Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Hillsborough Medical Practice

NIPSO Reference: 202000828

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration
Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202000828

Listed Authority: Hillsborough Medical Practice

SUMMARY

This complaint is about care and treatment the complainant's late father (the patient) received at Hillsborough Medical Practice (the Practice) between 21 October 2014 and 29 April 2020. The patient had a history of depression since 2004. He sadly died by suicide in late April 2020.

The patient attended the Practice intermittently between 2009 and 2014 and received treatment for depression. The patient did not have any interaction with the Practice between 2014 and 2020. It continued to prescribe his antidepressant medication during this time. The complainant raised concerns that the Practice did not review the patient's mental health or medication between October 2014 and January 2020.

Following a consultation in January 2020, the Practice changed the patient's medication. The complainant was concerned the Practice did not refer the patient to secondary care[1] for further treatment following this appointment. While the Practice arranged a follow up appointment with the patient in February 2020, he failed to attend. The complainant raised concerns that the Practice did not review the patient's new medication or follow up on his non-attendance at the review appointment.

The investigation considered information from the complainant, the Practice, its relevant records, and relevant local and national guidance. I also sought advice from an independent General Practitioner (GP) with experience in community practice. The investigation found the Practice provided appropriate care and treatment to the patient between October 2014 and 20 January 2020 regarding a review of the patient's mental health. However, it identified that in accordance with relevant guidance, the Practice ought to have reviewed the medication during that period. I considered this a failure in care and treatment.

[1] Secondary care is any care an individual receives for their illness or condition that occurs beyond the primary care (such as their GP) they have already received.

The investigation also found that in accordance with relevant guidance, the Practice ought to have referred the patient for further treatment following his relapse in January 2020. I again considered this a failure in care and treatment. Furthermore, the investigation found the Practice did not act in accordance with relevant guidance as it continued to prescribe the patient his new medication without undertaking a review. I considered this a failure in care and treatment. While the investigation identified the Practice did not follow up with the patient when he did not attend his review appointment in February 2020, the investigation did not find it had an obligation to do so.

I considered the failings identified caused the patient uncertainty, and the loss of opportunity for him to have a review of his medication and to access further treatment. I also considered the failings identified caused the complainant concern and uncertainty. I recommended the Practice apologise to the complainant for the failures identified. I also recommended actions for the Practice to take to prevent the failures from recurring.

The Practice accepted my recommendations.

THE COMPLAINT

1. This complaint is about the care and treatment the complainant's late father (the patient) received at Hillsborough Medical Practice (the Practice) between 21 October 2014 and 29 April 2020.

Background

2. The patient joined the Practice in October 2007. He had a history of mental health issues from 2004 and was prescribed antidepressant medication from this time. Following a referral from the Practice, the patient attended a Cognitive Behavioural Therapy (CBT)[2] session in June 2009. He did not attend any further CBT sessions. Between 2013 and 2020 the Practice prescribed the patient Citalopram[3] tablets to treat his depression.

3. On 20 January 2020 the patient's wife telephoned the Practice raising concerns about the patient's mental health. The Practice arranged a face-to-face appointment for the following day. On 21 January 2020 the patient attended the appointment with a General Practitioner (GP). The patient described his symptoms, and the Practice changed his medication from Citalopram to Mirtazapine[4]. The Practice arranged a follow up appointment for 11 February 2020. The patient did not attend this appointment.

4. On 24 March 2020 the patient's wife had a telephone discussion with a GP about her own treatment. She also discussed with the GP the patient's mental health. The Practice and the patient's wife have different recollections of this conversation[5]. The Practice did not record this conversation in the patient's notes. The patient nor his family made any further contact with the Practice regarding the patient until after his death. On 29 April 2020 the patient died by suicide.

Issue of complaint

5. I accepted the following issues of complaint for investigation:

[2] A talking therapy which is commonly used to treat anxiety and depression.
[3] A type of antidepressant often used to treat low mood depression.
[4] An antidepressant medicine used to treat depression and sometimes anxiety.
[5] Details of this will be addressed later in this report.

Issue 1: Whether the Practice provided appropriate care and treatment to the patient between 21 October 2014 and 20 January 2020.

Issue 2: Whether the Practice provided appropriate care and treatment to the patient between 21 January and 29 April 2020.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from a registered GP Independent Professional Advisor (IPA), MB FRCGP DRCOG, who has over 36 years' experience since qualifying as a GP in 1986.

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

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

Relevant Standards and Guidance

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

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

   - The Principles of Good Administration

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

- The Principles of Good Complaints Handling

10. 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 National Institute for Health and Care Excellence's 'Depression in adults: recognition and management' Clinical Guideline 90, Published 28 October 2009 (NICE CG90);
    - The National Institute for Health and Care Excellence's 'Common mental health problems: identification and pathways to care' Clinical Guideline 123, Published 25 May 2011 (NICE CG123);
    - The British National Formulary, March 2014 to September 2020 (BNF);
    - Health and Social Care Northern Ireland's Regional Mental Health Care Pathway, October 2014 (HSCNI Pathway);
    - The General Medical Council's Good practice in prescribing and managing medicines and devices, January 2013 (GMC's Guidance on Prescribing Medicines);
    - The British Medical Association's General Medical Services contract Quality and Outcomes Framework, April 2019 (the BMA's QOF); and
    - The Department of Health, Social Services and Public Safety's Quality of Outcomes Framework (QOF) Depression Indicator Set, January 2014 (the Department's QOF).

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

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

12. 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. Both the complainant and the Practice accepted my findings.

THE INVESTIGATION

Issue 1: Whether the Practice provided appropriate care and treatment to the patient between 21 October 2014 and 20 January 2020.
In particular this will consider:
a. A review of the patient's mental health; and
b. A review of the patient's medication.

Detail of Complaint

13. The complainant raised concerns that the Practice did not effectively manage the patient's 34 year history of depression. The complainant said the Practice treated the patient using prescribed medication only and did not refer him to a psychiatrist or to a specialist mental health team. She raised concerns that the Practice viewed the patient's illness as '*chronicity*' and treated each episode '*as the previous one'*.

14. The complainant explained the patient was on the same medication regime '*for some time'*. She said the Practice's care of the patient '*fell short of the standards that he deserved and warranted'*. She also explained the '*trauma, sadness and loss'* the patient's family have experienced since his sudden death.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following guidance:
    - NICE CG90;
    - The BNF;
    - GMC Guidance for Prescribing Medicines;
    - The BMA's QOF; and
    - The Department's QOF.

The Practice's response to investigation enquiries

Review of the patient's mental health

16. The Practice referred to the patient being on a '*depression register*'. It said, '*It would not necessarily be common practice to conduct a formal annual review process for all patients on a practice's depression register*.'

17. The Practice said that the patient presented to the surgery on seven occasions between 2008 and 2014 due to his mental health symptoms. The Practice said that on each occasion the patient consulted specifically in relation to his mental health '*there is a clearly documented consultation note with both a formal review period scheduled and/or the option for the patient to contact the practice at any time if he felt his mental health was deteriorating*.'

18. The Practice said it referred the patient for CBT in 2009. It said the patient attended one CBT session but did not attend any further sessions available to him.

19. The Practice said that on 20 January 2020 the patient's wife telephoned the surgery as she had concerns regarding the patient's mental health. The patient's wife expressed to the Practice that the patient was prone to bouts of depression and that his mood had slipped over the previous two weeks. The patient's wife made the Practice aware that the patient's brother had died by suicide six months previously and that this was a source of concern for her. The Practice arranged a face-to-face appointment for the patient to attend with a GP the following day (21 January 2020).

20. The Practice explained that prior to the contact in January 2020, the patient last attended the surgery for a depression related appointment on 22 March 2012. However, the Practice said that during a consultation on 21 October 2014 for a different matter, the patient confirmed he had no thoughts of self-harm or general suicidal intention. The Practice said that the patient attended the surgery on many occasions for appointments that were non-mental health related.

Review of the patient's medication

21. The Practice explained it prescribed the patient antidepressant medication for four to five month periods of each year between 2008 and 2013. The patient then *'settled'* on Citalopram in 2013 continuing on this consistently until 2020. The Practice said, *'Given the chronicity of [the patient's] low mood and anxiety and the positive response he had shown to this medication, it was felt that this was an appropriate course of action.*'

22. The Practice explained it was routine to prescribe only limited quantities of any antidepressant medication at any one time. It said the patient was prescribed no more than two months' supply of Citalopram at any one time. The Practice said this offered a further opportunity for an intermittent review of the prescribed medication. The Practice further said each review period offered to the patient satisfied the review criteria for depression in the BMA's QOF. This specified a review period '*not earlier than 10 days and not later than 56 days after the date of diagnosis*.'

Relevant Practice records

23. I enclose a chronology outlining the relevant records at Appendix four to this report.

Relevant Independent Professional Advice

Review of the patient's mental health

24. The IPA advised that the patient presented with recurrent anxiety and depression. He advised, *'The patient consulted when things were bad but then they got better and normal life resumed.'*

25. The IPA referred to NICE CG90[7] Section 1.9.1.6, which states, '*People with depression on long-term maintenance treatment should be regularly re-evaluated with frequency of contact determined by comorbid conditions, risk factors for relapse and severity and frequency of episodes of depression*.' The IPA advised this section would have applied to the patient but considered there

[7] NICE guidance is evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders. CG90 related to depression in adults.

is an ‘*imprecision of the words*’ about re-evaluating and frequency of contact. The IPA addressed this issue as summarised below.

26. The IPA said that the Practice ‘*clearly reviewed’* the patient’s depression on the 12 occasions when he presented with depressive symptoms between 2007 and 2020. The IPA advised that the fact the patient consulted so sporadically, and that he was not seen between 2015 and 2020 regarding his mental health, defines the ‘*wave*’ his GP described. He advised that there were occasions his symptoms overwhelmed him, but he quickly got back to normal.

27. The IPA advised that up until October 2014 the patient was seen on a number of occasions[8] for reasons other than his mental health. Therefore, there was ‘*plenty of opportunity for him to discuss his mood had he wanted to.*’ The IPA advised that the fact the patient did not do so suggests that his condition was ‘*stable*.’

28. The IPA further advised that there is ‘*no obligation’* for a Practice to offer a depression annual review.

29. The IPA referred to the BMA’s QOF[9]. The IPA advised ‘*this requires that patients should be reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis*.’ The IPA said it makes no reference to subsequent reviews.

30. In reference to the Department’s QOF[10], the IPA advised it requires ‘*a review not earlier than 10 days after and not later than 35 days after the date of diagnosis*.’

Review of the patient’s medication

31. The IPA advised that the patient was *‘settled on Citalopram’* between 2013 and 2020. The IPA advised that this is a widely prescribed and appropriate

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[8] Practice records show the patient attended on at least 17 occasions.
[9] Data from NHS England. It is a system for the performance management and payment of GPs in the UK National Health Service (NHS).
[10] Relevant to Northern Ireland.

medication which is commonplace for patients to stay on for many years *'because it works for them.'*

32. The IPA referred to NICE CG90 Section 1.9.1.5. It states, '*When deciding whether to continue maintenance treatment beyond 2 years, re-evaluate with the person with depression, taking into account age, comorbid conditions and other risk factors*.' The IPA advised this section '*would apply as guidance when deciding <u>whether or not</u> to continue maintenance treatment beyond 2 years*.'

33. The IPA advised that the patient was not on any medication that required specific monitoring[11]. However, the IPA advised it is good practice to review medication on a regular basis and the medication '*should have been reviewed in that time*.' The IPA said he saw no evidence that this was done by the Practice. The IPA further advised that it would have been good practice for a face-to-face review of medication to have been carried out but he did not believe '*it was harmful not to do so.*' The IPA advised '*it was reasonable to continue medication that was working and did not require monitoring*.'

34. In relation to the impact on the patient, the IPA concluded that *'…it appears that the patient's condition and medication were not reviewed but I do not believe that this had any impact on his wellbeing.'* The IPA advised there was '*every reason to think that [the patient's] anxiety/depression was well controlled by regular doses of Citalopram*.' The IPA added *'although it would have been good practice to review this, there was no indication to change a medication which appeared to be working well for him*.' On providing further advice the IPA continued '*I found no evidence that on balance the care offered by the practice fell below that standard of reasonableness.'*

Analysis and Findings

Review of the patient's mental health

35. The complainant said that the Practice did not effectively manage the patient's depression. Based on my review of the Practice's records, I am satisfied the

[11] Citalopram | Drugs | BNF | NICE [shows no specific monitoring requirements]

Practice did not undertake a specific review of the patient's mental health between 21 October 2014 and 20 January 2020.

36. The Practice said the patient attended the surgery on seven occasions between 2008 and 2014 reporting mental health symptoms. It said that on each occasion, the GP clearly documented with a formal review scheduled and/or the option for the patient to contact the practice if his mental health deteriorated. The Practice said that prior to January 2020, the patient last attended for an appointment relating to his mental health on 22 March 2012. However, it explained that a GP spoke to the patient about his mental health during a consultation relating to other matters in October 2014.

37. I note there is no requirement for Practices to undertake annual mental health reviews for patients. However, Section 1.9.1.6 of NICE CG90 states, '*People with depression on long-term maintenance treatment should be regularly re-evaluated, with frequency of contact determined by: comorbid conditions; risk factors for relapse; severity; and frequency of episodes of depression'*. The IPA advised this would apply in the patient's case. However, he also advised there was an '*imprecision of the words*' about re-evaluating and frequency of contact.

38. I considered this further. NICE CG90 states the frequency of contact is dependent on '…*risk factors for relapse, severity, and frequency of episodes of depression'*. The Practice's records evidence that the patient did not report a relapse between 2014 and 2020. They also do not evidence that the patient reported an increase in the severity of episodes, or in their frequency. I note the IPA advised this indicated the patient's condition was '*stable*' during this time. I accept his advice. While I appreciate the complainant's concern, especially given the absence of any review, I do not consider there was an obligation on the Practice to proactively review the patient's mental health during that period.

39. Furthermore, I do not consider there was any requirement for the Practice to refer the patient for any further intervention (such as a referral to mental health services) during that time.

40. Based on the evidence available to me, I am satisfied the Practice provided appropriate care and treatment to the patient between 21 October 2014 and 20 January 2020 in relation to the reviewing the patient's mental health.

41. I do not uphold this element of the complaint.

Review of the patient's medication

42. I note the Practice did not review the patient's medication with him between 21 October 2014 and 20 January 2020. The Practice said the patient responded positively and '*settled*' on Citalopram from 2013 to 2020. It also said it prescribed the patient no more than two months' supply of Citalopram on each occasion. The Practice explained this provided it the opportunity to review the medication intermittently.

43. I recognise that Citalopram itself does not require specific monitoring[12]. However, I refer to the GMC Guidance for Prescribing Medicines. It states, '*Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review, taking account of the patients' needs and any risks arising from the* medicines'. I also refer to Section 1.9.1.5 of NICE CG90. It states, '*When deciding whether to continue maintenance treatment beyond 2 years, re-evaluate with the person with depression, [my emphasis] taking into account age, comorbid conditions and other risk factors*.'

44. I note the IPA's advice that based on this guidance, it was good practice for the Practice to undertake a face-to-face review of the medication with the patient between 2014 and 2020. I accept his advice. While I acknowledge the Practice said it reviewed the medication intermittently, there is no evidence it did so with the patient [my emphasis]. I consider that in accordance with the GMC Guidance for Prescribing Medicines and NICE CG90, the Practice had an obligation to review the continuation of the medication with the patient after the initial two year period. I uphold this element of the complaint.

[12] The BNF.

45. I note the IPA's advice that the absence of a review between 2014 and 2020 did not impact the patient's wellbeing. However, I consider it led to a missed opportunity for the patient to have a review of his medication. I also consider it would have caused the patient uncertainty, as attending such reviews would likely have reassured him that he was receiving appropriate treatment.

Issue 2: Whether the Practice provided appropriate care and treatment to the patient between 21 January and 29 April 2020.
In particular this will consider:

a. A referral to Adult Mental Health Services;
b. A review of the patient's medication; and
c. The Practice's follow up to the patient's 'did not attend' appointment on 11 February 2020.

Detail of Complaint

A referral to Adult Mental Health Services

46. The complainant said the Practice did not appropriately manage signs of relapse in the patient. In particular the complainant raises the following issues:
   - The Practice did not carry out a '*mental state'* assessment for the patient.
   - The Practice overlooked and dismissed subtle cues and identifiable risks due to viewing the patient's recent presentations as '*chronicity*'. This resulted in the Practice '*undertreating*' the patient when he described '*key indicators'* of a significant mood disorder.
   - The Practice missed an opportunity to reassess and view the patient through a '*fresh lens of primary care'* and potentially refer to Adult Mental Health Services.
   - The Practice missed a number of opportunities to identify the patient's suicidal intent.
   - The Practice did not adequately consider that the patient's brother had died by suicide in April 2019 as a key risk factor.

47. The complainant said the Practice failed to escalate concerns the patient's wife raised during a telephone discussion on 24 March 2020. The complainant explained the patient's wife told the GP that the patient '*is the worst he has ever been, he is like a patient you would see sitting on the side of a bed in Purdysburn*[13]*.*' The complainant said she found it '*unbelievable*' there was no further exploration from the GP and that this was a '*missed opportunity'* to enquire about the patient's wellbeing.

48. The complainant considers that the Practice overlooked her mother's knowledge of the patient as her concerns were not acted upon or given the required attention. The complainant feels that the patient's wife was left to manage the patient's declining mental health on her own.

49. The complainant said the Practice told her the patient's presentation was considered a '*standard wave of depression*' due to his history of same. She also said the Practice informed her that the patient '*did not reach the worrisome stage to make a referral to mental health services*.' Adding, '*that in all the chronicity*[14] *there should have been a consideration it was undertreated and only a partial job not a full job done*.'

A review of the patient's medication (between 21 January and 29 April 2020)

50. The complainant said the Practice provided a '*poor standard of care to the patient'*. She said the Practice did not '*effectively or professionally'* review the patient's change of antidepressant medication from Citalopram to Mirtazapine in January 2020. She believed this increased the risk to the patient.

The patient's 'did not attend' appointment

51. The Practice arranged a follow up appointment with the patient for 11 February 2020. The patient did not attend the review appointment. The complainant said the Practice did not attempt to arrange a further appointment with the patient. The complainant said the Practice did not adequately consider this a '*key risk factor*.'

[13] A mental hospital in Belfast which at a time was intended to be a lunatic asylum.
[14] An illness persisting for a long term or constantly recurring: Often contrasted with acute.

Evidence Considered

Legislation/Policies/Guidance

52. I considered the following guidance:
    - NICE CG90 Section 1.1.4.6
    - NICE CG123;
    - GMC Guidance for Prescribing Medicines; and
    - HSCNI Pathway Section 5.2.

The Practice's response to investigation enquiries

53. The Practice explained that in the months prior to the patient's death there were two interactions regarding his mental health. The first on 20 January 2020 when the patient's wife requested an appointment as she was concerned for the patient's mental health. The second was on 21 January 2020 when the patient attended the arranged face to face appointment with a Practice GP.

54. The Practice said that mental state assessments form part of a GP's assessment of a patient attending with mental health problems. This would have formed an '*integral part'* of the each of the patient's consultations over the years including during his attendance on 21 January 2020. One type of such assessment was the PHQ-9, which the Practice referred to as the tool used to initially diagnose the patient. The Practice said this remains the most commonly used tool for screening for depression in primary care[15].

55. The Practice said that during the appointment with the GP on 21 January 2020 the patient *'admitted'* his mood had dipped and he felt like a failure. It explained he was suffering from '*somatic symptoms'*[16] such as poor energy, sleep and concentration. In particular, the patient said his anxiety had risen over the previous six months. The GP discussed management options and agreed a change of medication with the patient.

[15] Accuracy of Patient Health Questionnaire-9 (PHQ-9) for screening to detect major depression: individual participant data meta-analysis | The BMJ

[16] Any mental disorder that manifests as physical symptoms.

56. The Practice further explained that at the time of the assessment on 21 January 2020 the patient exhibited '*biological features of depression*.' He did not express thoughts of self-harm and was very open to a change of medication. The Practice said that had it been aware that the medication changes had not achieved their expected improvement, a referral to the mental health team would have been the next step in management.

57. The Practice explained the criteria for escalating a patient to mental health services includes;
    - Failure to respond to appropriate medication;
    - Worsening condition despite medication;
    - Patient requests an escalation; and
    - Patient deemed an acute risk[17] to themselves.

    The Practice considered the patient '*was not deemed [an]acute risk to himself and then Did Not Attend the follow up assessment*.'

58. In its response to my office, the Practice referred to a letter it sent to the Coroner's Office regarding the telephone call on 24 March 2020. In the letter, dated 27 May 2020, the Practice explained that the patient's wife said the patient had made '*little progress'*. However, it was a pattern she had seen for many years on and off, and she trusted his mood would begin to lift soon.

59. The Practice said it discussed with the patient the risk of symptoms worsening following any change of antidepressant. It also said it communicated information and advice about contacting the Practice, and the Practice records support this.

Relevant Practice records

The Practice's response to the complainant

60. The Practice's response documented, '*On reviewing the records, it does not appear that a number of opportunities were missed to identify [the patient's] suicidal intent*.' The Practice said it took immediate action by arranging a face-

[17] Arising suddenly and manifesting intense severity.

to-face mental state assessment with the patient following concerns his wife raised in January 2020. The Practice also referred to the telephone discussion with the patient's wife on 24 March 2020. The Practice said it took this opportunity to enquire about the patient. It said the GP did not record the conversation in the patient's notes, as the GP was in the patient's wife's record at the time of the call.

61. The Practice further documented that its recollection of the discussion was not clear. Further, it did not recall being advised that the patient was the '*worst he had ever been*' or the reference to '*Purdysburn*'. The Practice said it assured the complainant that if any GP in the Practice appreciated the severity of the patient's condition, it would have arranged a same-day appointment for a face-to-face mental health assessment. The Practice apologised '*if opportunities to ascertain [the patient's] state of mind were missed*.'

62. The Practice's response to the complainant documented it discussed with the patient options to manage his symptoms during the appointment on 21 January 2020. The Practice said given the period of time the patient was on his current medication, and the marked sleep and anxiety issues, it agreed with the patient to '*wean off Citalopram'* and commence Mirtazapine 15mg at night, increasing to 30mg if tolerated after two weeks. The Practice also prescribed Pregabalin[18] to ease the anxiety symptoms more acutely.

The SEA

63. The Practice undertook a Significant Event Audit[19] (SEA) dated 11 June 2020 in relation to the patient. The SEA documents the Practice '*did well'* as it made appropriate pharmacological changes in line with the presenting symptoms. Also, because it made a routine follow up appointment prior to the patient leaving, with worsening advice given. The SEA also documents what could have been done differently; the Practice issued a prescription which was not on repeat without challenge on several occasions. It was accepted that this is not normal practice. It documents that a repeat prescribing protocol will address

[18] A medication used to treat anxiety.
[19] A technique to reflect on and learn from individual cases to improve quality of care overall.

this issue: '*Observance of rules for issuing of non-repeat medication must be adhered to*.'

64. In relation to the patient's failure to attend the appointment in February 2020, the SEA documented, '*It was not felt appropriate nor good use of resources to contact each patient by telephone to discuss their reason for not attending but accepted that on occasions clinicians may wish to do so*.'

Relevant Independent Professional Advice

A referral to Adult Mental Health Services

65. The IPA advised the patient had recurrent anxiety/depression. The IPA advised in January 2020 the patient '*suffered another relapse*' and '*the symptoms described on 21 January 2020 were consistent with those presented in previous years*.'

66. The IPA advised that the Practice did not refer the patient to Adult Mental Health Services between 21 January and 29 April 2020. The IPA further advised that the Practice was '*entirely reasonable*' managing the patient's '*problem*' without referral to Adult Mental Health Services based on the consultation with the patient on 21 January 2020. He added, '*On the contrary, it would be poor and inappropriate practice to refer every relapse of depression to secondary care*.'

67. The IPA advised that the Practice's '*record of assessment*[20]' on 21 January 2020 did not refer to self-harm. The IPA referred to NICE guidance[21] which states, '*Always ask people with depression directly about suicidal ideation and intent*.' The IPA advised the '*NICE guidance suggests therefore that the question should have been asked*.' The IPA further advised '*I would note however that this was three months before the patient's death in April, so I would not consider his suicide to be a consequence of not asking this question in January*.'

[20] Refers to the GP consultation notes.
[21] The IPA referred to NICE NG222 published in June 2022. The applicable guidance at the time was NICE CG90 1.1.4.6. The guidance remains the same.

68. The IPA advised a PHQ-9 assessment '*is validated to monitor the severity of depression and response to treatment...not now widely used in routine general practice*.' The IPA said the Practice administered a PHQ-9 assessment prior to referring the patient for CBT in 2009. The IPA advised that a number of symptoms the patient described on 21 January 2020 appeared in a PHQ-9 assessment questionnaire. The IPA advised that on 21 January 2020 the Practice '*without doing a PHQ-9 the GP noted "all classical depressive somatic symptoms" and took action accordingly*.' The IPA added, the Practice had '*no contractual or clinical reason*' to use a scoring assessment. The IPA advised the Practice '*reached a clinical diagnosis on the basis of the story in the time-honoured way*.' I enclose a template PHQ-9 Assessment at Appendix five to this report.

69. NICE CG90 1.9.1.8 states, '*People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment)…should be offered one of the following psychological interventions:*

- *Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment*
- *Mindfulness based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression*.'

The IPA advised that NICE CG90 1.9.1.8 related to the prevention of a relapse of depression '*not to the treatment of relapse'*.

70. The IPA referred to the Practice's criteria to make a mental health referral.[22] He explained the '*problem*' is that the only contact between 21 January 2020 and the patient's suicide three months later, was an unrecorded conversation during the patient's wife's consultation for a different matter; the detail of which is unclear. Therefore, there is '*no evidence that any of the above four criteria necessarily applied*.'

[22] Outlined in Paragraph 57 of this report.

71. The IPA advised that '*Depression is a* <u>*risk factor*</u> *for suicide*.' The IPA considered that the patient '*clearly had some suicidal risk factors – male sex, family history, depression – but he had no past history of suicidal behaviour, had not expressed suicidal ideation and was well supported by his family*.' The IPA added that risk factors '*may raise the GP's level of concern and/or lower the threshold for action but then don't really increase the management options*.' The IPA considered that the Practice was not required to take any additional steps in light of the patient's risk factors.

72. NICE CG123 recommends a stepped care model to organise the provision of services and to help people with common mental health disorders and healthcare professionals to choose the most effective interventions. In line with NICE, Northern Ireland has a Regional Mental Health Care Pathway. The IPA advised he is aware of similar stepped pathways but he '*would not consider that they provide any useful guidance to a clinician*.' The IPA advised he saw no mention that the Practice used a stepped care model, adding he saw '*no reason why they should (or how it would have affected the care of the patient)*.'

A review of the patient's medication (between 21 January and 29 April 2020)

73. The IPA advised that between 21 January and 29 April 2020 the Practice prescribed the patient Mirtazapine 15-30mg and Pregabalin 50mg. The IPA advised that switching from one antidepressant to another is not uncommon either because the first is not working or because of side effects. The IPA further advised '*Mirtazapine is an entirely reasonable choice, widely used in the elderly and effective against anxiety*.'

74. The IPA advised the Practice's SEA documents it repeated the prescription three times without review since first prescribed. The IPA said that as an '*acute*' prescription[23] the Practice should have reviewed it on each of these occasions. The IPA advised this showed '*a breakdown in their systems but did not stop [the patient] receiving care*.'

[23] Medicines that have been issued but not added to the repeat prescription records. This is usually new medication issued for a trial period and will normally require a review visit with a GP prior to being added to repeat prescription records.

75. The IPA said the Practice's decision to change the medication, and the initial plan to increase the dose and review progress, was appropriate.

The patient's 'did not attend' appointment

76. The IPA said it was '*not unusual'* for Practices not to follow up on '*do not attend appointments'*. He referred to the Practice's response to our enquiries, and its reference to '*winter pressures...as well as the Covid pandemic'*. The IPA also referred to the Practice's explanation in its SEA report (paragraph 64 of this report).

77. The IPA advised it was difficult to *'know what the outcome would have been had [the patient] attended for a follow up appointment on 11 February (more than two months before his death) and there were no subsequent contacts with the Practice*.'

78. The IPA advised the Practice was not required to refer the patient to Adult Mental Health Services '*solely on the basis that [the patient] did not attend for a follow up appointment.'*

Analysis and Findings

A referral to Adult Mental Health Services

79. The complainant said the Practice did not appropriately manage signs of relapse in the patient. She explained it failed to consider onward referral to Adult Mental Health Services to manage the patient's presentation more robustly and safely. Based on my review of the Practice's records, I am satisfied it did not refer the patient to Adult Mental Health Services between 21 January and 29 April 2020.

80. I note the patient last attended the Practice on 21 January 2020. The Practice records evidence that the patient described depressive symptoms and a discussion took place regarding a change of antidepressant medication including a planned medication review and SOS[24] in the interim. I am satisfied

[24] Advice to patient to contact Practice if deteriorates.

that the Practice carried out a '*mental state assessment*[25]' during the consultation on 21 January 2020.

81. I note both the Practice and IPA said that PHQ-9 questionnaires are a type of mental health assessment. The Practice records evidence that it carried out a PHQ-9 assessment for the patient previously. The records do not evidence the Practice undertook such an assessment on 21 January 2020. I note the IPA advised the Practice had '*no contractual or clinical reason*' to do this. The IPA further advised that a number of symptoms the patient described on 21 January 2020 appeared in a PHQ-9 assessment questionnaire. He advised that the Practice '*without doing a PHQ-9 the GP noted "all classical depressive somatic symptoms" and took action accordingly*.'

82. While I accept his advice, I refer to NICE CG90 1.1.4.6, which states, '*Always ask people with depression directly about suicidal ideation and intent*.' The Practice records do not evidence it asked the patient this question on 21 January 2020. The IPA advised that the guidance suggests the Practice should have asked the patient this question. I reviewed the PHQ-9 Questionnaire noting questions relevant to the symptoms the patient described on 21 January 2020, namely feeling depressed, trouble sleeping, feeling tired, trouble concentrating, and feeling like a failure. I consider that these symptoms, and specifically someone expressing that they felt like a '*failure*', could be considered as a '*subtle cue*'[26]. I consider this should have prompted the Practice to directly ask the patient about suicidal ideation and intent in accordance with the NICE CG90. I consider this a failure in the Practice's care and treatment of the patient.

83. The Practice's response to the complainant refers to the 'chronicity' of the patient's symptoms and the complainant was told, '*that in all the chronicity there should have been a consideration it was undertreated and only a partial job not a full job done*.' The Practice further explained that the patient '*did not reach the worrisome stage to make a referral to mental health services*.' Given the Practice's use of this term on at least two occasions, I consider it likely the

[25] The IPA refers to consultations for depression/anxiety qualifying as mental health 'assessments.'
[26] Referred to by the complainant.

patient's presentations were seen as chronic. The Practice records said that '*the patient was not deemed an acute*[27] *risk to himself*.' I consider the Practice view of the patient may have influenced a decision not to refer to secondary health care such as Mental Health Services.

84. The IPA advised '*the symptoms described on 21 January 2020 were consistent with those presented in previous years*' and the patient '*suffered another relapse*.' NICE CG90 1.9.1.8 states, '*People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment)…should be offered one of the following psychological interventions:*

    - *Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment*
    - *Mindfulness based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression*.'

    The IPA advised that NICE CG90 1.9.1.8 related to the prevention of a relapse of depression '*not to the treatment of relapse'*.

85. I considered this further. The Practice's records evidence that the patient reported a relapse on 21 January 2020 during a time when the patient was taking Citalopram. While I acknowledge the IPA's advice that NICE CG90 1.9.1.8 related to the prevention of a relapse of depression, the advice that it does not relate to the '*treatment of relapse*' is not consistent with the wording of the guidance. The guidance expressly states that it includes '*those who have relapsed despite antidepressant treatment*.' I consider that the patient falls under this definition. I consider on that basis, in accordance with the guidance, that the patient should have been '*offered*' CBT as the relevant psychological intervention option. The Practice records show no evidence that CBT was offered to the patient on 21 January 2020.

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[27] Acute care is a branch of secondary health care where a patient receives active but short-term treatment for a severe injury or episode of illness. In medical terms care for acute health conditions is the opposite from chronic care or longer-term care.

86. Based on the evidence available to me, I consider that the Practice did not appropriately manage the patient's relapse in accordance with NICE CG90. I consider this a failure in the patient's care and treatment and I uphold this element of the complaint. I note the IPA's advice that '*this was three months before the patient's death in April, so I would not consider his suicide to be a consequence of not asking this question in January.*' However, I consider the failure to do so led to a loss of opportunity for the Practice to refer the patient for further treatment. I also consider the failing led the complainant to experience concern and uncertainty regarding the absence of further treatment for her father following his relapse.

A review of the patient's medication (between 21 January and 29 April 2020)

87. The complainant said the Practice did not '*effectively or professionally'* review the patient's change of antidepressant medication from Citalopram to Mirtazapine in January 2020. She believed this increased the risk to the patient.

88. Standard 56 of the GMC's Guidance on Prescribing Medicines states that doctors should '*agree with the patient…how their condition will be managed, including a date for review'*. On review of the records, I note the Practice arranged a medication review with the patient for 11 February 2020, three weeks after the patient started the new antidepressant, Mirtazapine. I acknowledge the patient did not attend this appointment. However, the Practice continued to issue the medication in the absence of a review.

89. Standard 51 of the same guidance states, '*Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review, taking account of the patients' needs and any risks arising from the medicines'*. I note the IPA's advice that as an '*acute*' prescription[28] the Practice should have reviewed the medication on each occasion. However, the records do not evidence that the Practice did so. The

[28] Medicines that have been issued but not added to the repeat prescription records. This is usually new medication issued for a trial period and will normally require a review visit with a GP prior to being added to repeat prescription records.

IPA advised this showed '*a breakdown in their systems but did not stop [the patient] receiving care*.' I accept his advice in that the Practice continued to treat the patient with medication. However, I consider that in continuing to prescribe the medication without a review, the Practice did not act in accordance with GMC's Guidance on Prescribing Medicines. I am satisfied this represents a failure in the Practice's care and treatment of the patient, and I uphold this element of the complaint. I consider this failure led to the patient missing the opportunity for a review of his medication. I also consider it would have caused the patient uncertainty, as a review would likely have reassured him that he was receiving appropriate treatment. Furthermore, I consider the failing led the complainant to experience concern and uncertainty regarding her father's treatment.

The patient's 'did not attend' appointment

90. The complainant was concerned that the Practice did not contact the patient following his non-attendance at his follow-up appointment on 11 February 2020. She said this was a further missed opportunity to assess the patient's mental health.

91. I appreciate this is a common occurrence for most GP Practices. Given the number of non-attendances the Practice had in February 2020, I consider it was likely impractical for the Practice to contact all patients who did not attend. I also note the IPA's advice that there is no requirement for Practices to do so. I recognise the complainant's concern given the very difficult circumstances at that time. However, I do not consider there was an obligation on the Practice to contact the patient following his non-attendance. Therefore, I do not uphold this element of the complaint.

92. The complainant said her mother spoke with the Practice in March 2020 and the GP enquired about the patient's health. The records provide evidence of the call. However, it does not document the conversation regarding the patient. I note the conflicting views surrounding the content of the conversation during this call. However, in the absence of any contemporaneous evidence I am unable to determine what was discussed, or whether the Practice ought to have

taken action based on the information provided. The Practice explained it did not take a note of the conversation as it was in the patient's wife's record at the time. However, I do not consider this would have prevented it from making a retrospective note after exiting the record. I would ask the Practice to ensure it documents such conversations in future.

CONCLUSION

93. I received a complaint about the care and treatment the complainant's late father (the patient) received between 21 October 2014 and 29 April 2020. I upheld elements of the complaint for the reasons outlined in this report. I consider this a failure in the Practice's care and treatment of the patient.

94. I consider the failings identified led to the patient's loss of opportunity for a review and to access further treatment, and uncertainty. I also consider the failings led the complainant to experience concern and uncertainty regarding the treatment of her father.

95. I wish to recognise the pain, trauma, and loss the complainant and her family felt during this incredibly difficult time. I offer through this report my condolences to the complainant and her family for the loss of their husband and father. My review has identified a number of areas where patient care could have been improved.

Recommendations

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

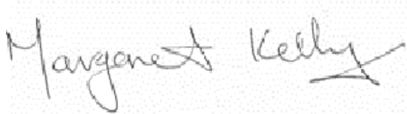
97. I also recommend that the Practice shares the findings of this report with relevant staff and asks them to reflect on the failures identified (within **one month** of the date of this report).

98. I further recommend the Practice provides training to relevant staff within **three months** of the date of my final report. It should provide evidence to confirm completion of the training and that it used the findings in this report as a training tool for staff. The training should incorporate:

   i. The importance of referring patients who suffer a relapse of depression for appropriate treatment in accordance with the revised NICE Guidance (NG222); and
   ii. The obligation to review medication with the patient in accordance with NICE NG222 and the GMC Guidance for Prescribing Medicines.

99. I note the SEA report recommended the Practice revise its repeat prescribing protocol. I further recommend the Practice provide me with an update on the implementation of this recommendation within **three months** of the date of this report.

100. The Practice accepted my findings and recommendations.



Margaret Kelly
Ombudsman **December 2022**

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.