Scottish Parliament Region: Glasgow

Case 200801102: A Medical Practice, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment; diagnosis

Overview

The complainant (Ms C) raised a number of concerns about the diagnosis of diabetes and aftercare offered to her by her GP practice (the Practice).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice failed to follow recognised procedures in reaching a diagnosis that Ms C was suffering from diabetes (*upheld*);

(b) the Practice did not arrange for appropriate follow-up for Ms C following the diagnosis of diabetes (*upheld*);

(c) the Practice's communication with Ms C regarding her diagnosis and test results was inadequate (*upheld*); and

(d) the Practice's response to Ms C's complaint was inappropriate *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice:

(i) put in place a protocol to ensure that diabetes is diagnosed in line with recognised practices;

(ii) put in place a protocol to ensure that newly diagnosed diabetics receive appropriate follow-up care;

(iii) take steps to ensure they deal with complaints in line with the NHS complaints procedure; and

(iv) write to Ms C with an apology for the failures identified in this report, including those relating to complaint handling and the content of the letter sent to Ms C on 14 July 2008.

The Practice have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant (Ms C) complained to the Ombudsman's office about the way her diabetes had been diagnosed by her GP practice (the Practice) and the manner in which she had been informed of the result of the test which confirmed the diagnosis. She also stated her belief that she was not offered appropriate follow-up care and that the way the Practice handled her complaint was inappropriate.

2. The complaints from Ms C which I have investigated are that:

(a) the Practice failed to follow recognised procedures in reaching a diagnosis that Ms C was suffering from diabetes;

(b) the Practice did not arrange for appropriate follow-up for Ms C following the diagnosis of diabetes;

(c) the Practice's communication with Ms C regarding her diagnosis and test results was inadequate; and

(d) the Practice's response to Ms C's complaint was inappropriate.

Investigation

3. In considering Ms C's complaint I obtained a copy of Ms C's clinical records. I also wrote to the Practice and sought their comments on Ms C's complaint; along with requesting a copy of their protocol and procedure for the diagnosis and continuing management of diabetes; protocol for how information on test results should be passed to patients; and complaints handling procedures. I also sought the advice of the Ombudsman's independent medical adviser (the Adviser) and, where appropriate, have quoted from his advice in this report.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Practice were given an opportunity to comment on a draft of this report.

(a) The Practice failed to follow recognised procedures in reaching a diagnosis that Ms C was suffering from diabetes

5. The Adviser explained that diabetes is a disease that comes on slowly and that there is a state of pre-diabetes, called impaired glucose tolerance, before diabetes itself becomes manifest. This is defined by various blood sugar levels. In an individual fasting the figures are those set out below:

below 5.5	Normal
5.5 - 7.0	Impaired glucose tolerance (pre diabetes)
above 7.0	Diabetes

6. In making her complaint to the Ombudsman's office, Ms C stated her belief that the Practice did not follow the correct procedure in diagnosing her with diabetes. She asked why she was diagnosed as being diabetic on the first occasion that her fasting blood sugar level was above 7.0. Having been tested initially, she believed that there should have been a further test carried out before the diagnosis was given. The first test was carried out in June 2007. Ms C indicated that she asked a GP at the Practice (GP 1) about the possibility of a second test being done and was initially told that some doctors carry out a second test and others do not.

7. The Practice's response to this aspect of Ms C's complaint was contained in a letter of 24 June 2008 sent to Ms C by GP 1. GP 1 stated that:

> 'Current SIGN [Scottish Intercollegiate Guidelines Network] guidelines advise that if a patient is asymptomatic a single fasting glucose over 7 is diagnostic. If asymptomatic a repeat is required to confirm the diagnosis. However, in view of your previous history of impaired fasting glucose and elevated BMI I think the correct diagnosis was made …'

8. This element of GP 1's letter is somewhat confusing, in that it refers to an asymptomatic patient being able to be diagnosed after a single test but also requiring to be tested twice before being diagnosed. In fact the SIGN guidance states that 'for the asymptomatic individual, at least one additional plasma glucose with a value in the diabetic range above is essential to diagnose diabetes accurately …'. The Adviser commented that one of the reasons for asking for two blood sugars was to make sure there had been no mistakes on the part of the clinician or patient in doing the test. On reviewing the draft of this report the Practice acknowledged the mistake and stated that the first use of the word 'asymptomatic' should read 'symptomatic'.

9. In commenting on Ms C's complaint and having considered Ms C's medical records and background correspondence relevant to the complaint, the Adviser stated that Ms C appeared to have a number of factors which would put her at risk from diabetes but did not have symptoms. Ms C was, therefore, asymptomatic and national guidance states that, in her circumstances, an additional test should have been carried out.

10. On the same date as GP 1 wrote to Ms C, 24 June 2008, another GP at the Practice (GP 2) also wrote to Ms C about the same complaint. He explained that GP 1 had addressed some of the aspects of her complaint but, as the senior partner and also the doctor who runs the Diabetic Clinic, he had also been asked to look at the case. He explained that:

> 'A lot of your concerns seem to be made regarding the exact diagnosis of whether you are diabetic or not. Currently in the medical world there is some debate about what level of glucose we should call 'diabetes' and what we should call 'pre-diabetes'. Currently by American criteria you would have been Diabetic about three years ago. In Britain the fasting level of 7 is taken as diabetes but America are moving to a diagnosis of 6 …'.

11. In response to my letter of enquiry asking for their comments on this aspect of Ms C's complaint, GP 1 conceded that the diagnosis being made after a single test was not consistent with SIGN guidelines but indicated that, given Ms C's medical history, the correct diagnosis was made.

12. In a separate letter to me, GP 2 elaborated. GP 2 explained that he was the partner in the Practice who ran the Diabetic Clinic and had attended a postgraduate course on diabetes in general practice. GP 2 explained that 'Diabetes is diagnosed on a combination of fasting and random blood sugar readings, family history, BMI and other risk factors such as cholesterol and hypertension.'

13. He continued, 'If a person has a strong family history of diabetes (which [Ms C] has) is hypertensive with a high BMI and high cholesterol (which also applies) and has failed to lose weight with basic dietary advice (which applies) and then has a fasting glucose of 8.0, then we would diagnose diabetes (which we did)'.

14. Having reviewed Ms C's clinical records and the correspondence between Ms C and the Practice, the Adviser commented that the Practice required to develop a protocol for the diagnosis of diabetes. I made an enquiry of the Practice to establish if they had any protocols referring to the diagnosis of diabetes in place at the time of the events being complained about.

15. In response GP 2 wrote that 'As it is only myself and [GP 1] who diagnose diabetes, we do not need a protocol. Diabetes is diagnosed on a combination of fasting and random blood sugar readings, family history, BMI and other risk factors such as cholesterol and hypertension'.

16. Having read GP 2's response to my letter of enquiry, the Adviser stated that he was not of the view that the number of doctors present in a practice should affect the requirement for protocols to be in place. He stated that, in his opinion, the initial management of Ms C's diabetes was chaotic. The Adviser stated that GP 1 needed to learn more about the diagnosis and early management of the disease and that the Practice needed to put in place a protocol to avoid a recurrence.

17. In his view, both the medical notes and the letters from the Practice suggested some misunderstanding of the management of diabetes. Additionally, he suggested that generally other members of the practice team, not just GPs, may benefit from protocols being in place when managing patients. In the Adviser's view, writing and reviewing a protocol is, in itself, an educational process which can benefit all members of a practice team.

(a) Conclusion

18. Ms C believes that her diabetes should not have been diagnosed without a second blood sugar test being taken to confirm the finding of the first. Her view is backed up by the SIGN guidance and supported by the Adviser.

19. In paragraph 11, GP 1 indicated that she accepted that the way the diagnosis had been made was not in accordance with the SIGN guidance but stated that, in her view, the correct diagnosis was made. This view was endorsed by GP 2 in his written comments to the Ombudsman's office.

20. The fact that the correct diagnosis was reached may or may not be the case but that is not the complaint made by Ms C. Her complaint relates to the way the diagnosis was made and I am clear from the evidence, and as GP 1 accepted, that the diagnosis was not made in accordance with nationally recognised procedures. I, therefore, uphold this aspect of Ms C's complaint.

(a) Recommendation

21. I recommend that the Practice put in place a protocol to ensure that diabetes is diagnosed in line with recognised practices.

(b) The Practice did not arrange for appropriate follow-up care for Ms C following the diagnosis of diabetes

22. Ms C complained to the Ombudsman's office that the follow-up care she received, having been diagnosed with diabetes, was insufficient in that it amounted only to a single meeting with a dietician who informed her that she had been referred too early. Ms C alleged that, thereafter, she did not receive appropriate communication from the Practice with regard to follow-up care.

23. In making her complaint initially to the Practice Ms C commented that, other than being told by the Practice that 'we usually start off first with the Dietician', she was given no other information about diabetes by the Practice.

24. In GP 1's initial response to Ms C's letter of complaint, GP 1 stated that she was unable to comment on this aspect of Ms C's complaint as the practice nurse was currently on holiday but that she understood that GP 2 would address the complaint more fully.

25. GP 2 did not do so. He did make reference to Ms C's weight and offered advice that if it were not possible for Ms C to lose weight by watching her diet then the Practice would seek to treat her cholesterol level, blood pressure and potential for vascular problems with medication. He also stated that:

> 'As you will be attending our Diabetic Clinic you will have some more detailed advice from our Diabetic Dietician and our Practice Nurse, [Name deleted], will be happy to check your weight on a regular basis to help you obtain a target where your diabetes may not be a problem.'

26. In my written enquiry of the Practice I asked for the Practice's comments on Ms C's allegation and for a copy of any protocol used by the Practice to ensure that patients received the appropriate follow-up care following the diagnosis of diabetes.

27. In response, GP 2 stated that he did not feel that the Practice had problems either diagnosing or managing diabetes.

28. Separately, GP 1 wrote to me with the following information on the follow-up care received by Ms C. She wrote:

> 'The diagnosis was added to the patient's record on the 27th June 2007. She was seen at the Diabetic Clinic on the 6th July 2007… [where Ms C

saw a podiatrist] but unfortunately, her records contain no information regarding advice she was given by the Dietician. As the Dietician involved is no longer involved in our Diabetic Clinic, I am unable to establish what advice she was given. She was seen by our Practice Nurse at that time, Nurse recalls not giving usual advice as [Ms C said] she was not diabetic.'

29. Ms C then returned to the Practice Nurse the following month for further tests.

30. Having considered Ms C's clinical notes and the Practice's correspondence with both Ms C and the Ombudsman's office, the Adviser stated that:

'New diabetics need a lot of care. They need education about the disease, their diet and lifestyle and the need for follow-up. Some practices use dedicated nurses, others a doctor perhaps with a special interest and some refer the patient to the diabetic clinic in hospital.'

The Adviser felt that the Practice should develop and write a protocol which would allow the Practice to ensure that diabetic services provided were done competently.

31. Having received and reviewed the draft of this report, GP1 wrote to me explaining that her letter of 11 June 2009 was based:

'on the patient's records. The Practice Manager has now reviewed the computer records which show the diagnosis was added in November 2007 with the date of onset 29/6/07 when fasting glucose result received. This would explain why she did not receive the usual care at the diabetic clinic in July 2007 as the diagnosis was still in doubt.'

GP 1's letter also stated that, having reviewed the situation, Ms C was not seen by the Practice Nurse at the diabetic clinic on 6 July 2007. I verified this with Ms C.

32. On receipt of this information, I asked the Adviser to consider the Practice's comments to ascertain whether the comments altered his earlier view on Ms C's complaint. He advised that his clinical advice did not change and, specifically in relation to the diagnosis being entered on the computer records, he advised that, while it may not have been written in a summary sheet until

November 2007, GP 1's handwritten note dated 29 June 2007 stated 'fasting glucose 8.0 = diabetic'.

(b) Conclusion

33. Ms C complained that she did not receive appropriate care from the Practice following her diagnosis with diabetes and that she was told by the dietician that she had been referred too early. The Practice stated that the dietician in question no longer works for the practice and that they are, therefore, unable to verify the veracity of Ms C's statement in this regard. It is clear, however, that Ms C felt the care she received was inadequate. Notwithstanding the fact that Ms C and the Adviser are of the view that a diagnosis should have been confirmed with a second test (see paragraph 18), the fact that Ms C had been diagnosed should, in my view, have resulted in her receiving the full range of advice and follow-up care which the Practice had in place. The fact that the Practice entered the diagnosis of diabetes onto Ms C's computerised records five months after the written clinical records identified that she had been diagnosed as having diabetes does not negate the fact that, having been diagnosed, Ms C deserved to receive appropriate follow-up care from the Practice.

34. The Practice has measures in place to provide follow-up care to patients diagnosed with diabetes. Despite the Practice diagnosing Ms C, she was not offered adequate support. I accept the view of the Adviser that the Practice going through the process of developing and writing a protocol for the provision of such follow-up care would ensure it was delivered effectively in circumstances such as Ms C's. This did not happen in Ms C's case and, for that reason, I uphold this aspect of Ms C's complaint.

(b) Recommendation

35. I recommend the Practice put in place a protocol to ensure that newly diagnosed diabetics receive appropriate follow-up care.

(c) The Practice's communication with Ms C regarding her diagnosis and test results was inadequate

36. Ms C also complained to the Ombudsman's office that the Practice's communication with her regarding her diagnosis and test results was inadequate. In part, this aspect of her complaint stems from the complaint relating to her not receiving the appropriate follow-up care for an individual diagnosed with diabetes. This was addressed in paragraphs 22 to 35. There

are, however, additional elements to Ms C's complaint, which include that she was given the diagnosis that she was diabetic in a telephone call and that she felt this was inappropriate; that Ms C was later told results were normal; and that she was not informed that a hospital consultant had not agreed to carry out a glucose tolerance test.

37. I asked the Adviser to comment on the question of how Ms C was informed of the test results. He stated that, understandably, patients often like getting their results as early as possible and that, in itself, giving results out over the telephone is not inappropriate. Some practices have policies which dictate that only doctors can give results over the telephone; though this can often delay the news to the patient. Others allow non-GP staff to give all results but, although this is much quicker, there are often extra questions and instructions which reception staff are unable to give. According to the Adviser, most practices have a system which allows reception staff to give out normal results and only the doctor to give out abnormal results.

38. In November 2007 Ms C had another blood sugar test carried out and stated that she was told by the practice receptionist that the results were 'normal'. She took from this that her diagnosis was that she was not diabetic but became aware at a later date that what had been meant was that the results were normal for someone with diabetes.

39. A further event that Ms C cited in making her complaint to the Ombudsman's office was that, in December 2007, while visiting the Practice for a prescription, she met GP 1 in the corridor and was informed that the Practice would arrange for her to have a glucose tolerance test carried out at Gartnavel Hospital. This did not transpire. When Ms C raised the matter with GP 1 in April 2008, GP 1 began to quote from a letter sent to the Practice by a specialist at Gartnavel Hospital explaining why a further test should not be carried out. The letter was dated 16 January 2008 but neither its existence nor content had been previously intimated to Ms C. As a consequence, prior to her meeting with GP 1, she had been unaware that a further test would not be carried out.

40. In a written letter to the Ombudsman's office, GP 1 indicated that she was of the view that she had apologised for the Practice's oversight in not informing Ms C that a further test would not be done at the hospital but that, as there is no record of an apology being given in the Practice's notes of the consultation she could not be adamant that she had done so. GP 1 indicated she had then

thought that GP 2 had apologised to Ms C for this in writing but having looked at his letter again, on being contacted by the Ombudsman's office, she was now aware that this was not the case. In fact the letter from GP 2 gave a reason – '… we get about a hundred letters a week and oversights can happen' – but no apology. In her letter to me GP 1 indicated that she was willing now to convey her sincere apologies to Ms C. She also advised that the Practice had subsequently moved to a new administration system which would make the possibility of such a recurrence less likely.

(c) Conclusion

41. Ms C complained that the results were given to her over the telephone. The Adviser stated that this is not, in itself, unusual and for that reason I have no criticism of the Practice in this regard.

42. Ms C also complained, however, about other elements of the Practice's communication with her. I sought the view of the Adviser on the confusion of her being informed that her results were 'normal' rather than 'normal for someone with diabetes'; and being informed in the Practice corridor that a further glucose tolerance test would be carried out only to find out some five months later that in fact the Practice had been informed three months previously that a further test would not be carried out, but had not informed her of this.

43. In the view of the Adviser, the way the Practice communicated with Ms C was characteristic of the initial management of her diabetes which he found 'chaotic'. Given this, and considering the events relating to Ms C's concerns about the Practice's communication, I uphold her complaint in this regard.

44. Given that the Practice has a new administration system in place to track correspondence, the Ombudsman does not have any procedural changes to recommend. However, there is a general recommendation at the end of this report that the Practice write to Ms C, apologising in full for the failings identified in this report.

(d) The Practice's response to Ms C's complaint was inappropriate

45. Ms C wrote to the Practice outlining her complaint in a letter dated 21 June 2008. The Practice responded in detail on the issues raised by Ms C in her complaint in two separate letters dated 24 June 2008 from GP 1 and GP 2. Ms C replied to GPs 1 and 2 on 27 June commenting on their letters. On

11 July 2008 Ms C wrote again indicating that she had not heard from the Practice in response to her letters of 27 June 2008 and stating that she wished a reply. In this letter Ms C wrote that, if any further discussion was required, then she hoped that it could be done face-to-face and not in writing.

46. On 14 July 2008 GP 2 did reply. His letter was as follows:

> 'As [GP 1] and [the Practice Manager] are on holiday just now and I am up to my eyeballs running the practice on my own your complaint is awaiting review after the summer when we may just have some time to look at it again. If you feel ill contact us sooner …'

47. On 23 July GP 1 wrote to Ms C. She stated that she agreed with Ms C that further discussion of the complaint should be done during a consultation.

48. NHS guidance on complaints states that a complaint made against a GP practice should be responded to within ten working days and that this should include information on the complainant's right to then take their complaint to the Ombudsman's office. The guidance specifically states that the final letter sent by a practice in response to a complaint should, amongst other information, include information on the complainant's right to escalate their complaint to the Ombudsman's office. None of the written correspondence sent to Ms C directly informed her of her right to contact the Ombudsman's office although she had, on first indicating that she wished to make a complaint, been given a copy of the Practice's complaints procedure, which did indicate that she had the right to escalate her complaint if she was unhappy with the Practice's handling of her complaint or the outcome.

(d) Conclusion

49. In my view the letter sent to Ms C on 14 July 2008 was inappropriate in its brevity, tone and content. The reason given for not giving a fuller response at the time – that the Practice was being run solely by GP 2 due to annual leave – perhaps explains the brevity of the correspondence but does not excuse it. It was not unreasonable for Ms C to expect a more expansive response. The internal annual leave arrangements of the Practice are not a valid reason why she did not receive one more quickly than she did.

50. Setting aside the content of the letter of 14 July 2008 there is also the general question of how the Practice responded to Ms C's complaint. On first indicating to the Practice that she wished to submit a complaint, Ms C was

handed a copy of the Practice's complaints process based on the standard NHS procedure. This included timescales of ten working days to respond to the complaint. As indicated in paragraph 45, by responding to Ms C on 24 June 2008 the Practice met these timescales. The Practice's letters of 24 June 2008 did not specifically then refer Ms C to the Ombudsman's office and, as she remained aggrieved, instead of escalating her complaint away from the Practice to the Ombudsman she wrote back to the Practice with her further comments.

51. The Practice should again have informed Ms C of her right to escalate her complaint to the Ombudsman's office. By not indicating the next step for her in pursuing her complaint Ms C then wrote back again. After GP 2 sent the holding letter on 14 July 2008 (see paragraph 46) GP 1 wrote again on 23 July 2008, noting the comments made by Ms C in her letter and agreeing with the request that any further discussion about the complaint should be carried out face-to-face. GP 1 suggested that this could happen during a consultation. This was a course of action that Ms C had suggested. I am of the view, however, that the exchanges of correspondence and subsequent delay in the Practice responding to Ms C was caused by the Practice not indicating clearly when their consideration of Ms C's complaint was complete and then clearly signposting her to the next step of pursuing her complaint if she remained aggrieved.

52. It is for this reason and the inappropriate content of the letter of 14 July 2008 that I uphold this aspect of Ms C's complaint.

(d) Recommendation

53. I recommend the Practice take steps to ensure they deal with complaints in line with the NHS complaints procedure.

General recommendation

54. I recommend that the Practice write to Ms C with an apology for the failures identified in this report, including those relating to complaint handling and the content of the letter sent to Ms C on 14 July 2008.

55. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Practice	Ms C's GP practice
The Adviser	The Ombudsman's independent medical adviser
GP 1	GP at the Practice
SIGN	Scottish Intercollegiate Guidelines Network; part of NHS Quality Improvement Scotland; develops evidence based clinical practice guidelines for the NHS in Scotland
GP 2	GP at the Practice

Annex 2

Glossary of terms

Asymptomatic	A patient would be asymptomatic if they did not report symptoms of a disease or infection they carried