



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against a GP practice

Report Reference: 202004023

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the care and treatment the Practice provided to the complainant from March 2022 to May 2022.

The investigation considered:

- The care and treatment during the period March 2022 to May 2022;
- The care and treatment relating to the mental health assessment; and
- GP C's home visit on 26 May 2022.

During the period, March 2022 to May 2022, the complainant was under a considerable amount of stress providing care for her brother whilst at the same time trying to look after her own mental health.

My investigation found the care and treatment the Practice provided relating to:

- the complainant's mental health during the period March 2022 to May 2022; and
- the mental health assessment

to be appropriate and as such I did not uphold these elements of the complaint.

However, my investigation also found GP C did not action the undertaking she gave the complainant on 26 May 2022 to:

- contact her weekly;
- oversee her mental health support; and
- provide feedback on the outcome of her mental health assessment.

GP C also failed to keep an accurate record of her discussion with the complainant that day. I found these to be a failure in the care and treatment GP C provided.

I recommended the Practice apologise to the complainant. I made additional recommendations for the Practice to prevent recurrence and improve its future practice.

THE COMPLAINT

1. This complaint was about care and treatment the Practice provided to the complainant from March 2022 to May 2022.

Background

2. The complainant sought support with her mental health from the Practice on a number of occasions during the period March to May 2022. During this time, the complainant was the sole carer of her brother. During one consultation, the complainant agreed for the Practice to refer her for a mental health assessment. This took place on 4 April 2022.
3. GP C made an unarranged visit to the complainant's home on 26 May 2022 at 18:20. At this visit, the complainant stated GP C undertook to contact her weekly to oversee her mental health treatment and provide feedback on her mental health assessment.
4. GP C did not keep this undertaking, which the complainant said left her feeling '*let down and abandoned*' by the Practice.

Issue of complaint

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

Whether the Practice provided appropriate care and treatment to the complainant during the period March 2022 to May 2022?

INVESTIGATION METHODOLOGY

6. 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 (IPA)

7. After further consideration of the issues, I obtained independent professional advice from a general practitioner (GP), D Av Med, FRCS, LLM (Med Law), FRCGP, MFTM RCPSG, PG Cert Med Edu. with experience:
 - as a partner and medical director of a large GP Group Practice; and

- working for the Appeals Tribunal, the Medical Practitioners Tribunal Service Fitness to Practise Panel and the Mental Health Commission.

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. 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 Principles¹ the Principles of Good Administration.

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 General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
- Guidance from The Royal College of Psychiatrists, 2010 (the RCPsych Guidance); and
- The Practice's Home Visit Protocol, Updated Sept 2015 (Home Visit Protocol).

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

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

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. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Whether the Practice provided appropriate care and treatment to the complainant during the period March 2022 to May 2022?

Detail of Complaint

Care and treatment during the period March 2022 to May 2022.

13. The complainant said she approached the Practice about her mental health and she received '*minimal treatment*' and support from the Practice. During this period, she felt she '*was in crisis*' as a result of both having been her brother's primary carer and then dealing with his sudden death.

The care and treatment relating to the mental health assessment

14. The Practice referred the complainant for an '*urgent*' acute mental health assessment, which she attended on 4 April 2022. The complainant said:
 - the Practice never discussed the outcome of the assessment with her; and
 - the Practice did not provide her with any feedback on the assessment.

GP C's home visit on 26 May 2022.

15. The complainant said GP C made an '*unsolicited visit*' to her home on 26 May 2022, during which GP C '*proactively*' undertook to contact her weekly on a Wednesday to provide support and healthcare, and to oversee her mental health care. She said GP C also undertook to follow-up on the complainant's mental health assessment. The complainant said these actions did not transpire, making the complainant feel '*abandoned, vulnerable and isolated*' when she was in crisis following her brother's death.

Evidence Considered

Legislation/Policies/Guidance

16. I considered:

- the GMC Guidance;
- RCPsych Guidance; and
- the Home Visit Protocol.

The Practice's response to investigation enquiries

17. The Practice provided this Office with its response to investigation enquiries. The Practice's stated that the care and treatment it provided to the complainant was reasonable and appropriate, for the most part. However, it acknowledged GP C had failed to fulfil the undertaking she made to the complainant during the home visit. It also acknowledged GP C had made an unsolicited call to the complainant's home on 22 April 2022 and had not recorded the details of that consultation. However, the Practice stated GP C's ability to meet her undertaking was affected by her workload and reduced hours. I outlined details of this response in my analysis and findings below.

Relevant records

18. I completed a review of the documentation the Practice provided in response to my investigation enquiries, and the documentation I received from the complainant.

Relevant Independent Professional Advice

19. I enclose the IPA's advice at Appendix two of this report. I outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Care and treatment during the period March 2022 to May 2022.

20. Standard 15 of the GMC Guidance states:

'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

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

- c. *refer a patient to another practitioner when this serves the patient's needs*'.

24 March 2022

21. The complainant had a telephone consultation with GP A. The consultation was originally in relation to her brother. I note, though, the medical records show GP A also consulted with the complainant about her own mental health as a result of the *'situational crisis'* symptoms the complainant presented on the call due to being her brother's carer.
22. I note this resulted in GP A contacting the complainant's brother's community mental health care manager and community psychiatric nurse (secondary care colleagues) as they were *'best placed to provide immediate assistance'* to alleviate the pressure the complainant was experiencing. I note this referral was in line with GMC guidance in *'referring a patient to another practitioner when this is in the patient's best interests'*.
23. The Practice stated GP A completed a *'risk assessment'* with the complainant as part of the consultation and arranged a follow-up call for the following week. It stated GP A subsequently fulfilled this commitment.
24. The IPA advised GP A's handling of this consultation was *'reasonable'* and in line with GMC Guidance (set out above). In particular, he advised GP A provided *'reassurance to the patient with explanation relating to her "situational" stress'*, undertook a *'risk assessment'* which highlighted there were no current acute risks, and provided *'safety-netting in case if she got worse'*.

28 March 2022

25. The RCPsych Guidance states *'referral to specialist mental health services for co-ordinated multidisciplinary care should be arranged if a person has:*
- *More severe depression and is at significant risk of self-harm or suicide, harm to others, or self-neglect.*
 - *Psychotic symptoms or suspected bipolar disorder.*
 - *More severe depression or chronic depressive symptoms affecting personal and social functioning, which have not responded to treatment in primary care'*.

26. I note GP A, as agreed, had a telephone consultation with the complainant. I am satisfied GP A therefore fulfilled his earlier commitment to the complainant of a follow up consultation. The Practice stated GP A *'discussed options to provide support and safety netting'*. These included a *'medication review, external private support and an internal referral to in-house senior mental health practitioner'* (MPH).
27. I note, the medical records show GP A also confirmed with the complainant the secondary care colleagues had been in contact and arranged additional support.
28. The IPA advised the consultation was *'well documented'* and *'in line with'* GMC Guidance and RCPsych Guidance. He advised in particular, GP A:
- provided *'the necessary support and treatment'* through *'therapy referral and advice'*;
 - undertook *'a risk-assessment'*; and
 - gave *'safety-net advice'*.
29. The IPA advised he did not think *'any additional support or treatment'* was needed having taken into account:
- the mitigating factors outlined in the consultation notes;
 - the complainant having *'capacity'* which *'GP A needed to respect'*; and
 - the complainant agreeing to be referred to the in-house mental health practitioner.

29 March 2022

30. The Practice stated GP B received a telephone call from another healthcare professional who wanted to highlight their concerns about the complainant's mental health.
31. In response to the telephone call, the Practice stated, GP B *'made contact'* with the complainant by telephone. It stated during the consultation, *'safety netting was provided'* and it was agreed to *'expedite an urgent referral to the mental health team'* as well as having *'a face to face consultation the next day'* after her existing blood test appointment. I note from the medical records, GP B made an urgent referral the same day.

32. The IPA advised GP B had '*undertaken a good assessment*' which was '*well documented*'. This meant for future clinicians there was a good history as well as relevant background factors and more recent issues.
33. The IPA further advised, '*even though very recently the complainant did not wish to be externally referred, GP B communicated well*'. As a result the complainant agreed to an urgent referral to the community mental health team. The IPA advised GP B dealt with the complainant's problems in the manner of a '*knowledgeable*' and '*reasonable*' GP '*with care and concern and still respecting her [the complainant's] intact capacity*' for deciding on the course her treatment would follow.
34. The IPA confirmed GP B's actions at this consultation '*conformed well*' to GMC Guidance, and also with the RCPsych Guidance.

30 March 2022

35. I note the complainant attended the agreed face to face consultation with GP B where GP B recorded in the medical notes, responding to the complainant's '*mental health as the acute priority*'.
36. The IPA advised the documentation for the consultation included history, other circumstances prevailing, examination, risk assessment, safety-netting, prescribing of a relatively safe sleeping pill and review arrangements. The IPA concluded this management was appropriate.
37. The IPA further advised the support and treatment GP B provided for the complainant's mental health were appropriate, reasonable and in line with the relevant guidelines.

12 April 2022

38. The Practice stated the complainant '*consulted with the MPH where he agreed to follow up*' with her in three days by telephone. The Practice stated the MPH was unable to contact the complainant earlier due to him being on holiday.

39. I note the records show the MPH undertook a mental health assessment with the complainant. The MPH subsequently contacted secondary care colleagues to explore and advise on additional carer support for the complainant. The MPH also sent the complainant links to self-help resources and confirmed their further call in three days.

40. The IPA advised the MHP *'offered good and practical advice to the complainant'* and the *'support and treatment was appropriate'* and *'reasonable'*.

15 April 2022

41. I am satisfied the records show the MPH left a voicemail for the complainant, stating he would follow up after his annual leave and sign posted her to *'make [a] sooner appointment with practice if needed'*. I am satisfied the MPH provided safety net advice for while he was away and provided a reassurance of the continuation of available care for the complainant in his absence.

20 April 2022

42. The Practice stated the complainant had a telephone consultation with GP B to review her general mental health covering:

- the 'good support' provided by the MPH and that she *'would like to speak with him again'*; and
- her interactions with and support from the secondary care colleagues for her brother.

43. The IPA advised the *'art of good patient care'* is about the *'doctor being able to use the right guidance'* and *'approach to help the patient'* as *'one size does not fit all'*. The IPA further advised GP B *'seems to have achieved much'* at this consultation and *'GP B's actions conformed to'* the GMC Guidance on good clinical care.

25 April 2022

44. The Practice stated, and the records confirmed, the MHP had a telephone consultation with the complainant. I note this meant the MPH fulfilled the commitment he made to the complainant in his voicemail on 15 April 2022.

45. During this consultation, the complainant told the MPH sadly her brother had died the day before. The records show the MPH reviewed her medication with her and offered her a call with a GP that day. I note the complainant declined the offer of a GP call due to how she was feeling over the death of her brother and the way she felt the Practice had dealt with her brother in the hours preceding his death. The MPH therefore sign posted her back to the Practice and other crisis support, if needed.
46. The records show the MPH made a commitment to follow up with the complainant the following week.
47. The IPA advised the MPH's primary role is to '*offer talking therapy and building up confidence on self-coping*' but the MPH was able to move the focus to '*bereavement counselling*' on hearing the sad news of the complainant's brother's death. The IPA confirmed the overall management was '*reasonable and appropriate*' in the circumstances.

3 May 2024

48. I note the records show the MPH fulfilled his commitment to the complainant with a follow up telephone consultation. During the consultation, the Practice stated the MPH offered for a partner within the Practice to contact her and the complainant asked for '*GP C to make contact*'.
49. I accept the IPA's advice in '*looking at the global picture*' the '*support and documentation with risk-assessment and safety-netting appear to be appropriate and reasonable*'.

Summary and Finding

50. Having reviewed all relevant evidence, including the IPA's advice, I am satisfied the Practice conducted each of the consultations I outlined above in line with the relevant GMC Guidance and RCPsych Guidance.

51. I acknowledge that during this period the complainant was under a considerable amount of stress providing care for her brother, whilst at the same time trying to look after her own mental health. However, based on the evidence available, including the IPA's advice, I consider the care and treatment the Practice provided to the complainant for her mental health during the period March 2022 to May 2022 was reasonable, appropriate and in line with relevant standards. As such I do not uphold this element of the complaint.

The care and treatment relating to the mental health assessment

4 April 2022

52. I note from the records, the complainant attended the mental health assessment following GP B's referral.

21 April 2022

53. The Practice stated they received the mental health assessment clinical letter from the mental health team and *'date stamped [it] upon [its] arrival at the surgery'*.

54. The Practice stated their standard process for incoming clinical mail is for it to be *'digitised'* into the document repository making it *'available for all members of the team providing care'*. It is then allocated for review by one of the GPs. The GP reviews it and then *'post it to the patient's clinical records within the EMIS clinical system'*.

25 April 2022

55. The Practice stated it digitised the letter and allocated to GP B for review. The same day, GP B reviewed the letter and placed it onto the complainant's medical records.

56. The Practice stated it will only contact the patient where the contents of the letter necessitates it. In this instance, the Practice stated the letter showed the *'action plan was discussed'* with the complainant during the assessment and the action plan included input from secondary care colleagues. However, it stated there were *'no action points'* for the Practice to follow-up on. The Practice stated the letter from the mental health team *'was to update'* the GP rather than to request any action. It stated this meant there was no need for the Practice to contact the complainant to discuss it further.

57. The IPA advised when a referral is made to a specialist healthcare professional, it is expected they *'will read that letter and to ask their own questions and assess the patient'*. The IPA further advised *'the patient would have been fully informed of the outcome of the assessment by [the mental health team] themselves'* as part of the assessment appointment. Also, in the clinical letter to the Practice, the IPA noted there was *'no task [for them] to complete'*. On foot of this advice, I am satisfied it was unnecessary for the Practice to contact the complainant to discuss the content of clinical letter with her.
58. I am satisfied from the information and records supplied by the Practice and from the IPA's advice, that GP B and the Practice acted appropriately and in line with its own procedures in relation to the handling of the clinical letter. This meant GP B reviewed the information contained in the clinical letter; ascertained it did not necessitate a call to the complainant; and made it available for subsequent clinicians to provide a continuation of care to the complainant. As such, I do not uphold this element of the complaint.
59. As part of my consideration of this issue, I note the day before the Practice received the clinical letter, GP B spoke with the complainant about the assessment to obtain *'feedback'* from her. Therefore, whilst the Practice did not discuss the letter with the complainant, I am satisfied it did discuss the assessment itself with the complainant.

GP C's Home Visit on 26 May 2022

60. Standard 1 of GMC Guidance states *'Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law'*.
61. The Home Visit Protocol states:
- *'the patient is recorded as an appointment in "Home Visits" with a telephone number & symptoms';*
 - *and 'Computer records are updated by the doctor on return to the practice. Some of the doctors use the laptop facility for home visits'.*

62. The Practice stated during the home visit, GP C verbally *'offered to provide regular contact'* to the complainant, oversee her mental health support and provide feedback on the outcome of her mental health assessment. It stated the complainant accepted this offer. However, GP C did not fulfil her undertaking.
63. The Practice also stated the care and support GP C agreed with the complainant during the home visit *'was unknown to others in the surgery'*. I note this meant GP C did not pass on her undertaking of care to others in the Practice.
64. The IPA advised GP C had the same *'professional responsibilities'* *'on this home visit'* as any other and her *'professional responsibilities'* did *'not diminish'* with it being an unscheduled *'home visit'*. The IPA further advised GP C's *'commitment to the [complainant] was a professional undertaking'*. In *'not keeping up with the commitment [GP C] had made, GP C had departed from the guidance of the good medical practice'* in the GMC Guidance.
65. Having reviewed all relevant records, I am satisfied GP C failed to keep her undertaking to conduct regular telephone calls with the complainant to discuss her health. She also failed to discuss the outcome of the mental health assessment with the complainant on one of those calls, as she had promised to do. Furthermore, when GP C realised she would not be able to keep her undertaking, she did not inform the complainant of this, and did not arrange for one of her colleagues at the Practice to provide this service. I consider this to be a failure in the care and treatment GP C provided to the complainant, which impacted the complainant's continuity of care. I also consider GP C's actions to be contrary to Standard 1 of the GMC Guidance. The complainant said she felt *'abandoned, vulnerable and isolated'*.
66. I do not accept the Practice's explanation that GP C's workload had increased as she reduced her hours as sufficient justification for GP C's omissions. Neither of these factors prevented GP C from arranging for another GP at the Practice to take on this responsibility. If the Practice did not have scope to meet this undertaking as a whole, GP C, or one of her colleagues should have contacted the complainant to discuss this with her.

67. Furthermore, I note GP C did not keep a record of this visit in the complainant's medical records, either contemporaneously, or when she returned to the Practice six days later. This resulted in a gap in the complainant's records which had the potential to impact on her continuity of care. I note and accept the IPA's advice that GP C was expected '*to document her assessment findings and management plan in the patient's notes*'. By not doing so, the IPA advised GP C '*departed from good medical practice of the GMC*' Guidance. I find GP C also departed from the Practice's own Home Visits Protocol in this respect. I consider this to be a further failure in the care and treatment GP C provided to the complainant. I therefore uphold this element of the complaint.
68. I find the failures identified caused the complainant to sustain the injustice of uncertainty, frustration, and upset regarding the care she received from the Practice. She also lost the opportunity to discuss her health with her GP on a regular basis, as promised to her. I note the complainant eventually left the Practice to find a new GP and accept these failings may have contributed to her decision.

CONCLUSION

69. I received a complaint about the care and treatment the Practice provided to the complainant from March 2022 to May 2022. I found GP A, GP B and the MHP provided reasonable and appropriate care and treatment to the patient that was in line with relevant standards. However, I found failures in the care and treatment provided by GP C during her unscheduled home visit.
70. I recognise the failures caused the complainant upset, frustration and uncertainty during a time of situational crisis following her brother's death. She also lost the opportunity to have her health reviewed regularly in line with GP C's undertaking.
71. I therefore partially upheld this complaint.
72. I also offer through this report my condolences to the complainant for the sad loss of her brother.

Recommendations

73. 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).

74. I further recommend for service improvement and to prevent future recurrence:-

- The Practice brings the contents of this report to GP C's attention so that she can reflect on the learnings identified in it – in particular the importance of keeping professional undertakings made to patients;
- Although I note the Practice reviewed and updated its Home Visit Procedure following the complaint to the Practice, I recommend the Practice considers further updating the Procedure to include:
 - GPs must record all home visits on the appointment system prior to being undertaken;
 - the procedures for completing patient notes after attending a home visit must be undertaken by all clinical staff..
- The Practice takes action to ensure the partners and staff at the Practice:
 - comply with the Home Visit Protocol;
 - are aware of the changes and requirements of the updated Home Visit Procedure; and
 - are provided with appropriate training for its application.

75. I recommend the Practice implements an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report. The Practice should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

76. The Practice accepted my findings and recommendation.

MARGARET KELLY
Ombudsman

January 2025

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.