Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a GP Practice within Bangor Health Centre

NIPSO Reference: 20560

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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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SUMMARY

I received a complaint regarding the actions of a GP Practice within Bangor Health Centre (the GP Practice). The complainant's late husband (the patient) was a patient of the GP Practice. The patient first presented with symptoms of chest pain and discomfort in January 2018, was diagnosed with metastatic pancreatic cancer in July 2018 and sadly passed away in August 2018.

The complainant believed that the GP Practice should have 'red flagged' a referral for an endoscopy in March 2018. She considered that the GP Practice's concentration on her husband's symptoms of anxiety resulted in a delay in his diagnosis for pancreatic cancer. The complainant believed that an earlier diagnosis may have prolonged the patient's life or at least made the experience of dealing with the patient's diagnosis and death soon afterwards less difficult

In order to assist with my consideration of the issues raised by the complainant I obtained advice from an independent General Practitioner with experience in the diagnosis of patients with pancreatic cancer. I considered the responses from the GP Practice and took account of the advice provided by the independent advisor.

Taking into account the relevant guidance I established that the patient did not meet the criteria for a red flag referral for endoscopy. I also established that the patient did not present with symptoms of pancreatic cancer that would have required a two week referral under the relevant guidelines.

I identified the following areas where I considered the actions of the GP practice fell below relevant standards of good medical practice:

- A raised GGT level in a blood sample was not acted upon. The GP Practice did not advise the patient of the abnormal result and he did not call him back for a retest.
- The GP did not adequately explore or record the patient's symptoms of loss of appetite and related weight loss.

- The clinical records were brief and lacked detail. In particular, information about the level of pain the patient was experiencing was lacking. The rationale for a prescription of Amitriptyline was also absent from the records.

If the failures in the care and treatment of the patient had not occurred, it may have been possible for the patient to have received an earlier diagnosis however the failures had no impact on the prognosis or outcome.

As a result of the complaint the GP Practice advised they held an internal Cancer Care Review meeting on 13 March 2019 and listed the learning points taken from this case. In order to provide assurance on the learning and improvement from this complaint I recommended that the GP Practice implements an action plan to incorporate the learning points they identified and those identified by the IPA and to demonstrate how they were addressed.

I also recommended that the GP Practice carries out an audit of a sample of cases in order to be satisfied that the records of pain relief prescribed are sufficiently detailed to convey the rationale.

In order to address the injustice suffered as a result of the failings identified I recommended that the GP Practice issues an apology to the complainant.

I welcome the GP Practice's acceptance of my findings and recommendations.

THE COMPLAINT

1. The patient attended Bangor Health Centre (the GP Practice) on a number of occasions in 2018. He had first attended his GP on 18 January 2018 with symptoms of chest pain and discomfort. His wife stated at subsequent appointments he also presented with symptoms of problems with sleep, reduced appetite and weight loss. He sadly passed away on 21 August 2018 following a diagnosis of metastatic pancreatic cancer on 6 July 2018. His wife complained that the GP Practice failed to diagnose pancreatic cancer at any stage despite abnormal blood results in January 2018. She complained that the GP's focus on treating her husband's symptoms of anxiety contributed to a misdiagnosis.

2. The issue of complaint which I accepted for investigation was:

   - **Whether the care and treatment provided to the patient by the GP Practice met good practice standards?**

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the GP Practice all relevant documentation together with the GP Practice's comments on the issues raised by the complainant. This documentation included information relating to the GP Practice's handling of the complaint.

4. After further consideration of the issues, the Investigating Officer obtained advice from an experienced General Practitioner who has worked as a doctor in the NHS for nineteen years, including twelve years as a GP. He is a GP trainer and has diagnosed patients with pancreatic cancer.

5. I have included the information and advice which have informed my findings

and conclusions within the body of my report. The IPA provided me with 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Principles for Remedy

7. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the staff whose actions are the subject of this complaint.

The specific standards relevant to this complaint are:

- General Medical Council (GMC) Good Medical Practice Guidance 2013 (the GMC Guidance);
- National Institute for Health and Care Excellence (NICE) guideline NG85 Pancreatic cancer in adults : diagnosis and management 7 February 2018 (NICE NG85);
- National Institute for Health and Care Excellence guideline NG12 recognition and referral for suspected cancer 2015. (NICE NG12).

8. I have not included all of the information obtained in the course of the

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

investigation in this report but I am satisfied that I have taken into account everything that I consider to be relevant and important in reaching my findings.

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

THE INVESTIGATION

Whether the care and treatment provided to the patient at the GP Practice met good practice standards?

Detail of complaint

10. The complainant explained that her complaint focuses on the following issues which she considered to be significant:-
'Why was there no follow up to the bloods report in January 2018?
Why were these bloods not repeated in the 5-month period?
Why did the symptoms of chest pain and ongoing weight loss, 3 stone in the 5-month period, not raise alarm bells?
Why was [my husband] not prescribed effective pain relief as, and when, this was requested?'

11. The complaint made to the GP Practice stated that '*medical intervention at the early stage and at various intervals from January 2018 to July 2018*' may have prolonged her husband's life, '*and at the very least could have made his, and our experience less difficult'.*

12. The complainant is seeking an acknowledgement from the GP Practice of its failings, an apology to the family for the undue stress caused to the patient and an undertaking that patients with a history of anxiety are treated on equal terms to others.

Evidence considered

13. In deciding whether care and treatment is appropriate and reasonable, I consider the applicable clinical standards and guidelines. I then assess whether the relevant care and treatment provided meets those standards.

14. The GMC Guidance states at paragraph 15:
'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a. *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
b. *promptly provide or arrange suitable advice, investigations or treatment where necessary*
c. *refer a patient to another practitioner when this serves the patient's needs.*

15. Paragraphs 19-21 of the GMC guidance state you must:
'*Record your work clearly, accurately and legibly:*

- *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the [my same time as the events you are recording or as soon as possible afterwards.*
- *You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.*
- *Clinical records should include:*

a. *Relevant clinical findings*
b. *The decisions made and actions agreed, and who is making the decisions and agreeing the actions*
c. *The information given to patients*
d. *Any drugs prescribed or other investigation or treatment*
e. *Who is making the record and when.'*

16. Nice NG12 1.13.2 describes non-site specific 'Symptoms of concern in adults' as follows:

- For people with unexplained weight loss, which is a symptom of several cancers including colorectal, gastro-oesophageal, lung, prostrate, pancreatic and urological cancer, carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- Offer urgent investigation or a suspected cancer pathway referral (for an appointment in 2 weeks).

1.13.3 For people with unexplained appetite loss, which is a symptom of several cancers including lung, oesophageal, stomach, colorectal, pancreatic, bladder and renal cancer:

- Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- Offer urgent investigation or a suspected cancer pathway referral (for an appointment in 2 weeks).

1.2.1 Offer urgent direct access upper gastrointestinal endoscopy (to be performed within two weeks) to assess for oesophageal cancer in people:

- With dysphagia **or**
- Aged 55 and over with weight loss and any of the following:

- Upper abdominal pain
- Reflux
- dyspepsia

1.2.4 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice.

1.2.5 Consider an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss **and** any of the following:
diarrhoea
back pain

abdominal pain
nausea
vomiting
constipation
new-onset diabetes.

17. The complainant submitted the following chronology of the care and treatment the GP Practice provided to her husband, taken from the GP notes and records:

'18 January 2018

[My husband] first visited [GP A] complaining of chest pain. Normal checks were carried out at this stage with referral for an ECG[2] and bloods check.

19 January 2018

Blood results received on 19 January 2018 showed increased levels of Serum potassium and Serum gamma GT levels with "! ADMISSION PROFILE"[3] noted on the record. No further action carried out.

7 March 2018

[My husband] returned to the surgery to be seen by [GP2], again complaining of chest pain. Examination carried out and Diazepam [4]medication prescribed. Review 1 week.

12 March 2018 *(this date should read 17 April 2018)*

ECG normal.

14 March 2018

Review appointment with GP B [my husband] reporting problems with sleep and appetite.

Anxiety with depression diagnosed – Mirtazepine[5] prescribed.

27 March 2018

Another appointment. Ongoing chest discomfort noted by [GP B] – referral for OGD.[6]

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[2] An electrocardiogram - or **ECG** - is a simple and useful **test** which records the rhythm, rate and electrical activity of your heart.
[3] The GP Practice explained that this term is used when a GP requests a combination of blood tests to test both kidney and liver function.
[4] A sedative used for the management of anxiety disorders
[5] A drug used to treat depression
[6]A gastroscopy, a procedure to examine the inside of the gullet, stomach and upper part of the small intestine

24 April 2018

Due to ongoing pain and no alleviation of symptoms, [my husband] attends the Kingsbridge Private Hospital for an endoscopy.

Endoscopy report notes indications as weight loss and chest pain.

Large sliding hiatus hernia diagnosed. CLO[7] test positive. Follow up Review 2 weeks with pathology.

14 May 2018

[GP2] prescribed Esomeprazole[8]. [My husband] to be considered for laparoscopic fundoplication[9].

15 June 2018

[My husband] visits surgery again and asks [GP B] to expedite hospital appointment due to worsening symptoms. [GP B] prescribed Amitriptyline[10] to help with pain and sleep but no additional pain relief.

3 July 2018

Due to severity of symptoms and GP's apparent dismissal of symptoms I take [my husband] to Ulster hospital A & E.

Blood test shows heightened Serum gamma GT[11] level. Admitted for investigation.

6 July 2018

MRI scan reveals metastatic pancreatic cancer.

13 July 2018

[My husband] discharged home for palliative care.

16 July 2018

Home visit from [GP B] who informs [my husband] that he is "a VIP patient now". [GP2] provides medical certificates back-dated to April 2018 noting "Palliative Care".

24 July 2018

Home visit from [GP A] due to concerns from district nursing staff. [My husband] appears toxic due to high levels of medication administered orally and via syringe driver, for ongoing pain.

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[7] Campylobacter-like organism test),
[8] A proton pump inhibitors which decreases the amount of acid made in the stomach
[9] A keyhole procedure to reduce severe acid reflux,
[10] A drug primarily used to treat depression
[11] An enzyme found in the liver or bile duct which indicates an abnormality

[My husband] readmitted to UHD.[12]

21 August 2018

My husband dies at the Marie Curie hospice.'

18. The Investigating Officer asked the GP Practice to comment on each of the questions the complainant raised. GP A explained why she did not follow up on the bloods' report in January 2018. She stated that the priority at the consultation on 18 January 2018 was to exclude ischemic heart disease. She referred the patient to the rapid access chest pain clinic in the Ulster Hospital where he was seen on 25 January 2018. She stated that in response to the raised gamma glutamyl transferase (GGT) level in his liver function test, she marked an action in the notes '*speak to [GP A] not urgent'*. She stated that the patient's GCT level had been '*raised to a similar level'* when last tested in 2007. She concluded '*The patient made his review appointment with another doctor in the practice rather than myself hence I did not have the opportunity to be further involved in his care at that stage'.*

19. The GP Practice stated *'unfortunately with the high volume of blood test results received daily we are not in a position to contact patients with the results'.* The practice added *'the abnormality of liver function which showed up is relatively common and at subsequent consultations the attending doctor did not feel there was a clinical indication to repeat this.'*

20. In response to investigation enquiries, GP B responded to the complainant's concern that her husband's symptoms of anxiety caused the GP Practice to dismiss his complaints of pain. He explained that the patient's anxiety and stress '*was considered alongside appropriate investigation of cardiovascular, respiratory and gastrointestinal symptoms'.*

21. It is noted that GP B recorded the first reference to problems with sleep and appetite on 14 March 2018. GP B saw him again on 27 March 2018 and he referred the patient for a scope investigation at that time '*in view of ongoing*

[12] Ulster Hospital Dundonald

chest discomfort and long term use of ranitidine and Gaviscon'. The referral included the comment 'no RFs' (red flags)[13]. There is no record regarding weight loss. GP B responded to the complainant's question about why the symptoms of chest pain and significant ongoing weight loss *'did not raise alarm bells'*. He stated that the gastroscopy, which was subsequently carried out privately, revealed a significant hiatus hernia *'which would have been enough to cause symptoms of chest pain and weight loss on its own. In light of this neither the consultant who saw him, nor I were minded to look for other pathology at that time.'*

22. In response to the question '*Why was [my husband] not prescribed effective pain relief as, and when, this was requested?'* The Practice responded: *'Effective pain management can be difficult to manage both in the community and in hospital. Whilst we strive to provide excellent palliative care and have a lot of experience in this field, at times it is not possible to achieve good symptom control and therefore an admission to hospital or the hospice becomes appropriate. Unfortunately, in [the patient's] case despite the involvement of the palliative care team, ourselves and the district nursing service, we were unable to achieve adequate pain [control].'*

23. I note that the Northern Ireland Hospice wrote to GP B on 20 July 2018 and detailed *'the main problems identified and agreed plan*.' The letter described the patient's pain in the chest and abdomen. It is recorded that pain medication provided included Morphine Sulphate and oral Oramorph.

24. The GP Practice held an internal Cancer Care Review meeting on 13 March 2019 and listed the following learning points from this case:

- *'Increased awareness of pancreatic cancer as a diagnosis in patients with a family history, smokers, new diabetics, and previous pancreatitis.*
- *High index of suspicion in new presentations of lower chest pain/upper GI patients.*

[13] Red flag is the term used to indicate that this is a referral for a patient who is suspected of having cancer.

- *Be more conscious of asking about weight loss and recording a baseline weight and serial weight, in patients with any GI symptoms or patients re-presenting with vague symptoms.*

- *Consider serial blood measurements even if initial blood is normal if patients are representing.*

- *Consider urgent early ultrasound scan referral for GI/chest symptoms that don't fit in any other definite pattern*

- *With respect to end of life care the importance of building a relationship with the patient and family particularly if other family members are not already known.'*

25. The GP Practice provided the Investigating Officer with notes and records of the patient's attendances in 2018. These were subsequently provided to the GP IPA.

The IPA advice

26. The IPA explained:

'The patient was seen at the Practice on 18 January 2018 with two weeks of chest pains. These were stabbing and he possibly had some general tightness. He had an examination of his cardiovascular system which was normal. An ECG, blood tests were arranged. He was referred to the Rapid Access Chest Pain Clinic. The assessment and management were in line with NICE Clinical Knowledge Summaries guidance on Chest Pain. There was nothing to suspect Pancreatic Cancer based on this consultation'.

27. The Investigating Officer asked the IPA to explain the relevance of the report of the blood tests carried out on 18 January 2018, particularly GGT 97 and potassium. The IPA advised:
'The patient's blood test results showed he had a raised level of Gamma-glutamyl transpeptidase (GGT)[14] of 97, the upper limit of normal being 61…The patient's other liver blood tests were normal… There is no national guidance on

[14]Gamma-glutamyl transpeptidase is an enzyme which is found in hepatocytes and biliary epithelial cells

how to manage an isolated raised GGT level. There is not a clear cause for the raised GGT level. Normal practice would have been to have made contact with the patient, to advise them of the raised level and to enquire about alcohol intake as a possible cause. If the patient was drinking alcohol to excess, they would be advised to reduce'.

28. The IPA was asked whether the GP ought to have arranged for the liver function blood tests to be repeated at any time. He advised '*normal practice would be to arrange a repeat GGT level. The time interval for checking the repeat level would vary depending on clinician, with the range being between one and six months'.*

29. The IPA was asked whether any other tests or examinations ought to have been ordered as a result of the abnormal liver blood tests. He advised:
'*If the patient's LFTs had been repeated at three months, the midpoint of the acceptable range, this would have been on 19 April [2018]. On the balance of probability they would have been abnormal and the next step would have been to arrange a routine abdominal ultrasound scan. The waiting time for this would vary depending on locality, but would typically be one to two months. Based on this it would have been done by 19 June [2018]. Again on the balance of probability this would have shown the pancreatic cancer at which point the patient would have received a two week wait referral to see a specialist. He would probably have been seen near the start of July 2018 in outpatients. The patient was admitted as an emergency on 3 July 2018. So the impact if the patient's LFTs had been repeated may have been that he received a diagnosis a few days earlier, and a hospital admission may, but not definitely, have been avoided. Other than this the patient's outcome would not have been different as the cancer was already metastatic'.*

30. The IPA was asked whether the presenting symptoms of problems with sleep and appetite were properly considered at the consultation on 14 March 2018 in accordance with NG12 1.13.3
The IPA advised:
'The details of what problems [the patient] was having with sleep and appetite is

not recorded. It is assumed he had poor sleep and a reduced appetite. It is not possible to comment further based on the information provided. For example if pain was preventing [the patient] from sleeping then the prescription of Mirtazapine (a sedating antidepressant) would not have been appropriate. If anxiety was keeping [the patient] from sleep then it would have been. NICE NG12 1.13.3 refers to unexplained appetite loss. If it was felt that [the patient's] appetite loss was due to his mental state then it was not unexplained'.

31. The IPA was asked whether the symptoms of chest pain were properly considered by the GP on 27 March 2018. The IPA advised:
'[The patient's] symptoms of chest pain were properly considered on 7 and 27 March 2018. NICE Clinical Knowledge Summaries guidance on Chest pain gives a long list of "Other causes" of chest pain, however the list does not include Pancreatic Cancer.'

32. He also advised:
'On 27 March 2018 the patient had ongoing chest discomfort and an endoscopy was arranged. The GP was right to investigate for gastrointestinal causes of the pain as cardiac and pulmonary causes had been excluded. NICE Clinical Knowledge Summaries guidance on Chest pain includes several causes which could be diagnosed by endoscopy, including peptic ulcer disease, gastro-oesophageal reflux and oesophagitis'.

33. The IPA was asked whether the GP Practice considered the patient's ongoing weight loss, at all or sufficiently, prior to diagnosis of cancer in secondary care. The IPA advised: '*There is no record of the patients' weight. On 27 March 2018 when the patient was referred for an endoscopy "No RFs" is recorded. No RFs probably stands for no red flags. Weight loss would be a red flag so it is assumed this was enquired about, but it is not explicitly recorded'.*

34. The IPA was asked whether the referral for a scope in March 2018 should have been classed as urgent. He advised '*NICE NG 12 includes guidance for when a scope should be requested urgently and these are for when patients having food getting stuck when swallowing, or are aged 55 or over with weight loss and*

upper abdominal pain, reflux or dyspepsia. The patient did not clearly meet these criteria'.

35. The Investigating Officer asked the IPA if sufficient attention was given to the need for pain relief at any time. He advised:
'The patient was prescribed medication for pain, or the dose of his pain relief medication was adjusted at several consultations. This shows that his need for pain relief was being considered… According to the British National Formulary Amitriptyline can be used for abdominal pain or discomfort (in patients who have not responded to laxatives, loperamide or antispasmodics) or neuropathic[15] pain. It is not clear that the patient fitted into either of these categories'.

36. The IPA was asked if on 15 June 2020 GP2 ought to have considered and investigated possible causes for his worsening symptoms other than the hiatus hernia, which was diagnosed following attendance at a private clinic on 24 April 2018. He advised:
'The consultation record is brief, it does not indicate if the patient's pain is worse, has changed or if it is the pain preventing sleep. Good Medical Practice (2013) states: "21. Clinical records should include: a. relevant clinical findings". Having said that the patient did have a large hiatus hernia diagnosed which could have been the cause of his symptoms, and he was waiting for surgical treatment of this. Therefore, his symptoms were explained and there was not a need to consider another cause of his symptoms, based on the brief records'.

37. The Investigating Officer asked the IPA whether the GP Practice's role in the patient's palliative care met good practice standards. He advised:
'The patient did receive good palliative care based on the records. He was seen on 16 July, 23 July and 24 July. He was prescribed appropriate medication and the appropriate paperwork for the Department of Work and Pensions was completed (DS1500 form)'.

[15] Neuropathic pain is a symptom that develops as a result of damage to, or dysfunction of, the nervous system

38. The IPA concluded:

'*The patient did not present with symptoms of pancreatic cancer that should have triggered a two-week referral according to NICE NG12. He presented with chest pain and this was managed as per NICE guidance. The patient did have a raised GGT level which was not acted upon.*

If the patient' raised GGT level had been acted upon he may have received his diagnosis a few days earlier and avoided a hospital admission. There would have been no other change in his outcome. The patient's clinical picture was complicated as the endoscopy arranged appropriately for his symptoms showed a potential cause for his symptoms'.

39. The Investigating Officer asked the IPA if he could identify any learning or service improvements from the complaint. He advised:

'To recognise the possible significance of a raised GGT result, and to follow-up with the patient

and

To actively contact patients with abnormal test results, rather than wait for the patient to make contact'.

The GP Practice's response to the IPA advice

40. GP B was asked to explain why Amitriptyline was prescribed on 15 June 2018. He responded '*On 15th of June Amitriptyline was prescribed as a second line adjuvant analgesic*[16] *in addition to the proton pump inhibitor therapy he was already taking. It was hoped that this might help if there was a neuropathic element to his pain.'*

41. GP A stated that it was her practice at that time to advise patients, when they were getting their blood tests taken that they should telephone the GP Practice

[16] An **adjuvant analgesic** is a medication that is not primarily designed to control pain but can be used for this purpose.

to obtain their results. She stated:

'When the patient's blood results were received, I reviewed them. When reviewing blood tests, this is done in the context of the patient's history, any concerns they have reported and any ongoing investigations. I noted that that there was an elevation in the patient's GGT level, which was part of the liver function test. All other liver blood tests were within the normal range. Elevations in GGT are a common blood abnormality. I made an entry in the patient's notes that the patient should speak to me about his blood test results, but that it was not urgent (same day matter). The intention of this note was that, when the patient telephoned to get his blood test results, the Reception staff would have informed the patient that he should speak to me about his blood tests results but that it was not urgent. As far as I am aware, the patient did not call to get his blood test results and this message was not, therefore, passed to him.'

42. The Practice informed the Investigating Officer that a review was subsequently undertaken of its system for dealing with blood test results. The Practice has introduced a text message system for test results and doctors and receptionists are encouraging patients to sign up for the service. The GP Practice explained: *'If a patient 'signs up' they would receive a text message from the Practice when their blood test results have arrived, to notify them that their blood tests Results have been received by the Practice and what, if any, action they should take.'*

    On receipt of the draft report, the GP Practice confirmed that there had been an increase in take up of the service, with approximately 64% of the patients on the Practice List now signed up.

43. The Practice informed the Investigating Officer of 'further learning' undertaken as a result of this complaint. The Practice held a Cancer Care Review Meeting on 13 March 2019 'where cases of pancreatic cancer were discussed, the NICE guidelines (pancreatic cancer in adults: diagnosis and management) and BSG [17]Guidelines (Guidelines for the management of patients with pancreatic cancer periampullary and ampullary carcinomas[18]) were reviewed and learning

[17] British Society of Gastroenterology

[18] Cancer located at or near the ampulla of Vater, where the bile duct and pancreatic duct join and

points were highlighted.' I have included these learning points in the conclusion to this report.

Analysis and findings

Blood test results

44. The complainant asked why there was no follow up to the bloods report in January 2018 at any time in the following five months. GP A stated, in response to the raised GGT level in his liver function test '*I noted that that there was an elevation in the patient's GGT level, which was part of the liver function test. All other liver blood tests were within the normal range. Elevations in GGT are a common blood abnormality.'* She recorded an action in the notes '*speak to Dr [GP A] not urgent'.* She explained that *'when the patient telephoned to get his blood test results, the Reception staff would have informed the patient that he should speak to me about his blood tests results but that it was not urgent'.* She assumes that the patient did not call to get his blood test results and therefore did not get this message.

45. In the IPA's opinion, normal practice would be to contact the patient and advise him of the raised level and to enquire about alcohol intake as a possible cause.

46. The GP Practice stated *'unfortunately with the high volume of blood test results received daily we are not in a position to contact patients with the results'.* GP A stated that it was her practice at that time to advise patients, when they were getting their blood tests taken that they should telephone the Practice to obtain their results. It is not recorded in the notes that the patient was informed to ring for his results. Therefore, I am not able to determine if GP A conveyed this instruction to the patient on this occasion. I acknowledge that contacting patients about test results was not the normal practice at the GP Practice at that time. However, I accept the IPA advice that it should have been.

47. The IPA also advised that it would be normal practice to arrange a repeat GGT level, within one to six months' time. The IPA further advised that, if the test had

empty into the small intestine.

been repeated, the patient '*would probably have been seen near the start of July 2018 in outpatients'.* He advised that, as the patient was seen on 3 July 2018, when he was admitted as an emergency, there was minimal impact from the failure to arrange a repeat of the test.

48. On balance, I find that it is a failure in care and treatment that the abnormal GGT test result was not communicated to the patient following receipt in January 2018 and at subsequent consultations in March, May and June 2018. I also consider it was a failure that a plan was not put in place to repeat the test. The period of one to six months quoted by the IPA for retesting is wide. However it is possible if the test had been carried out towards the start of the range quoted that the results would have been available as early as March 2018. If the test was repeated towards the end of the range then it could have been July 2018 before the results would have been available. The IPA has advised that in his opinion a repeat test would probably have shown a raised GGT which would have led to a referral for a routine abdominal ultrasound scan which would have led to a two week wait for a referral to see a specialist and receive a diagnosis of pancreatic cancer. It is likely that, even if the repeat test had been at the start of the range and a scan organised, the cancer had metastasised at that stage and the outcome would not have been different. However the patient and his family could have been given this devastating news in a planned manner in a more comfortable setting. Had the patient's raised GGT level been acted upon he may have avoided a hospital admission. He endured the upsetting experience of being admitted to hospital as an emergency on 3 July 2018 where he received his cancer diagnosis. Therefore, I uphold this element of the complaint.

49. I note that the GP Practice has introduced a text message system to inform any patient who signs up for the service that his blood tests results have been received by the Practice and what, if any, action he should take. I welcome this service improvement.

Loss of appetite, Weight loss and chest pain

50. The complainant asked why the symptoms of chest pain and ongoing appetite and weight loss, three stone in the five month period, did not raise 'alarm bells'. I note that the patient attended GP B on 7 March 2018 with chest pain and was sent for an xray, which was normal. There is no record of loss of appetite. He attended again on 14 March 2018 with anxiety and depression and was prescribed medication for sleep and appetite. There is no record of issues with weight.

51. The IPA advised *'On 27 March 2018 the patient had ongoing chest discomfort and an endoscopy was arranged. The GP was right to investigate for gastrointestinal causes of the pain as cardiac and pulmonary causes had been excluded'.* I accept the advice of the IPA that NICE Clinical Knowledge Summaries guidance on Chest pain gives a long list of "Other causes" of chest pain, however this list does not include Pancreatic Cancer. Therefore, I consider that the patient's symptoms of chest pain were properly considered on 7 and 27 March 2018. There is no record of the patient complaining about weight loss at these consultations.

52. NICE guideline NG12 1.13 describes non-site specific 'Symptoms of concern in adults' as follows:
1.13.2 For people with unexplained weight loss, which is a symptom of several cancers including colorectal, gastro-oesophageal, lung, prostate, pancreatic and urological cancer:
    - Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
    - Offer urgent investigation or a suspected cancer pathway referral (for an appointment in 2 weeks).

53. On 27 March 2018, GP B referred the patient for a scope investigation because he was complaining of chest pain. The referral included the comment 'no RFs' (red flags)[19]. GP B responded to the complainant's question about why the

[19] The term Red flag referral indicates that a patient is suspected of having cancer.

symptoms of chest pain and significant ongoing weight loss *'did not raise alarm bells'*. He stated that the gastroscopy, which was subsequently carried out privately, revealed a significant hiatus hernia *'which would have been enough to cause symptoms of chest pain and weight loss on its own. In light of this neither the consultant who saw him, nor I were minded to look for other pathology at that time.'*

54. I note that NG12 1.13.3 states :
For people with unexplained appetite loss, which is a symptom of several cancers including lung, oesophageal, stomach, colorectal, pancreatic, bladder and renal cancer:
- Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- Offer urgent investigation or a suspected cancer pathway referral (for an appointment in 2 weeks).

55. As I have previously noted, there is no record of the patient complaining about weight loss until he attended his private appointment on 24 April 2020. However he did complain about appetite at a consultation on 14 March 2020. He also complained about problems with sleep. I accept the IPA advice that the records do not detail what the problems with sleep and appetite were or what might be causing them. The patient was prescribed a sedating antidepressant, which the IPA advises would be suitable for treating anxiety. Therefore on balance I consider that GP B was attributing his symptoms to an anxiety disorder and therefore did not consider loss of appetite was unexplained. I am not able to determine whether that was an accurate diagnosis at that time. Therefore I cannot determine that it was a failing not to offer urgent investigation. However, I am critical that GP B did make a more detailed note of how he reached his diagnosis. There is no evidence that GP B considered and recorded his consideration of a differential diagnosis for the patient's loss of appetite. I think this is a failing.

56. I note that the endoscopy was carried out privately on 24 April 2018. The IPA was asked whether the referral for a scope in March 2018 should have been

classed as urgent. He advised '*NICE NG 12 includes guidance for when a scope should be requested urgently and these are for when patients having food getting stuck when swallowing or are aged 55 or over with weight loss and upper abdominal pain, reflux or dyspepsia. The patient did not clearly meet these criteria'.* I accept that the patient did not meet this criteria because no evidence of weight loss was noted at that time.

57. The patient was aged 59 and, according to the complainant, had been suffering from reduced appetite and weight loss for some time. The complainant refers to a significant weight loss of three stones over a five-month period. However, as the IPA advised: '*There is no record of the patients' weight. On 27 March 2018, when the patient was referred for an endoscopy "No RFs" is recorded. No RFs probably stands for no red flags'.* However, the GP Practice received a copy of the endoscopy report from the private hospital on 25 April 2018 that indicates 'weight loss'.

58. In addition, as loss of appetite, whatever the cause, must inevitably lead to weight loss, it is a failing that GP B did not attempt to quantify this by recording a baseline weight and forming a plan to monitor further weight loss. As a result, although endoscopy was an appropriate investigation, GP B did not give sufficient consideration to all the relevant factors that would have determined whether the referral should have been urgent or red flagged. It was a failing that his symptoms of loss of appetite were attributed to anxiety and depression and not adequately explored. It was an injustice to the complainant and the patient that they felt obliged to seek a private appointment for the endoscopy. I uphold this element of the complaint.

59. The patient's endoscopy was performed privately on 24 April 2020, therefore there was no significant delay in diagnosis of a hiatus hernia which required surgery. I accept the advice of the IPA that this could have been the cause of his symptoms, including weight loss *'Therefore, his symptoms were explained and there was not a need to consider another cause of his symptoms, based on the brief records'.* At this point the patient's weight loss was no longer 'unexplained' and did not meet the criteria listed in the Nice guideline NG12

1.13.2. for a referral for pancreatic cancer. Therefore, I consider that the consultation with GP B on 15 June 2018 was appropriate, apart from the significant failure to redo the GGT test (I have referred to this in paragraph 47 above).

Pain relief and palliative care

60. The complainant believes that her husband was not prescribed effective pain relief when it was requested.

61. I accept the advice of the IPA that '*the patient was prescribed medication for pain, or the dose of his pain relief medication was adjusted at several consultations'.*

62. However, the IPA described the consultation record on 15 June 2018 as brief and *'does not indicate if [the patient's] pain is worse, has changed or if it is the pain preventing sleep'*.

63. I also note the IPA's advice that it was not clear from the records why Amitriptyline was prescribed, although it can be used for abdominal pain or discomfort. GP2 explained that it was prescribed on 15 June 2018 for additional pain control. GP2 stated *'It was hoped that this might help if there was a neuropathic element to his pain.'* The GP Practice recognised that the patient was in pain and I accept that he was seeking to alleviate that pain. On balance, I consider that the prescription of Amitriptyline was appropriate to address the patient's abdominal pain and discomfort.

64. However, I refer to section 21 of the GMC guidance which states that *'clinical records should include relevant clinical findings'* I find that it was a failing that the clinical records are brief and contain insufficient information about the level of pain the patient was experiencing and the rationale for the prescription of Amitriptyline. This caused the complainant the injustice of distress that her husband's pain may not have been adequately addressed and controlled.

65. GP B explained that *'despite the involvement of the palliative care team, ourselves and the district nursing service, we were unable to achieve adequate pain [control].'* I note that the palliative care team had included morphine sulphate and oramorph in the plan of care for symptom control. I accept the advice of the IPA that *'The patient did receive good palliative care based on the records. He was seen on 16 July, 23 July and 24 July. He was prescribed appropriate medication and the appropriate paperwork for the Department of Work and Pensions was completed (DS1500 form)'.*

CONCLUSION

66. The complainant submitted a complaint to me about the actions of the GP Practice. I investigated the following issue of complaint:

Whether the care and treatment provided to the patient by the GP Practice met good practice standards?

67. The complainant described in her letters of complaint how the suffering and death of her husband seven weeks after diagnosis on 6 July 2018 impacted on the family. She has stated that '*the impact of that trauma and the loss of a husband and father will continue for a considerable time.'* It is a tragedy for the complainant and her family that her husband was taken from them so quickly and at such a young age.

68. In my experience, some cancers only present when already established and as a result the patient's decline can be very rapid. This is a devastating experience for the patient and his family in any circumstances. This distress is amplified when the family has doubts about the care and treatment provided.

69. Paragraph 15 of the GMC Guidance states:
'*You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*

a. *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
b. *promptly provide or arrange suitable advice, investigations or treatment where necessary*
c. *refer a patient to another practitioner when this serves the patient's needs.*

70. I accept the advice of the IPA that '*the patient's clinical picture was complicated as the endoscopy arranged appropriately for his symptoms showed a potential cause for his symptoms'.* This routine referral was in line with the GMC guidance as GP B had not established that there was a weight loss justifying a red flag referral. At the private endoscopy weight loss is recorded for the first time. A hiatus hernia was diagnosed. NG12 1.13.3 applies to people with unexplained appetite loss, which is a symptom of several cancers including, pancreatic cancer. Weight loss was attributed to the hiatus hernia and therefore was not unexplained. Therefore, I accept the IPA advice that the patient did not present with symptoms of pancreatic cancer that should have triggered a two-week referral according to NICE NG12.1.13.2. I accept that the patient's symptoms of chest pain were also managed in accordance with NICE guidance.
71. However, I identified several areas where I consider the GMC standard was not met and this resulted in a failure in care and treatment:

- The patient had a raised GGT level which was not acted upon. He was not advised of the abnormal result and not called back for a re-test.
- The patient's symptoms of loss of appetite and related weight loss were not adequately explored or recorded.
- The clinical records are brief and lacking in detail. In particular, information about the level of pain the patient was experiencing was lacking. The rationale for the prescription of Amitriptyline was absent.

72. The complainant felt that her husband was not being listened to. She states that he suffered from anxiety. She believes that some of his symptoms were mistakenly attributed to that condition and as a consequence were not adequately explored. As a result of the failings I have identified, the complainant

and her husband suffered the injustice of further stress and upset and the loss of opportunity for an earlier diagnosis.

73. On receipt of the draft report, the complainant acknowledged the failings I identified. However she does not agree with the findings summarised at paragraph 70 above stating:
'The patient was 59, had lost weight, upper abdominal (or chest) pain and reflux plus most likely dyspepsia. If the GP had addressed the patient's concerns earlier he would have opted to go privately to have a CT scan in line with the NICE 12.1.13-2 guidance. This would undoubtedly have diagnosed the cancer at an earlier stage'.

74. The complainant maintains that the patient's condition was misdiagnosed as anxiety. In her view the symptoms reported from an early stage indicated that his illness was physical not psychological. She states that as a result of the misdiagnosis, the patient resigned from work. This had significant financial implications for the family due to loss of earnings and pension entitlement.

75. The complainant stated:
'*I welcome the fact that the GP practice has identified a number of learning points from this case, the majority of which address the failings experienced. However, I feel that the practice has not acknowledged full responsibility for these failings nor for the emotional, physical and financial sufferings to the patient and his family. On 16 July 2018, GP B visited my husband at home following his release, albeit short lived, from hospital and on leaving informed him that he was "VIP patient now". While that comment caused a tremendous amount of pain then and still now, it somehow summed up his negligent care of my husband. This has not been addressed at all. In summary, I feel that in addition to an unreserved apology we are entitled to, and would expect, some form of compensation for this distress'.*

76. The question of remedy for any injustice experienced is a matter for my discretion. However, compensation for loss or damages due to negligence is a matter for the Courts. In this case I did not determine that the patient's decision to leave his employment was a consequence of the failings of the GP Practice that I identified. I do not consider, for this reason, that a consolatory payment is appropriate in this case. I therefore recommend a remedy which I considered proportionate to meet the injustice.

RECOMMENDATIONS

77. The Investigating Officer asked the IPA if he could identify any learning or service improvements from the complaint. He advised:
'To recognise the possible significance of a raised GGT result, and to follow-up with the patient.'
and
'To actively contact patients with abnormal test results, rather than wait for the patient to make contact'.

78. I am pleased to note that the GP Practice has introduced a text message system for test results as follows:
'If a patient 'signs up' they would receive a text message from the Practice when their blood test results have arrived, to notify them that their blood tests results have been received by the Practice and what, if any, action they should take.' I welcome the GP Practice's confirmation that uptake of 10% of patients recorded in August 2019 has increased to 64%. I recommend that the GP reviews the Practice's policy/guidance on how those patients who do not sign up to the text messaging system, are informed of abnormal blood test results.

79. I also recommend that the GP Practice carries out an audit of a sample of cases in order to be satisfied that the records of pain relief prescribed are sufficiently detailed to convey the rationale.

80. The GP Practice held an internal Cancer Care Review meeting on 13 March 2019 and listed the following learning points from this case:

- *'Increased awareness of pancreatic cancer as a diagnosis in patients with a family history, smokers, new diabetics, and previous pancreatitis.*
- *High index of suspicion in new presentations of lower chest pain/upper GI patients.*
- *Be more conscious of asking about weight loss and recording a baseline weight and serial weight, in patients with any GI symptoms or patients re-presenting with vague symptoms.*
- *Consider serial blood measurements even if initial blood is normal if patients are representing.*
- *Consider urgent early ultrasound scan referral for GI/chest symptoms that don't fit in any other definite pattern*
- *With respect to end of life care the importance of building a relationship with the patient and family particularly if other family members are not already known.'*

81. I recommend that the GP Practice implements an action plan to incorporate these learning points and those identified by the IPA and to demonstrate how they have been addressed. The GP Practice should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies.

82. I also recommend that the GP Practice issues an apology to the complainant for the injustice caused to her as a result of the failings I have identified. This should be issued within one month of the date of my final report.

83. The GP Practice accepted my findings and recommendations.

Paul McFadden **July 2020**
ACTING OMBUDSMAN

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and 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.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.