Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a GP Practice in County Down

NIPSO Reference: 202001523

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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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Case Reference: 202001523
Listed Authority: A GP Practice in County Down

SUMMARY

I received a complaint regarding the actions of GP Practice in County Down (the Practice). The complaint concerned the care and treatment the Practice provided to the complainant's late mother (the patient) between October 2018 and October 2019. The patient had a previous history of skin cancer. The complainant said the patient attended the Practice on several occasions during this time period, but the complainant said the Practice failed to make an urgent referral to a dermatologist.

Subsequently on 15 October 2019, the patient was diagnosed with Squamous Cell Carcinoma (SCC)[1] of the nose. The complainant questioned whether the patient's care and treatment from the Practice was reasonable and appropriate. The complainant also questioned whether the patient's cancer diagnosis should have been identified earlier, particularly given the patient's medical history.

The investigation examined the details of the complaint, the Practice's response and both national and regional guidelines. I also obtained independent professional advice from a General Practitioner (GP IPA) and a Consultant Oncologist (O IPA).

The investigation found that the care and treatment provided to the patient during appointments between October 2018 and January 2019 was reasonable and appropriate. However, in relation to the patient's subsequent appointments between March 2019 and August 2019, I found that the care and treatment provided to the practice was below the reasonable standards one should expect. As this was the patient's third presentation in March 2019 of the same problem and the condition was worsening, I found this was not good management of the patient's condition. I also identified a service failure with respect to record keeping of consultations.

The investigation established that while the treatment plan administered to the patient would have been the same, with an earlier referral, the opportunity to control

[1] Cutaneous squamous cell carcinoma (SCC) of the skin is the second most common form of skin cancer, characterized by abnormal, accelerated growth of squamous cells.

the cancer better would have been greater as the volume of the disease would have been smaller. I acknowledge the O IPA advised materially, this would have altered the chance of the patient surviving her cancer. While it is not possible to conclude this would have changed the patient's survival prospects there was a loss of opportunity to receive treatment at an earlier stage.

I recommended that the Practice provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also a made further recommendations for the Practice to address to instigate service improvement and to prevent recurrence of the failings identified.

THE COMPLAINT

1. This office received a complaint about the care and treatment the Practice provided between October 2018 and October 2019 to the complainant's late mother (the patient). The complainant believed that despite numerous consultations and despite the patient's history, the Practice did not investigate the patient's concerns regarding a lesion on the right side of her nose appropriately. This resulted in her late diagnosis of squamous cell carcinoma (SCC) in October 2019.

Background

2. The patient attended the Practice on 4 October 2018 and had a consultation with Dr A, complaining of difficulty breathing for three days. The Practice prescribed the patient Prednisolone[2].

3. The patient attended the Practice on 11 January 2019 and spoke to Dr B about a slow growing thickened area on the right side of her nose. Dr B made a routine referral[3] to dermatology at Daisy Hill Hospital.

4. The patient attended the Practice again on 25 January 2019 and Dr B reviewed her. Records for this consultation document the patient's symptoms as Rosacea[4] on the right side of her nose. Dr B prescribed Doxycycline Hyclate[5] and informed the Patient to wait for her dermatology appointment.

5. The patient attended the Practice on 28 March 2019 and Dr C reviewed her. The record documents the patient's symptoms indicate Rhinophyma[6], and the patient was not responding to Doxycycline. Dr C also documented that the

[2] Prednisolone is a steroid medication used to treat certain types of allergies, inflammatory conditions, autoimmune disorders, and cancers. Some of these conditions include eye inflammation and asthma.
[3] A routine or non-urgent referral to see a specialist if your GP feels that waiting a short time is unlikely to cause any harm. The wait may be several months.
[4] Rosacea is a common skin condition that causes blushing or flushing and visible blood vessels in your face. These signs and symptoms may flare up for weeks to months and then go away for a while.
[5] Doxycycline is an antibiotic that is used to treat infections including chest infections, skin infections and conditions such as rosacea.
[6] Rhinophyma is a skin disorder that causes the nose to enlarge and become red, bumpy, and bulbous. It is thought that it may result from untreated, severe rosacea.

patient had a large sebaceous cyst on her nose and was awaiting a dermatology appointment.

6. The patient attended the Practice on 30 April 2019 and Dr C reviewed her. During this consultation, Dr C noted that the Rhinophyma had improved, and the patient was to continue with the current treatment. Dr C also referred the patient to ophthalmology[7].

7. The patient attended the Practice on 23 July 2019 as she had lost her medication. Dr C reviewed her. Dr C noted that her symptoms in relation to Rhinophyma had initially improved but seemed to have plateaued. Again, Dr C noted that the patient was awaiting a dermatology appointment.

8. The patient attended the Practice on 27 August 2019 and Dr D reviewed her. Following this appointment, Dr D made an urgent referral to dermatology. The referral letter discussed the patient's history of SCC and Basal Cell Carcinoma (BCC)[8]. It also documented that the Practice had initially referred the patient to dermatology in January 2019 with a slowly growing thickened area on the right side of her nose, but it had deteriorated greatly.

9. On 30 September 2019, the patient attended Daisy Hill Hospital for a biopsy of her nose.

10. On 15 October 2019, the patient was diagnosed with SCC of the nose. The patient sadly passed away on 1 February 2021.

11. A full chronology can be found at Appendix four to this report.

Issue of complaint

12. I accepted the following issue of complaint for investigation:

[7] Area of medicine that deals with the diagnosis and treatment of eye conditions.
[8] Basal cell carcinoma is a common form of skin cancer.

Whether the care and treatment provided to the patient, by the Practice between October 2018 and October 2019 was reasonable and appropriate and in accordance with relevant standards.

13. This will examine the care and treatment of the patient's lesion and the referrals made to dermatology which will discussed throughout this report.

INVESTIGATION METHODOLOGY

14. 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 handling of the complaint.

Independent Professional Advice Sought

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

    - A General Practitioner (MB, BS, FRCGP, DRCOG) with 37 years' experience of community practice since 1985 (GP IPA); and
    - An Oncologist (MD FRCR FRCP) with over 29 years' experience and who is lead cancer clinician within their employing Trust (O IPA).

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

16. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs 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

17. 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[9]:

- The Principles of Good Administration

18. 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.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, as updated April 2019 (GMC Guidance);
- Department of Health, Cancer Waiting Times, June 2019 (NI Cancer Waiting Times);
- National Institute for Health and Care Excellence (NICE), NICE Guideline 12 – Suspected Cancer: Recognition & Referral guidelines, June 2015 (Nice Guideline G12);
- National Institute for Health and Care Excellence (NICE), Clinical Guideline 27 – Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria, December 2012 (Clinical Guideline 27); and
- National Institute for Health and Care Excellence (NICE), Cancer Service Guideline 8 – Improving outcomes for people with skin tumours including melanoma, May 2010 (Cancer Guideline 8)

19. I also considered Safety Netting to Improve Early Cancer Diagnosis in Primary Care: Development of Consensus Guidelines. Final Report. 4 May 2011. Clare Bankhead et al.

20. I enclose relevant sections of the guidance considered at Appendix three to this report.

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

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

22. 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.

THE INVESTIGATION

Whether the care and treatment provided to the patient, by the Surgery between October 2018 and October 2019 was reasonable and appropriate and in accordance with relevant standards.

Detail of Complaint

23. The complainant said that despite numerous consultations, the Practice did not investigate the patient's concerns regarding a lesion on the right side of her nose appropriately. The complainant said that the Practice did not refer the patient to dermatology with enough urgency, particularly given the patient's history. The complainant believed there was a failure in terms of the course of action the Practice took, including not making the appropriate, urgent referral.

24. The complainant believed that had the Practice treated the patient with greater care and diligence, her chances of survival may have been greater and potentially led to a different outcome. He said the family have unanswered questions.

25. The complainant questioned whether the care and treatment the Practice provided was reasonable and appropriate.

Evidence Considered

Legislation/Policies/Guidance

26. I considered the following policies and guidance:

Cancer Guideline 8 which states:

Squamous cell carcinoma

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of squamous cell carcinoma.

Basal cell carcinoma

Consider routine referral for people if they have a skin lesion that raises the suspicion of a basal cell carcinoma. (Typical features of basal cell carcinoma include: an ulcer with a raised rolled edge; prominent fine blood vessels around a lesion; or a nodule on the skin [particularly pearly or waxy nodules].)

- Red Flag referral (Squamous cell carcinomas), patients:
  with non-healing keratinizing or crusted tumours larger than 1 cm with significant induration on palpation. They are commonly found on the face, scalp or back of the hand with a documented expansion over 8 weeks.

- The GMC Guidance which states:
  Standard 15
  'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
  a. *adequately asses 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*

  Standard 21
  '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*.'

The Practice's response

27. Following the complainant's initial complaint to the Practice on 26 October 2021, the Practice responded in a letter to the complainant on 23 November 2021 and stated -

'Medical staff in the practice met to discuss the case and to reflect on the delayed diagnosis. Following our reflection of this matter, we have all reviewed the guidance and literature regarding squamous cell carcinomas, Rhinophyma, rosacea and other related conditions. We will never forget your mother and it is likely to change our clinical practice in the future… We are very sorry regarding the late diagnosis of your mother's cancer'.

28. In response to this Office's investigation enquiries, the Practice stated that:

'With the benefit of hindsight, we regret that the patient was not referred as a red flag. However, her presentation did not meet the specified referral criteria for that referral pathway. We have reviewed NICAN guidance. We will consider red flag referral for atypical lesions that we are unsure of diagnosis that could be in keeping with a cancer.

The NICAN guidance of referral for a non-healing keratinizing or crusted tumour larger than 1cm with significant induration on palpation. They are commonly found on the face, scalp or back with a documented expansion over 8 weeks. This guidance is not exhaustive and we should consider whether this could this be a cancer with lesions that do not fit this criteria.

It is not Practice Policy to follow up on routine or urgent referrals. We do follow up red flag referrals to ensure that the patient has been seen but we just simply would not have the time or resources to follow up on all referrals sent from the

practice'.

29. In terms of learning and development, the Practice informed this Office it signed up for the NI LES Enhanced Dermatology Photo Triage Pathway. It is hoped that this will significantly speed up the process of identifying and treating moles or skin irregularities. The process involves digital images taken in the GP practice and sent directly to a dermatologist who then decides whether the patient needs further assessment. The Practice also provided this Office of a of NICAN educational meetings attended (Appendix five refers).

30. The Practice also stated it will review all new cancer diagnoses at its monthly practice meetings to ensure patients received a timely referral and to identify any other learning points.

Relevant Practice records

31. I reviewed the relevant Practice records. Relevant extracts from the clinical records are included at Appendix six to this report.

Relevant Independent Professional Advice

32. The full independent professional advice I received is attached in Appendix two to this report.

33. *Appointment 4 October 2018*
In terms of this appointment the GP IPA advised that this appeared to be for the flu vaccine with the practice nurse. The patient had a consultation with Dr A, complaining of difficulty breathing. The GP IPA advised there are no notes of a discussion relating to the patient's growth on her nose or any other issues.

34. *Appointment 11 January 2019*
The GP IPA advised that the patient attended her appointment and presented with a thickened area of skin on the side of the nose. The examining doctor

(Dr B) carried out a visual inspection and gave consideration as to what may be the cause of the growth.

35. Following this examination, a routine referral to dermatology was made for a *'slow growing thickened area on right side of nose'* of approximately nine month's duration. The GP IPA advised that no further action was needed following this appointment and that while the doctor did not make a firm diagnosis or recognise this as a malignancy, there is evidence that they did assess it and give due consideration for the nature of the growth. Given the length of time the growth had been present and that the doctor was *'unsure of its nature',* the doctor's actions were appropriate.

36. *Appointment 25 January 2019*
The GP IPA advised that this appointment was just two weeks after the first and it was the same doctor reviewing the patient. He advised Dr A documented the skin changes were *'red and squidgy'*. The GP IPA advised; *'There is no evidence from the notes or referral that the patient's past history of skin cancer (14-Dec-2015 basal cell carcinoma and 12-Nov-2013 squamous cell carcinoma) had been considered'*.

37. The GP IPA advised, in terms of reassessing the urgency of the referral to dermatology, *'as only two weeks had passed, it would be reasonable that no further action was taken'* on this occasion and the care and treatment provided was appropriate.

38. *Appointment 28 March 2019*
The GP IPA advised that on this occasion, the patient attended the Practice as she was not responding to the medication, doxycycline which had been previously prescribed. In addition to this, the patient presented with *a 'new swelling of the nose, which the GP (almost certainly wrongly), identified as a sebaceous cyst'.*

39. The GP IPA advised this was a different doctor (Dr C) in the Practice examining the patient, thus seeing the growth for the first time. The GP IPA advised '*as*

this was the third presentation of the problem and the situation was worsening, I feel the presumed diagnosis could have been questioned and the problem re-evaluated in more detail, which might have led to a different management approach'.

40. The GP IPA advised that in terms of the documented record of the appointment, *'a more considered record would have included a description of the examination findings which would have provided justification for the new diagnosis of a sebaceous cyst and either supported the existing diagnosis of non-responsive rosacea and/or introduced a differential diagnosis'*.

41. The GP IPA went on to advise *'it is easy to take on trust of a colleague's diagnosis and because what looks like a sebaceous cyst (which is a very common diagnosis) rarely turns out to be anything other of significance.*

42. Prior to the urgent referral being placed on 27 August 2019 by Dr D, Dr C examined the patient a further three times (30 April 2019, 10 June 2019, and 23 July 2019) at the Practice. On two of these occasions the patient presented with further concerns regarding the lesion on her nose. The response and management plan for this was to continue to wait on a dermatology appointment.

43. In response to further IPA enquiries on 12 December 2022, the GP IPA advised that the care provided by Dr C, '*was not good management of the patient's condition and below a reasonable standard of care'*.

44. *Conclusion*
The GP IPA acknowledged that based on the information provided, *'it would appear to me that this was an unusual presentation of a reasonably uncommon cancer. The first GP recognised that they did not know what the precise diagnosis was but was not alarmed by it, did not suspect cancer and therefore made a routine referral. Had the GP thought it looked potentially cancerous, they might have enquired specifically about past skin problems or looked at the patient's problem summary where the past squamous cell cancer was listed'*.

45. The GP IPA advised the Practice did miss opportunities to make appropriate referrals and take a different management approach to the patient's symptoms. The GP IPA advised *'that if the previous diagnosis had been at the front of their minds, they might have treated this with greater suspicion and been more forceful in their management. This is acknowledged in the practice's significant analysis of 7 November 2019'*.

46. The GP IPA advised there were missed opportunities to take a different and more forceful action plan and the management during the patient's appointment on 28 March 2019 was below a reasonable standard of care. The GP IPA however, advised that overall, based on the consultations they see '*no evidence that the overall care was deficient'*.

47. In addition to the GP IPA, I also obtained advice from an Oncologist (O IPA). He reviewed the patient's medical notes both prior to and following the patient's diagnosis. The O IPA advised that with an earlier referral, the treatment administered would have still been the same. The O IPA advised however that the chance of controlling the cancer would have been better with an earlier referral as there would have been a smaller volume of the disease. The O IPA advised that *'the delay in diagnosis has thus materially altered the chances of this lady surviving her cancer'.*

48. Both GP IPA and O IPA in their learning and service improvements, recognise that the Practice has instituted several learning and service improvements.

Analysis and Findings

49. I carefully considered this complaint in terms of both IPAs' advice and guidance as well as the Practice's response to the complaint. In addition to this, I examined the relevant clinical records from the Practice and examined the relevant policies and guidance.

50. The complainant and his family have suffered the loss of their mother and their pain and upset has been made worse by the worry that the care and treatment

the Practice provided may not have been to an acceptable standard. I acknowledge their concerns that the diagnosis of SCC could also have been identified earlier than was the case. I considered the GP consultations below:

51. *11 January 2019*

I note that there are no records of discussions regarding concerns about a growth on the patient's nose until 11 January 2019 consultation, when Dr B made a routine referral to dermatology. I accept the GP IPA's advice that following an examination, Dr B gave thought as to what may be the cause of the growth, considering potential possibilities and reasoning for making the routine referral. There is no evidence however that in Dr B's considerations, Dr B considered the patient's history. While the patient's medical history is outlined in the referral form to dermatology, this information is prepopulated when creating the referral.

52. *25 January 2019*

I note only two weeks had passed from the previous appointment. The same doctor (Dr B) reviewed the patient and therefore would have been familiar with the patient's symptoms. During this appointment there are no notes or a record of a discussion about the patient's history of skin cancer. I consider that in the interim, treatment for a presumed diagnosis of rosacea had begun while the patient waited for their dermatology appointment.

53. I accept the GP IPA's advice that given the short time that had passed from the last appointment, it would be reasonable to continue to wait for dermatology appointment.

54. *28 March 2019*

I note this was the third presentation with the same concern. I note the GP IPA advised as this was the patient's third presentation with the same concern and she was not responding to the medication, *'a different management approach should have been considered'*. In addition to this, the patient's symptoms were deteriorating.

55. I accept the GP IPA's comments that Dr C could have questioned the presumed diagnosis and re-evaluated the patient's symptoms. While Dr C was seeing the patient for the first time, this was the patient's third presentation with the same concerns. In addition to this, there are no notes to show whether Dr C considered the patient's history of both BCC and SCC.

56. It is my view that many of us will be examined by different GP's each time we attend a doctor's appointment and reiterating what the GP IPA advised, had patient records for all appointments included a more detailed description of examinations, this may have helped to promote or encourage thoughts of other diagnoses.

57. I accept the GP IPA's advice that on this occasion, this was not good management of the patient's condition and below a reasonable standard of care. I consider that at this point, there was a failing in the care and treatment provided to the patient.

58. *30 April, 10 June, and 23 July 2019*
Dr C examined the patient again on 30 April 2019, 10 June 2019, and 23 July 2019. During appointments on 30 April 2019 and 23 July 2019, the patient presented with the same symptoms and concerns regarding the growth on her nose. During each of these appointments, records reference Rhinophyma[10], but no notes of other potential causes or diagnoses recorded. The routine referral to dermatology was not escalated, given this was the patient's fourth and fifth presentation with the same concern.

59. Standard 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 asses 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*

[10] A skin condition affecting the nose in which the skin is thickened and the sebaceous (oil) glands are enlarged.

b. promptly provide or arrange suitable advice, investigations or treatment where necessary

60. As point 'a' of standard 15 highlights, a patient's history must be taken into account. Despite the number of appointments that the patient attended, it was not until an urgent referral was made on 27 August 2019 that the patient's history of BCC and SCC was specifically mentioned in the body of the referral to dermatology.

61. Point *'b'* of standard 15 states that investigations must be promptly provided and arranged. As this was an ongoing concern over an eight month period, I accept the GP IPA advice that an urgent referral should have been made, despite records stating patients symptoms had improved. To reiterate the GP IPA's comments; *this was 'below a reasonable standard of care'*.

62. Following the patient's appointment on 27 August 2019, an urgent referral to dermatology was placed. A biopsy was carried out on 30 September 2019 and the patient was diagnosed with SCC on 15 October 2019.

63. In relation to the O IPA's advice, I accept his advice that with an earlier and more urgent referral, the chance of controlling the cancer would have been greater because the volume of the disease would have been smaller. The delay in diagnosis therefore *'materially altered the chance the patient had of surviving her cancer'*. I note the patient had an appointment with dermatology on 30 September 2019 following the urgent referral on 27 August 2019. Had an urgent referral been placed on 28 March 2019, I consider the patient would have likely been seen by 11 April 2019.

64. The GP IPA advised that in terms of the documented record of the appointment on 28 March 2019, that a more considered record may have introduced a differential diagnosis. The GP IPA also advised if the patient's history had been stated in any of the consultations, it may have prompted or encouraged other GPs reviewing the patient to consider the possibility of cancer.

65. I refer to the GMC Guidance which states: '*Clinical records should include: the decisions made and actions agreed, and who is making the decisions and agreeing the actions'.* It is my view, the clinical records should accurately record the details of any decisions made by clinicians in order to ensure clarity for those clinicians who will later rely on the information recorded in these records. I am satisfied that these actions in relation to record keeping fall below the required standard and constitute a service failure. However, I am unable to determine if the patient suffered detriment because of these record keeping failures.

66. I consider the failure to provide an earlier and more urgent referral to be a failure in the patient's care and treatment.

Injustice

67. In terms of the overall care and treatment provided by the Practice, I considered whether the failings identified caused an injustice to the patient, complainant, and wider family.

68. I consider the patient suffered the injustice of loss of opportunity to have an earlier assessment of her condition and to optimise possible treatment options. This is because she was not referred to dermatology with greater urgency. I acknowledge and reiterate the O IPA's advice when he stated the delay in the patient's diagnosis '*materially altered the chance the patient had of surviving her cancer'* due to the volume of cancer present when she was treated. Nevertheless, I cannot conclude whether this delay would have made an overall difference to the outcome for the patient.

69. I also consider the complainant sustained the injustice of uncertainty and upset. This is because he will always question if the outcome would have been different if the patient had been reviewed at an earlier stage.

CONCLUSION

70. I received a complaint about the care and treatment provided to the patient when she attended the Practice due to concerns about a growth on her nose. The complainant said his mother attended the Practice on multiple occasions with the same concerns which were worsening and causing her a great deal of distress. Despite these appointments and the patient's history, the Practice did not make an urgent referral until August 2019.

71. I upheld the complaint for the reasons outlined in this report. Specifically, I accept that there was due consideration and thought given for a routine referral made in January 2019. However, I consider there was a failure to make an urgent referral to dermatology sooner, from the patient's appointment in March 2019. Given the patient's history of skin cancer along with the presenting symptoms which were worsening, more consideration and a more forceful management approach should have been taken. This failure caused the patient the loss of opportunity to be seen at an earlier time and the loss of opportunity to have appropriate treatment sooner.
72. It also caused the complainant and wider family a significant amount of upset and uncertainty. It has in ways, delayed the grieving process for the family due to the unanswered questions about their mother's care.

73. I offer through this report my condolences to the complainant and their family for the loss of their mother.

Recommendations

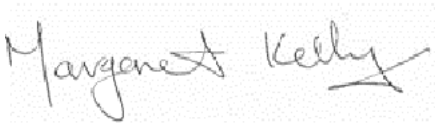
74. I recommend the Practice provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

75. I acknowledge the Practice's Significant Event Analysis Form (15 October 2019) in which it highlights that it should have considered SCC. It further outlines the Practice has reviewed NICAN guidance. The Practice staff has

attended NICAN primary care education sessions on recognition of cancer and referral which have been occurring monthly from October 2021. I welcome this learning.

76. I recommend all GPs involved in the patient's care have the opportunity to consider the findings in this report and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in the future.

77. I recommend the Practice implements an action plan to incorporate this recommendation and should provide me with an update within three month of the date of my final report and to include any additional training completed by staff. The Practice should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).



NAME Margaret Kelly
Ombudsman **March 2023**

Appendix 1

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.