients by telephone initially*' and to '*reduce*' face to face appointments '*as much as possible*'. She further advised, however, that GPs were also '*reminded*' about the '*importance*' of arranging face to face consultations with patients where they were '*clinically necessary*' or '*essential*'. I note the IPA's advice that determining clinical necessity was '*a challenge*' during the pandemic.

28. The investigation must determine, therefore, whether at any point during the relevant period, it became a clinical necessity for the Practice to consult with the patient face to face.

29. I note the patient had a COPD diagnosis. Upon review of the GP records, I also note the Practice recorded that the patient had been suffering from a '*chest infection for 6 months*' at the time of his first telephone consultation on 8 June 2020. He subsequently presented with a recurring cough and chest infection four months later, and again six months after that. He presented with these symptoms again over two months later, and again two months after that. The final presentation during the relevant period was three months after that. I note the colour of the sputum the patient produced varied across those presentations.

30. The IPA referred to NICE 115 and advised during this period the patient suffered '*frequent exacerbations*' of his existing COPD – being two or more in the period of one year. She advised an '*exacerbation*' is '*a sustained worsening of the patient's symptoms and is acute in onset'*. She further advised that a '*cough with increased sputum production and change in sputum colour*' is '*commonly*' a sign of such an '*exacerbation*'.

31. The IPA advised that given the patient's symptoms during this period and his medical history of COPD with '*frequent exacerbations*', the Practice should have '*examined*' the patient and '*assessed*' him for bronchiectasis. I note the Bronchiectasis CKS states a clinician should suspect this condition where a patient has a cough that persists for more than eight weeks, '*especially with sputum production*'. It states if a clinician suspects this condition they should take a '*full medical history*', as well as arrange an x-ray and sputum culture.

32. The IPA advised to examine and assess the patient for this condition, the Practice should have taken a sample of the patient's sputum for '*culture*' analysis and arranged an onward referral to a respiratory consultant, to include a chest x-ray. The Practice should have also discussed a '*future management plan*' with the patient for his symptoms. The IPA advised the Practice should

have taken these steps from his first presentation on 8 June 2020, but it did not take any of these steps.

33. Given the patient had been suffering from a chest infection for six months on 8 June 2020, and continued to experience recurring chest infections over the subsequent 17 months, I accept the IPA's advice in this respect.

34. Having reviewed all relevant records, including the IPA's advice, I consider the Practice should have fully examined and assessed the patient for suspected bronchiectasis from 8 June 2020, given his medical history and the symptoms he experienced at the time. Having considered the IPA's advice about what this examination and assessment should have entailed, I am satisfied there was a clinical necessity for the Practice to have consulted with the patient face to face, rather than by telephone only from this point. Having reviewed the Practice's triage process outlined, and the IPA's advice, I consider after the Practice's initial telephone triage of the patient on 8 June 2020, it should have offered him one of its limited face to face appointments. I am satisfied this is the case also for the five subsequent telephone consultations during the relevant period for these reasons.

35. I accept the Practice had to take serious precautions to limit the spread of COVID-19 and to comply with government instructions. I acknowledge this inevitably had an impact on the care and treatment it was possible to provide to patients. However, even during the strictest restrictions in place, the Practice could conduct face to face consultations with patients where it was clinically necessary to do so.

36. Standard 15 of the GMC Guidance requires doctors to '*provide a good standard of practice and care*'. This includes '*adequately*' assessing a patient's condition, taking account of their medical history, and examining the patient '*where necessary*'. It also requires doctors to provide '*suitable*' advice, investigations or treatment '*promptly*'. I consider the Practice failed to act in accordance with this standard when it failed to offer face to face appointments to this particular patient during the relevant period. I find this to be a failure in the care and

treatment the Practice provided to the patient. I therefore uphold this element of the complaint.

37. I note the IPA's advice that the patient was subsequently diagnosed with bronchiectasis. I consider the failure in care and treatment caused the patient to lose the opportunity for potential earlier diagnosis and treatment of this underlying reason for his recurring cough and chest infections. It also caused him to sustain the injustice of uncertainty, frustration and anxiety regarding the-underlying reason for his symptoms.

Observations

38. I note the IPA's observation that there is no evidence the Practice investigated potential red flag[9] symptoms with the patient during the consultations, with the exception of 9 April 2021. I further note her observation that it should have done so on each occasion. The Cough Assessment CKS states clinicians should ask a patient about symptoms such as a change in cough, especially for smokers over 45 years old. I am satisfied it was not necessary for the Practice to hold a face to face consultation with the patient to explore these potential symptoms. While I do not make a finding in-relation to this matter I do note the IPA's comments with concern and, I encourage the Practice to reflect on the IPA's observation in-relation to this in respect of its future practice.

39. I also note the IPA's observation about the dosage of antibiotics the Practice prescribed to the patient on 8 June 2020, 12 October 2020 and 21 June 2021. She observed the Practice prescribed a higher dosage on these occasions than that recommended in the BNF Extract. She observed the Practice did not document its rationale for prescribing an increased dosage in the GP records, and advised it should have done so. She advised this increased dosage would not have had an impact on the patient's health, and the Practice may have had a valid reason for prescribing it. I note the Practice's comment on the draft report that an increased dosage is permissible under Management of Infection

[9] Signs of serious underlying diseases such as cancer, infection or nerve damage.

Guidelines. Nonetheless, I encourage the Practice to reflect on the IPA's observation regarding its record-keeping in this respect.

CT report in March 2022

40. I note the complainant's concern that the Practice failed to act on the patient's asbestos-related cancer diagnosis in March 2022. I also note the Practice's position that this CT report did not show a cancer diagnosis.

41. The patient underwent a chest CT scan on 21 March 2022, and the Practice obtained the CT report on 23 March 2022. I reviewed the report and note it states *"There are calcified pleural plaques and lower lobe bronchiectasis but no evidence of malignancy*". I reviewed the patient's GP records and note the practice sent an urgent referral on the same day to a respiratory consultant and attached a copy of the CT report to the referral and I further note the GP practice discussed the findings from the CT report with the patient enquiring if there had been any asbestos exposure.

42. The IPA referred to the Bronchiectasis CKS, and advised the Practice's actions in making this onward referral were appropriate. She further advised there was no evidence of cancer until further tests in July 2022. The Bronchiectasis CKS states where a clinician suspects this condition, they should refer the patient to a respiratory physician to '*confirm the diagnosis*' and '*determine the underlying cause*' of the condition. Having reviewed the patient's GP records and this guidance, I accept the IPA's advice.

43. I am therefore satisfied the Practice appropriately referred the patient for onward care following the CT scan for investigation, where he subsequently received a diagnosis of bronchiectasis. I therefore do not uphold this element of the complaint.

CONCLUSION

44. I received a complaint regarding the actions of the Practice. The complaint concerned the care and treatment it provided to the patient between June 2020 to March 2022. I partially upheld the complaint for the reasons outlined in this report. I found a failure in the care and treatment the Practice provided to the

patient which caused him to sustain the injustice of uncertainty, frustration and anxiety, as well as the loss of opportunity for potential earlier diagnosis and treatment of his bronchiectasis.

Recommendations

45. I recommend the Practice provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified within **one month** of the date of the final report.

46. I further recommend, for service improvement and to prevent future reoccurrence, that the Practice:

    I. discusses the contents of this report, and the learnings identified in it, with its doctors;
    II. reminds its doctors about the importance of offering face to face consultations for patients for whom is it a clinical necessity given their presenting symptoms and medical history;
    III. Reminds its doctors about the importance of considering and investigating for bronchiectasis in line with relevant guidance for patients with COPD with frequent exacerbations; and
    IV. provides my office with evidence of having done so within **six months** of the date of the final report.

47. I acknowledge the distress and pain of the patient's sad death on the complainant and her family. Throughout this investigation her, and her family's, care and devotion for her father was evident. I offer through this report my condolences to the complainant and her family for the loss of their father.

MARGARET KELLY
Ombudsman
2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.

- Acting in accordance with the public body's policy and guidance (published or internal).

- Taking proper account of established good practice.

- Providing effective services, using appropriately trained and competent staff.

- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.

- Informing customers what they can expect and what the public body expects of them.

- Keeping to its commitments, including any published service standards.

- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances

- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.

- Stating its criteria for decision making and giving reasons for decisions

- Handling information properly and appropriately.

- Keeping proper and appropriate records.

- Taking responsibility for its actions.

4. **Acting fairly and proportionately**

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. **Putting things right**

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. **Seeking continuous improvement**

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.