Investigation of a complaint against a GP Practice

Report Reference: 202003466

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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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Listed Authority: Mid Ulster Health Centre

SUMMARY

This complaint was about care and treatment Mid Ulster Health Centre (the Practice) provided to the complainant's mother (the patient) on 13 June 2022. The complainant believed the Practice failed to correctly diagnose the patient's chest pain as heart failure.

The patient's care home telephoned the Practice on the morning of 13 June 2022 to report the patient's complaint of chest pain and shortness of breath. The Practice informed the care home that a GP would visit the patient later that day. The GP examined the patient and, not suspecting a cardiac cause, diagnosed musculoskeletal pain. It also made a diagnosis of obesity impacting breathing and constipation. The investigation found the Practice examined and diagnosed the patient's symptoms in accordance with guidance. It did not identify a failure in care and treatment.

The complaint was also about the Practice's decision to remove the patient from its Patient List in August 2022. The complainant believed the Practice unfairly removed the patient because he submitted a complaint on the patient's behalf. The investigation found the Practice's decision to remove the patient was intrinsically linked to the complaint. It established the Practice's actions were not in accordance with the relevant guidance. It also found its decision to remove the patient was unfair. I considered this maladministration.

I recommended that the Practice apologise to the complainant for the injustice caused. I also recommended actions for the Practice to take to prevent this maladministration from reoccurring. The Practice accepted my recommendations and implemented learning following consideration of the draft report.

I understand the patient has passed away since the complainant raised his concerns with this Office. I wish to offer my sincerest condolences to the complainant for the loss of his mother.

THE COMPLAINT

1. This complaint was about care and treatment the Mid Ulster Health Centre (the Practice) provided to the patient on 23 June 2023. The complainant is the patient's son. This complaint was also about the Practice's decision to remove the patient from its Patient List.

Background

2. The Practice diagnosed the patient with an LRTI (Lower Respiratory Tract Infection) on 15 April 2021. It suspected heart failure on initial presentation but found no significant heart failure on investigation. The Practice treated the patient on three further occasions until the end of 2021.

3. The Practice assessed the patient on 27 May 2022 and found she required a paramedic visit. The paramedic documented *'exacerbation of H.F. (Heart Failure)*' however, further investigation found no evidence of heart failure.

4. A Practice GP attended the patient at her care home on 13 June 2022 following her report of chest pain and shortness of breath. The GP examined the patient and diagnosed musculoskeletal pain. The Practice stated the complainant behaved inappropriately towards the GP during his visit with the patient on 13 June 2022.

5. The complainant raised concerns with the Practice on 29 July 2022 regarding care and treatment it provided to the patient for chest pain on 13 June 2022. The Practice responded to the complaint on 15 August 2022. This letter also informed the complainant of the Practice's decision to remove the patient from its Patient List.

Issues of complaint

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

   Issue 1: Whether the Practice provided appropriate care and treatment to the patient on 13 June 2022.

Issue 2: Whether the Practice removing the patient from its Patient List was reasonable and in accordance with guidance.

INVESTIGATION METHODOLOGY

7. 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.

Independent Professional Advice Sought

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

    - A General Practitioner with experience of providing care in the community.

    I enclose the clinical advice received at Appendix two to this report together with the relevant extracts from medical records at Appendix three.

9. 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

10. 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[1]:

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

11. The specific standards and guidance referred to are those which applied at the

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

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 Guidance on Heart Failure Diagnosis and Management, Published 12 September 2018 (NICE NG106);
- The National Institute for Health and Care Excellence's Clinical Knowledge Summaries on Chest Pain Diagnosis, Revised August 2021 (NICE Chest Pain CKS);
- The National Institute for Health and Care Excellence's Clinical Knowledge Summaries on Breathlessness, February 2022 (NICE Breathlessness CKS);
- The National Institute for Health and Care Excellence's Clinical Knowledge Summaries on Constipation Management, Revised September 2021 (NICE Constipation CKS);
- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004, Schedule 5, Part 2 (HPSS Regulations);
- General Medical Council's Guidance on Ending your Professional Relationship with a Patient, Published 25 March 2013 (GMC Guidance);
- British Medical Association's Guidance on Removing Patients from your Practice List, Updated 7 September 2020 (BMA Guidance);
- The Practice's Guide to Making a Complaint (Practice complaint procedure); and
- The Department of Health's Guidance in relation to the health and social care complaints procedure, April 2022 (the DOH's Complaints Procedure).

12. 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.

13. 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

Issue 1: Whether the Practice provided appropriate care and treatment to the patient on 13 June 2022.

Detail of Complaint

14. The complainant said when the Practice GP arrived at the patient's care home on the evening of 13 June 2022 '*it was clear from his demeanour'* he didn't want to be there. He believed the Practice GP did not take the patient's chest pain seriously and made the patient feel like an inconvenience.

15. The complainant said the Practice '*quickly*' diagnosed the patient with having muscle pain and advised the patient needed to '*move more*.' He was surprised at this advice as the Practice was aware the patient was '*practically immobile.*' The complainant felt the Practice failed to carry out adequate clinical investigations to correctly diagnose the patient.

16. The complainant understood, from the patient's symptoms and the indication from other clinical professionals, including the Practice's first responder, that the patient was suffering from a heart condition. The complainant believed the Practice misdiagnosed the patient with muscle pain and failed to provide an acceptable level of care to the patient.

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following:
    - NICE NG102;

- NICE Chest Pain CKS;
- NICE Breathlessness CKS; and
- NICE Constipation CKS.

Practice's response to investigation enquiries

18. The Practice stated it visited the patient on 13 June 2022 as the care home reported the patient complained of chest pain and on/off shortness of breath over the weekend. It found the patient complained of '*pain generally*.' On examining the patient, the Practice diagnosed her with muscular pain of chest wall (re: chest pain) and distended abdomen together with marked obesity / immobility, all impacting on the patient's breathing. There was '*no clinical evidence of heart failure*.' The patient's symptoms were due to '*musculo-skeletal chest wall pain rather than of cardiac origin*.' It telephoned the care home the next day and the nurse informed the Practice the patient was '*well settled*.'

19. The Practice referred to a paramedic[2] visit with the patient on 27 May 2022. The paramedic documented a planned referral to a heart failure nurse. Correspondence dated 8 June 2022 from the Heart Failure Community Team said the patient did not qualify as a candidate for the heart failure service as the patient had no Echocardiogram (ECG)[3] or updated B-type natriuretic peptide (BNP)[4]. An ECG was ordered[5] and BNP blood test taken. The BNP result was normal, showing '*no evidence of heart failure on BNP testing*.'

Relevant Independent Professional Advice

20. The IPA advised the Practice arranged to visit the patient following a call from her care home, at 11:21 hours on 13 June 2022, due to her complaints of chest pain and shortness of breath. The Practice record of the call documented that a Practice GP would visit later that day, '*possibly teatime'*. It is unclear from the

[2] Employed by GP Federation to Armagh and Dungannon GP Practices.
[3] Test used to check a person's heart rhythm and electrical activity to detect cardiac problems.
[4] Blood test often used to help diagnose heart failure or other heart problems.
[5] The Practice does not specify by whom.

records how the Practice triaged[6] the patient's chest pain or why the visit was '*not deemed urgent*[7].'

21. The IPA advised the Practice's record of examination documented the patient's symptoms on 13 June 2022 as '*pain generally*.' The Practice record entered on 16 June 2022 documented generalised tenderness of chest wall, limbs of a '*fibromyalgia*[8] *type*' and diagnosis of obesity impacting breathing together with a diagnosis of constipation. The Practice prescribed an appropriate laxative in accordance with guidelines.

22. Regarding the patient's history referred to by the Practice, the IPA advised the results of a recent BNP test, as per guidance, would '*make a diagnosis of heart failure less likely*.'

23. The IPA advised the Practice did not suspect a cardiac cause of the patient's chest pain, carried out the appropriate examinations and made the correct diagnosis based on guidance. The non-cardiac cause diagnosed did not require hospital admission or further investigation on 13 June 2022.

24. The IPA advised the Practice '*appropriately examined for muscular chest pain'* and followed guidance in '*management of the patient*.'

Analysis and Findings

25. The complainant said the Practice failed to appropriately diagnose and treat the patient on 13 June 2022. He believed the patient's symptoms indicated she had a heart condition and the Practice failed to undertake appropriate investigations to determine this.

26. I note Practice staff discussed the patient's symptoms during the telephone call from the care home at 11:21 hours on 13 June 2022. Following this call, the

[6] The preliminary assessment of patients in order to determine the urgency of their need for treatment and the nature of treatment required.
[7] This is the IPA's opinion.
[8] Long -term condition that causes widespread pain and other symptoms, such as fatigue, stiffness, sleep problems and mood issues.

Practice arranged for a GP to visit the patient later that day. The records do not document the rationale for triaging the patient as not urgent.

27. NICE Chest Pain CKS[9] sets out the physical examinations clinicians should carry out on patients with chest pain. The Practice said on examination of the patient she complained of pain generally and there was '*no clinical evidence of heart failure*.' The IPA advised the Practice records documented '*fibromyalgia type'* tenderness on examination of the chest wall and limbs and '*constipation feature'* on abdominal examination with '*marked obesity'* all impacting breathing. The records did not document that the patient reported 'chest pain' during the GP's assessment. The IPA advised the examinations undertaken were appropriate. She advised the Practice records documented '*sats and observations[10] ok'*. However, the Practice did not record any figures and noted '*no evidence of cardio-resp issue per se*.' Following consideration of the NICE guidance and IPA advice, I am satisfied the Practice carried out appropriate examinations based on the patient's symptoms.

28. NICE Chest Pain CKS states that clinicians should ask about a patient's history of chest pain and previous investigations. I note the Practice referred to investigations in May/June 2022 which showed '*no evidence of heart failure*.' The IPA advised the Practice records document a BNP result of 365pg/ml on 8 June 2022. She also advised in accordance with NICE NG106[11] the result makes '*a diagnosis of heart failure less likely*.' Based on the evidence, I accept the IPA's advice.

29. I note NICE Chest Pain CKS states chest pain can have causes other than cardiac or pulmonary reasons. This can include musculoskeletal causes such as fibromyalgia. The IPA advised, based on the Practice's examination findings it made a diagnosis of fibromyalgia type chest pain together with obesity and constipation impacting the patient's breathing. This was in accordance with

[9] As detailed in Appendix four.
[10] Vital signs that include measurements of body temperature, rate of respiration (breathing), pulse rate, blood pressure, and oxygen saturation (amount of oxygen circulating in the blood).
[11] Relevant extract in Appendix four.

NICE CKS guidance on chest pain, breathlessness, and constipation.[12] The IPA advised musculoskeletal chest pain is a clinical diagnosis.[13] As the Practice did not suspect a cardiac cause of the patient's chest pain, a diagnosis of another cause was consistent with NICE guidance. Based on the guidance, IPA's advice and documentation of the patient's signs, symptoms and history, I am satisfied the Practice appropriately diagnosed the patient with a non-cardiac related cause of chest pain.

30. I note the IPA also advised the Practice records do not document it communicated the cause of the chest pain or shortness of breath to the patient or complainant. I note the complaint letter to the Practice said the GP '*advised*' [the complainant] that the patient's '*heart condition*' (as the complainant's suspected cause of the chest pain) was '*muscular*.' Having considered the evidence, I am satisfied the Practice did have a discussion with the patient and complainant about the diagnosis and treatment. However, I accept the IPA's advice that the Practice did not document this discussion. I do not consider this impacted the patient's care and treatment. However, I expect the clinician to record that they communicated the diagnosis and care plan to their patient in line with guidance. I would ask the Practice to remind staff to ensure they document such information in patients' records in future.

31. The IPA advised the Practice contacted the care home the following day, 14 June 2022, to review the patient. The Practice records document the patient was '*settled and well'*.

32. Having considered the evidence available, I am satisfied the Practice appropriately diagnosed and treated the patient in accordance with NICE guidance on 13 June 2022. I have not identified a failure in care and treatment. As such I do not uphold this issue of complaint.

[12] Relevant extracts from each in Appendix four.
[13] The process of identifying a disease or condition based on signs, symptoms and medical history.

Issue 2: Whether the Practice removing the patient from its Patient List was reasonable and in accordance with guidelines.

Detail of Complaint

33. The complainant felt the Practice unfairly removed the patient from its Patient List. He believed this was because he raised a concern about the care and treatment it provided for the patient's chest pain on 13 June 2022.

Evidence Considered

Legislation/Policies/Guidance

34. I considered the following [legislation/policies/guidance]:
    - HPSS Regulations;
    - GMC Guidance;
    - BMA Guidance; and
    - Practice's complaint procedure.

Practice's response to investigation enquiries

35. The Practice stated it removed the patient from its Patient List following the removal of the complainant who had power of attorney for the patient. It removed the complainant based on an '*irretrievable breakdown*' of the professional relationship. The Practice said it removed the patient in accordance with HPSS Regulations. However, it '*did accept there is no specific [regulation] accounting for the removal of [the patient].*'

36. The Practice stated given the complainant's removal, as he had questioned the GP's *'professional integrity*,' it '*would not have been practical'* for the patient to remain on its List. The complainant was '*invariably closely involved and ever present*' in the care of [the patient]. It was therefore '*inconceivable*' to provide ongoing medical care to the patient without involving the complainant.

37. The Practice considered the complaint raised in June 2022 '*vexatious*.' This constituted a '*breakdown in the doctor/patient relationship*.' Therefore, it decided to remove both the complainant and the patient from its List.

Analysis and Findings

38. This issue of complaint was about the Practice's decision to remove the patient from its Patient List. In considering complaints of maladministration, my role is to identify the relevant statutory framework and whether the Practice applied those procedures that give effect to that framework appropriately. It is also to consider if the patient was treated fairly.

39. The Practice stated it removed the patient from its Patient List in accordance with Schedule 5, Part 2 Paragraph 20(2)(b) of the HPSS Regulations. The Regulations permit removal on the grounds of an '*irrevocable breakdown*' in the patient and Practice relationship.

40. I considered this paragraph of the Regulations. It states that a Practice may only request a removal if it warned the patient, within the previous 12 months, that they are at risk of removal. However, the records do not evidence that the Practice issued the patient with a warning prior to her removal. Therefore, I am satisfied the Practice did not act in accordance with this section of the Regulations when it made its decision to remove the patient.

41. In this event, I considered whether it was appropriate for the Practice to remove the patient under paragraph 21 of the regulations. This states the criteria for removing a patient with '*immediate effect'*. This can occur if '*the patient has committed an act of violence'* against a member of staff '*or behaved in such a way that any such person has feared for his safety*'. However, as the patient did not behave in this manner, I am satisfied the decision to remove the patient did not fall under this section of the HPSS Regulations.

42. The Practice said it removed the patient based on the complainant's behaviour and removal. However, the Regulations do not permit removal based on the behaviour of anyone other than the person it removes. Based on the evidence available, the Practice did not act in accordance with the HPSS Regulations when it made its decision to remove the patient.

43. As I stated previously, I must also consider if in making its decision, the Practice treated the patient fairly. I considered the complainant's view that the Practice removed the patient in August 2022 because he submitted a complaint on behalf of the patient about care and treatment provided in June 2022.

44. The complainant raised his concerns with the Practice in his letter dated 29 July 2022. I considered the Practice's complaints procedure. This states that patients can raise a complaint or concern regarding care and treatment. Complaints will be handled '*Practice-based*' in accordance with HSC Guidelines. As the letter referred to care and treatment the Practice provided to the patient, which any patient or person representing a patient is entitled to query, there is nothing that would cause me to agree with the Practice's view that the complaint was '*vexatious*'. I am satisfied the Practice took punitive action against the patient in contravention of its own complaints' procedure. I find this action highly concerning and undermining to the integrity and purpose of the Practice's complaints procedure.

45. The partners of the Practice met to consider the complaint on 1 August 2022. The notes of this meeting document '*Given the content of the letters it was agreed that there had been a complete breakdown in doctor/patient relationship and that [the complainant] should be removed from the [Patient List]*'. The partners also agreed that as the patient did not have capacity, and the complainant is usually involved in her care, the patient '*as a result of this should also be removed*.' I considered the Practice's letter to the complainant, dated 22 August 2022. I note this letter both responded to the complaint about the patient's care and treatment and notified the complainant of the patient's removal from the Patient List.

46. Based on the evidence available, it is clear the complaint about the patient's care and treatment and the Practice's decision to remove her from its Patient List are intrinsically linked. I have already found that the reasons for the Practice's decision did not fall under any of the criteria stated in the HPSS Regulations. Also, as the patient did not receive a prior warning, I am satisfied

it was the complaint that prompted the Practice's decision to remove the patient from its list. I consider in doing so, the Practice treated the patient unfairly.

47. The GMC Guidance states '*you should not end a professional relationship with a patient solely because of a complaint the patient has made about you or your team*.' Based on the evidence available, I do not consider the Practice acted in accordance with this guidance when it made its decision to remove the patient, who was clearly vulnerable, from its List.

48. The BMA Guidance states the behaviour of one patient's removal '*does not mean the removal of other family members…should automatically follow*. *An explicit discussion with other family members [ie: the patient in this case]…should take place.*' Therefore it clear the Practice did not act in accordance with this guidance when it made the decision to remove the patient from its List.

49. The First Principle of Good Administration, '*Getting it Right'* requires bodies to act '*in accordance with the law and relevant guidance, with regard for the rights of those concerned*.' The Fourth Principle of Good Administration, '*Acting Fairly and Proportionately'* requires bodies to ensure its '*decisions and actions are proportionate, appropriate and fair*.' I consider the Practice's actions in removing the patient unfair and disproportionate. I am satisfied this constitutes maladministration.

50. It is of great concern that the Practice removed the patient from its list in these circumstances. The patient was elderly, lacked capacity, residing in a care home, and as a result, has additional medical needs. I have not seen any evidence to suggest the Practice took the patient's personal circumstances into consideration when it made its decision to remove her as a patient. I consider the maladministration identified caused the patient to sustain the injustice of a loss of opportunity to access primary healthcare. This is more significant given the patient's situation and at a time in her life where she has greater need for access to healthcare. In addition, I consider it caused the complainant to

experience undue stress and uncertainty in relation to the provision of primary healthcare for his mother.

51. Any patient, or their representative, has the right to raise a complaint or enquire about the care and treatment they have received. They should be able to do so without fear of reprisal or punitive action from the healthcare provider they complain to. The actions of the Practice in this case are in contravention of that ethos, particularly as this patient was removed based on the Practice's view of someone else's actions. I would ask the Practice to reflect carefully on the impact such actions have on a patient before considering removing anyone from its patient list in the future.

CONCLUSION

52. I received a complaint about care and treatment the Practice provided to the patient on 13 June 2022. I did not identify a failure in the Practice's care and treatment of the patient for the reasons outlined in this report. I understand the patient and complainant's concern given the patient's past heart failure investigations. However, the Practice did not suspect a cardiac cause of chest pain on this occasion and made the appropriate diagnosis and treatment. I hope my findings reassure the complainant that the care and treatment the Practice provided was appropriate and in accordance with relevant guidelines.

53. The complaint was also about the Practice's decision to remove the patient from its Patient List. I identified maladministration in the process the Practice followed when it made its decision.

54. I recognise the maladministration caused the patient to sustain the injustice of a loss of opportunity to access primary healthcare. Furthermore, I consider it caused the complainant to experience undue stress and uncertainty in relation to the provision of primary healthcare for his mother.

55. I understand the patient has passed away since the complainant raised his concerns with this Office. I wish to offer my sincerest condolences to the complainant for the loss of his mother.

Recommendations

56. I recommend that within **one month** of the date of this report:

    (i) 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 maladministration identified; and

    (ii) The Practice shares the findings of this report with its Partners and relevant staff to provide them with the opportunity to reflect on the failing identified.

57. I note that following its consideration of the provisional findings outlined in the draft report, the Practice delivered training to relevant staff on the removal of patients for the reason of a breakdown of the patient/Practice relationship of a family member. The training referred to the HPSS Regulations. The Practice also reviewed BMA and GMC Guidance regarding a patient's right to raise a complaint about concerns over care and treatment provided. I welcome the learning the Practice implemented.

58. The Practice accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **26 March 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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