



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against

Report Reference:

The Northern Ireland Public Services Ombudsman

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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

This complaint was about whether the Practice provided appropriate care and treatment for the patient (the complainant's brother) on 22 April 2022 in line with the relevant policies and guidelines.

I want to first extend, through this report, my condolences to the complainant at the sad death of her brother and I hope the findings in this report go some way to reduce the distress caused by his sudden death.

The investigation established the Practice followed its relevant policy, procedures and guidance in the care and treatment it provided. As a result, I did not find any failure in the care and treatment the Practice provided to the patient that day. I therefore did not uphold the complainant.

THE COMPLAINT

1. This complaint was about the care and treatment the Practice provided to the patient on 22 April 2022. The patient was the complainant's brother.

Background

2. The patient was a 58 year old gentleman who had lived with schizophrenia for most of his adult life. The patient lived with the complainant, who was his primary carer.
3. The patient telephoned the Practice at 09.18 on 22 April 2022 seeking '*urgent help*' as he was in pain. Unfortunately, by the time the patient called, the Practice had filled all patient bookable appointments for that day. The patient '*insisted*' he was in pain and needed urgent help. The receptionist referred the matter to a GP and on the instructions of the GP, scheduled a telephone consultation for later in the day. The GP called the patient at 14.39. However, the patient was unable to answer the call at that time. However, the GP phoned back at 17.50 the same day and had a telephone consultation with the patient.
4. The patient sadly died during the night of 24 April 2022 from an intestinal ischaemia due to volvulus¹ and cardiac enlargement.

Issue of complaint

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

Whether the Practice provided appropriate care and treatment to the patient on 22 April 2022?

INVESTIGATION METHODOLOGY

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

¹ Twisted bowel

Independent Professional Advice Sought

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 Principles² - 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);
- The Royal College of General Practitioners' It's your Practice – A patient guide to GP services, July 2011 (RCGP Home Visit Information);
- British Medical Association's Guidance to Safe Working in General Practice (BMA Appointments Guidance); and

² These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The Practice's Home Visit Protocol, Updated Sept 2015 (Home Visit Protocol).

I outlined the relevant sections of the guidance considered in my analysis and findings below.

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 patient on 22 April 2022?

Detail of Complaint

13. The complainant said the patient rang the Practice at 09.18 on Friday 22 April 2022 seeking '*urgent help*' due to the pain he was experiencing. The receptionist informed him there were no available appointments and to call back on Monday at 08.00.
14. The complainant said the patient and herself continued to '*insist*' to the receptionist the patient needed an urgent appointment as he was in pain. During this time, the receptionist twice placed them on hold whilst consulting a GP. After her second conversation with the GP, the receptionist scheduled a telephone appointment for later in the day.
15. The complainant said the receptionist had been '*inflexible*' and '*dismissive*' of the patient's needs and the Practice should have been aware of the patient's need for urgent in-person help as he was on its housebound list. It was the patient and complainant's belief the Practice had classified him as housebound in February 2022, and this meant he would receive priority when asking for a clinician to see him. However, they were unaware the Practice had not marked the patient as housebound in his records.

16. During the telephone consultation at 17.50 the same day, the complainant said the GP did not know the patient or his circumstances, which resulted in the call providing *'no help whatsoever'*. The complainant said the Practice did not provide any *'effective help'* to the patient that day. The patient sadly died from a twisted bowel two days later, on 24 April 2022 leaving the complainant *'hurt'* and *'angry'* at the way the Practice had treated her brother.

Evidence Considered

Legislation/Policies/Guidance

17. I considered:

- the GMC Guidance;
- RCGP Home Visit Information;
- BMA Appointments Guidance; and
- the Home Visit Protocol.

The Practice's response to investigation enquiries

18. The Practice provided this Office with its response to my investigation enquiries. The Practice denied any failure in the care and treatment it provided to the patient on 22 April 2022. However, it identified it had not provided service at its usual standard in respect of:

- how the receptionist handled the patient's call; and
- the patient's records not showing he was housebound.

The Practice stated it had acknowledged and apologised for these matters as part of its internal complaints process. I outlined details of the Practice's response in my analysis and findings below.

Relevant Practice's records

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

Relevant Independent Professional Advice

20. 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

21. The complainant was concerned the Practice did not act with sufficient urgency to arrange and then conduct a consultation with the patient on 22 April 2022.
22. I note the BMA Appointments Guidance states extending the time of a GP session (e.g. by increasing the number of appointments and/or time spent consulting) to outside the guidelines *'risks harm to patients and clinicians'*.
23. The Practice stated to maintain *'a safe working capacity'*, it makes available a limited number of acute appointments bookable by patients from 08.00 based on the number of GPs working that day. The Practice's Appointment Booking Protocol also states the receptionists have *'exclusive'* access to a limited number of *'afternoon urgent slots'* for *'patients who they feel need seen on the day'*. I note this means the receptionists and GPs have a framework to work within to meet the BMA Appointments Guidance.
24. The Practice stated the patient called requesting an urgent appointment at 09.18. It stated unfortunately, the last acute *'appointment was filled'* at 09.02 meaning the Practice had reached its *'maximum safe capacity'* and it would have been *'potentially unsafe'* to accept further morning acute appointments.
25. I note the Practice's Appointment Booking Protocol provides the receptionists with a pre-defined script to follow. In its responses to this Office's investigations, the Practice stated the receptionists are *'not clinically trained'* and *'are not permitted to triage calls'* or *'access clinical systems'*. The patient and complainant were *'insistent'* the patient needed an urgent appointment as he was housebound. The Practice explained as there were no morning acute appointments available, the receptionist used the script to *'gather further information'* on the patient's medical condition and relayed this information to the GP *'to make a decision on how to best deal with the request'*.
26. The Practice stated the GP confirmed the patient did require an appointment and to tell the patient he *'would be contacted back that same day'*. This meant the patient received a generalised timescale for the call back that day. The receptionist placed the patient *'on the afternoon urgent call back list'* so the appointment would be *'added to the system when the slots were released at 13:53'*.

27. I note from documentation the Practice supplied, when the receptionist referred the matter to the GP, it was during time allocated to the GP for speaking with other patients. This would mean the GP would not necessarily have been immediately available when the receptionist referred the matter to her.
28. The IPA advised the receptionist *'had acted in accordance'* with the Practice's policy by referring it to the GP for a decision on whether *'the GP would be able to undertake a telephone consultation with this patient immediately or later in the day'*. The IPA further advised the *'GP agreed to make a phone call towards the end of the session'* to the patient. This indicated the GP did not feel *'this was an emergency situation'* requiring immediate patient contact or referral to emergency services. The IPA advised this was reasonable. Furthermore, I note the IPA's advice that, in the circumstances, the Practice acted with sufficient urgency when it arranged this consultation.
29. I acknowledge the patient and complainant had some difficulty in their interaction with the Practice's receptionist that morning. I note the Practice also acknowledged this and apologised for it as part of the internal complaints process. I have no doubt this was frustrating for the patient, who was in pain at the time. However, the patient did receive a telephone consultation for later that day. Furthermore, when the patient missed the locum GP's first call, the locum made a second call later that day. Having considered all available evidence, including the IPA's advice, I am satisfied the Practice treated the patient's needs with reasonable and appropriate urgency that day. I am also satisfied the Practice acted in line with relevant standards in doing so. Furthermore, I am satisfied that even if the Practice had marked the patient as housebound, this would not have had any impact on the urgency with which it arranged this consultation.

30. Regarding record-keeping, I note there are no records of the verbal interaction between the receptionist and the GP apart from the note attached to the electronic appointment by the receptionist. The Practice stated it was standard procedure to attach an electronic note *'for the purpose of the urgent telephone call'*. The call between the patient and the receptionist was recorded but was automatically deleted after 90 days. This means there is no longer a recording of the call between the receptionist and the patient/complainant and it is not the Practice's policy for detailed written notes to be made of the conversations due to the phone recording and the electronic note. As a result, I am unable to review what was said in relation to the patient obtaining a priority urgent appointment as he was housebound and how the conversation was conducted. Having reviewed all relevant evidence, including the Practice's responses, I accept it was not necessary for the receptionist or the GP to have kept any additional written or electronic record of the conversations they had to arrange the patient's telephone consultation that day.
31. Furthermore, the IPA advised the fact there were no written records of these conversations would not have *'any adverse impact on the patient'* as the Practice arranged the telephone consultation the same day and *'there did not seem to be an acute problem'* at the time of the referral to the GP. I accept this advice.
32. The complainant was also concerned the Practice scheduled a telephone appointment for the patient instead of a face-to-face appointment. In particular, she felt the patient's status as a housebound patient should have entitled him to a priority in-person consultation. I note RCGP Home Visit Information states *'If you are housebound or are too ill to visit the GP Practice you can request a home visit. You cannot insist that your GP visits you at home. Your GP will also visit you at home if they think that your medical condition requires it and will also decide how urgently a visit is needed.'*
33. The Practice acknowledged it had not marked this patient as housebound. However, it explained when it does do so, it marks a patient's housebound status on a patient's records. The Practice explained this is to *'notify clinicians'* a patient cannot attend the surgery premises. Where a face to face treatment, service or consultation is required this would result in a home visit by *'district nursing services'* or the GP.

34. The IPA advised housebound status '*does not automatically mean a housebound patient will always receive a [face to face] home visit by a clinician*' or increase the priority of when they will be seen. The IPA further advised '*speed with which medical services are provided relates to medical emergency*'. This means the housebound status of the patient would not:
- impact on the urgency of when a consultation took place; nor
 - mean the Practice would automatically schedule a face-to-face consultation, with GPs having the option to conduct telephone consultations in line with RCGP Home Visit Information.
35. The IPA further advised, having reviewed the patient's medical records, the Practice's decision to arrange a telephone consultation instead of a face-to-face consultation was reasonable and appropriate in the circumstances. He advised the symptoms the patient reported when he asked for the urgent appointment supported '*the use of a telephone consultation*' and meant the '*Practice acted appropriately in arranging for a telephone consultation*'. Having reviewed all relevant records, I accept this advice.
36. As set out above, I am satisfied that even if the Practice had marked the patient as housebound, this would not have impacted upon his prioritisation that day. I note the IPA's observation that the discrepancy between the parties as to whether the patient was marked as housebound may have contributed to the patient and complainant's frustration on the call with the Practice. However, having reviewed all relevant evidence, including the IPA's advice, I am satisfied that this even if the Practice had marked the patient as housebound, this would not have had any impact on the reasonableness of the Practice's decision to arrange a telephone consultation instead of a face-to-face one.
37. The complainant was further concerned that when the locum GP conducted her telephone consultation with the patient, she did not provide any effective help. The complainant explained her brother sadly died within a few days of this consultation.
38. I note Standard 15 of the GMC Guidance states:
- '1. *Good clinical care must include:*

- a. *adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient;*
- b. *providing or arranging advice, investigations, or treatment where necessary; and*
- c. *referring a patient to another practitioner when this is in the patient's best interests”.*

39. The Practice stated the locum GP phoned the patient at 14.39 but patient did not answer the call. I confirmed this in the medical records as well as noting the locum's entry undertaking to *'try again later in clinic'*. The records confirmed she phoned the patient at 17.50 at *'the end of my [GP's] clinic that day'*.
40. The IPA advised *'the medical history'* did not indicate *'any symptoms at a level that could indicate a recurring volvulus'* and the symptoms *'did not indicate a twisted bowel'* being presented *'for the first time'*.
41. I note the medical records from the time of the telephone consultation stated the patient said he *'was in good form'* now having visited the supported living facility earlier in the day, but *'he was feeling down earlier'* when he made the appointment. The locum GP concluded the consultation with safety netting advice including advice on where to approach if the patient's symptoms worsened. I further note the locum GP's report to the Coroner stated the patient *'denied having any physical or mental health concerns that he wanted to speak to me about at the time of our call'*.
42. The IPA advised the locum GP followed *'the standard practice'* to start a consultation with *'how the patient is feeling at that moment in time'*. The IPA further advised *'as there was no continuing issue'*, the GP provided *'reassurance, safety-net advice and signposting advice'* for if the patient got worse. The IPA advised this *'was reasonable and appropriate'*.
43. The IPA advised the *'level of pain/symptoms associated with a twisted bowel or one being recently "untwisted" would not have allowed'* the patient to visit the supported living facility earlier in the afternoon *'or present as he did at the afternoon telephone consultation'*.

44. I appreciate the suddenness of the patient's sad death, so soon after this consultation. I further appreciate the pain the patient described in his initial contact with the Practice that day. In the circumstances it is completely understandable the complainant has questions and concerns about the treatment the patient received. I also acknowledge the locum GP did not provide or recommend any further active treatment on the call. However, I note the patient described feeling better on his call with the locum GP. I further note he had been able to leave the house to attend an appointment in the intervening period. I do not question the complainant's experience of the patient's condition and pain that day. However, the locum GP was only able to address the information the patient presented to her on the call. Therefore, having reviewed all the relevant evidence, and the IPA's advice, I am satisfied the locum GP's consultation was reasonable and appropriate in line with the relevant standards, including Standard 15 of the GMC Guidance.

Summary

45. Having reviewed all relevant evidence, including the IPA's advice, I found the Practice acted with sufficient urgency to arrange a same-day consultation with the patient, following his call to the Practice on 22 April 2022. I found the Practice's decision to conduct a telephone consultation instead of a face-to-face one was reasonable, appropriate and in line with relevant standards. In addition, I found the care and treatment the locum GP provided to the patient when she conducted the consultation with him was reasonable and appropriate. Whilst I acknowledge the discrepancy between the parties regarding the patient's housebound status, I am satisfied that even if the Practice had marked him as housebound, this would not have had any impact on the reasonableness of the Practice's actions.

46. I therefore do not uphold this complaint.

CONCLUSION

47. I received a complaint about whether the Practice provided appropriate care and treatment for the patient on 22 April 2022 in line with the relevant policies and guidelines.

48. I offer through this report my condolences to the complainant for the loss of her brother. I note the complainant's comments that she witnessed the patient experience significant pain that day, and I do not question her experiences. However, I accepted the IPA's advice that there was nothing at the time of the consultation on 22 April 2022 to indicate *'any symptoms at a level that could indicate a recurring volvulus'* and the symptoms *'did not indicate a twisted bowel'* being presented *'for the first time'*.
49. For the reasons set out in this report I am satisfied the care and treatment the Practice provided to the patient was reasonable, appropriate and in line with relevant standards. I therefore did not uphold this complaint.
50. I note the Practice apologised to the complainant during the internal complaints process for the patient's interactions with their receptionist that day. It also apologised for not marking the patient as housebound in February 2022. I note the Practice has identified learning in this respect. It has provided care navigation and appointment booking refresher training for reception staff and updated its housebound policy. I welcome these actions.
51. I acknowledge how sudden the patient's passing was, and that he sadly died so soon after his call with the locum GP. I appreciate this must have been very difficult for the complainant. Throughout my investigation of this complaint, the complainant's love and devotion for her brother is clear. I hope my report provides the complainant with some reassurance regarding the care and treatment the Practice provided to her brother on 22 April 2022.

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.