Investigation of a complaint against a GP Practice

Report Reference: 202005270

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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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Case Reference: 202005270
Listed Authority: Braid Family Practice

SUMMARY

The complaint is about care and treatment Braid Family Medical Practice [now called Braid View Medical Practice] provided to the patient during December 2021 and January 2022. The complainant was the patient's brother. The Practice referred the patient to the Northern Health and Social Care Trust (the Trust) in December 2021 under its safeguarding procedures. In response, the Trust placed the patient into a care home, where she resided until February 2022.

In response to its concerns that the patient had difficulty moving, the Practice arranged for her to attend hospital for an x-ray on 24 December 2021. However, it later cancelled this appointment. The complainant raised concerns about its decision to cancel the x-ray. He was also concerned about the length of time it took the Practice to reschedule the x-ray. The investigation did not identify any failures in care and treatment for this issue. It found the decision and rationale for cancelling the x-ray appropriate. It also found it was not the Practice's responsibility to reschedule the x-ray given the patient no longer resided within its area.

The complainant raised a further concern that the Practice did not notify him that it submitted an APP1 form[1] to the Trust's Adult Protection Safeguarding Team. The investigation established the Practice did not have a responsibility to advise the complainant they had submitted a notification. Therefore, it did not identify any maladministration. I did not uphold the complaint. A GP discussed the referral with Trust social work staff, who had the responsibility to communicate with the complainant.

I appreciated the concern the complainant had for his sister and the circumstances that led to his complaint. I hope the findings of this report reassure the complainant that the Practice acted appropriately. I was sad to learn that the patient passed away

[1] A form used to refer a safeguarding concern to the Trust.

shortly after these events. I wish to pass on my condolences to the complainant for the loss of his sister.

THE COMPLAINT

1. The complaint was about care and treatment Braid Family Practice (the Practice) provided to the patient during the period 23 December 2021 to 12 February 2022. It was also about the Practice's communication with the complainant about a referral it made to the Northern Health and Social Care Trust's Adult Protection Safeguarding Team[2]. The complainant was the patient's brother and carer.

Background

2. The patient lived with Downs Syndrome and possible dementia. She had a severe learning disability and was non-verbal. On 20 December 2021, a District Nursing Team reported welfare concerns to the Practice after they attended to the patient at home. The patient's GP conducted a welfare visit at her home on 21 December 2021. The GP was concerned about the patient's wellbeing and discomfort. They arranged for the patient to attend Antrim Area Hospital for an x-ray on 24 December 2021. The Practice cancelled this appointment. The Practice later rearranged the x-ray, which took place on 11 January 2022. The x-ray did not identify any fracture.

3. The Practice also submitted an APP1 form to the Trust's Adult Protection Safeguarding Team, highlighting its concerns about the patient's safeguarding in her home. Following a Multidisciplinary Team (MDT) consultation involving the Direct Assessment Unit, Learning Disability Team and the Community Nursing Team, social services removed the patient and placed her into a residential care home (the Home) on 23 December 2021. The patient remained in the Home until 12 February 2022.

Issues of complaint

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

Issue 1: Whether the care and treatment the Practice provided to the patient during the period 23 December 2021 to 12 February 2022 was appropriate and in accordance with relevant guidance and standards.

[2] The team, together with other agencies, has a responsibility to investigate safeguarding concerns.

Issue 2: Whether the GP appropriately communicated to the complainant the reasons why the patient was removed from the family home.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

    - A GP with over 30 years' experience as a General Practitioner (IPA).

    I enclose the clinical advice received at Appendix 2 to this report.

7. 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

8. 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[3]:

    - The Principles of Good Administration

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative

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

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 2014 (the GMC Guidance).
- Department of Health, Social Services and Public Safety's Adult Safeguarding, Prevention and Protection Partnership, July 2015 (Safeguarding Policy).
- The Northern Health and Social Care Trust's Safeguarding Vulnerable Adults, A Shared Responsibility, Standards & Guidance for Good Practice in Safeguarding Vulnerable Adults, October 2010 (Northern Trust Safeguarding Policy).

I enclose relevant sections of the guidance considered at Appendix 3 to this report.

10. 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.

11. 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 complainant's comments were carefully considered before finalising the report.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Practice provided to the patient during the period 23 December 2021 to 12 February 2022 was appropriate and in accordance with relevant guidance and standards.

In particular this will consider:

- The cancellation of the patient's x-ray on 24 December 2021; and
- The rearrangement of the patient's x-ray appointment.

Detail of Complaint

Cancellation of the patient's x-ray on 24 December 2021

12. The complainant said the Practice should not have cancelled the patient's x-ray appointment on 24 December 2021.

Rescheduling of the patient's x-ray

13. The complainant said the Practice took longer than necessary to reschedule the patient's x-ray.

14. The complainant believed that if the patient attended for an x-ray earlier than she did, she would not have needed to remain in the Home until February 2022.

Evidence Considered

Guidance

15. I considered the following guidance:

    - GMC Guidance

Practice's response to investigation enquiries

Cancellation of the patient's x-ray on 24 December 2021

16. The Practice stated the GP booked an appointment for the patient to undergo an x-ray on 24 December 2021. The patient required an ambulance to transport her from the Home to her appointment. The Practice initially telephoned the Northern Ireland Ambulance Service (NIAS) on 23 December 2021 to arrange the ambulance. However, NIAS told the Practice there were no ambulances available, but it should try calling again the following morning. The Practice called NIAS again at 07:10 on 24 December 2021. However, due to pressures on the system, it was not possible to arrange an ambulance transfer.

17. The Practice stated there was an option for an ambulance to transfer the patient to the hospital's emergency department (ED). However, given it was Christmas Eve, it was likely the patient would '*face a lengthy wait'* for an assessment. Also, there was a possibility the hospital would admit the patient to

a ward, which may have posed a risk to her given the presence of Covid-19 at that time.

18. The Practice stated it felt that given the x-ray was intended to rule out any underlying injury, as opposed to it following an acute incident, it was more appropriate to rearrange the x-ray for a later date.

Rescheduling of the patient's x-ray ss

19. The Practice stated that the change in the patient's address [to the Home] meant she resided outside its catchment area. Therefore, the GP presumed that given '*the Disability Learning Team[4] was now involved in (the patient's) care, they would make arrangements for a new x-ray appointment*'. However, when the GP contacted the Home on 5 January 2022, *'it became apparent that this had not happened'*. The GP contacted the MAU[5] at the hospital on 6 January 2022 and arranged for the patient to attend for an x-ray on 11 January 2022.

Relevant Practice and NIAS records

20. I considered the following records:
    - GMC Guidance
    - GP Records
    - Patient Clinical Records
    - NI Ambulance Records

Relevant Independent Professional Advice

Cancellation of the patient's x-ray on 24 December 2021

21. The IPA advised the Practice's referral for an x-ray was in line with relevant GMC guidance.

22. The IPA advised that initially the patient was booked to have an x-ray at the Braid Valley in Ballymena. On the 23 December 2021 the patient was moved by Ambulance to a care home in Antrim. The IPA explained that the GP

[4] Healthcare team within the Nursing Home the patient was placed in.
[5] Medical Assessment Unit

Practice had unsuccessfully tried to arrange transport on 23 December but that arranging transport for the patient for her x-ray was only possible '*by ringing an ambulance on the morning of 24 December*'. The GP rang ambulance control '*at 07:10 on the 24th but due to demands on the service, it was not possible'*. There was another option to take the patient to the ED, but she would likely '*endure a lengthy wait'*.

23. The IPA advised '*given the purpose of the x-rays was to rule out potential underlying injury rather than a suspected fracture*' the x-ray was postponed. The IPA did not identify any failings with the GP's decision to cancel the x-ray appointment.

Rescheduling of the patient's x-ray

24. The IPA advised the patient was resident at that time in a care home '*out of the Practice area*'. Therefore, the patient needed '*to be temporarily registered with an Antrim GP should she require a visit*'. The IPA explained that as the patient '*was under the care of the disability team in a nursing home*', it '*would be them or the [new] Practice*' covering the Home who was responsible for rearranging the x-ray. Therefore, the Practice's assumption that another team would rearrange the x-ray was '*reasonable*'.

25. The IPA advised that by telephoning to check if the x-ray was carried out, and then subsequently re-booking the appointment, the Practice '*went above and beyond for the patient'*.

Analysis and Findings

Cancellation of the patient's x-ray on 24 December 2021

26. It is not in dispute that the Practice cancelled the patient's x-ray planned for 24 December 2021. It said this was because an ambulance was not available to transfer the patient to hospital.

27. I considered the relevant NIAS records. They evidence that the Practice initially telephoned ambulance control on 23 December 2021. However, as there were no ambulances available, NIAS asked the Practice to call back the following morning to check if the situation had changed. The records further evidence the

Practice contacted ambulance control at 07:10 on 24 December 2021. However, there was no ambulance available. Based on this evidence, I am satisfied the Practice made sufficient attempts to arrange for an ambulance to transport the patient to her appointment.

28. The Practice advised that NIAS offered to transport the patient to the hospital's ED as an emergency. However, the Practice did not consider this appropriate given the patient would likely have had a '*lengthy wait'* for the x-ray. It also considered there was an increased risk of the patient contracting Covid-19 in the hospital environment. Therefore, it cancelled the appointment.

29. The IPA did not identify any failing in the Practice's decision to cancel the appointment. He also did not identify any failings in the Practice's rationale for its decision, as the x-ray was to rule out potential underlying injury rather than as a reaction to a '*suspected fracture'*.

30. I fully appreciate why the complainant was concerned about the decision to cancel the x-ray, especially as it may have established a cause for the patient's discomfort. It is unfortunate that circumstances led to the Practice cancelling the appointment. However, I accept the IPA's advice that the decision to do so was reasonable.

31. GMC Guidance requires clinicians to '*make the care of your patient your first concern'*. I am satisfied the Practice made its decision in the patient's best interests. Therefore, I have not identified a failure in its care and treatment of the patient. As such, I do not uphold this element of the complaint.

32. I note the patient had her x-ray on 11 January 2022 and it did not identify any concerns. I hope this helps to reassure the complainant.

Rescheduling of the patient's x-ray

33. It is disappointing that the patient had to wait until 6 January 2022 before it was realised that no one had rearranged her x-ray.

34. The Practice's records evidence that following the patient's move to a care home on 23 December, it informed both the Home and the Trust that while the patient resided in the Home, she fell outside the Practice's remit. Therefore, she should temporarily register with a local Practice for that period.

35. I note the IPA's advice that therefore, the responsibility for rescheduling the patient's appointment fell to either the Practice the patient was temporarily registered with or the Disability Learning Team. I accept this advice. As such, I consider it was reasonable for the Practice to expect the new provider or the Trust to rearrange the x-ray appointment.

36. I consider there was a delay in rescheduling the x-ray. The complainant was rightly concerned about this. However, I do not consider the Practice was responsible for the delay and I have not identified a failure in the Practice's care and treatment of the patient. I therefore do not uphold this element of the complaint. This will be little consolation to the complainant as ultimately the x-ray was delayed by failures within the overall system.

37. I note the GP followed up with the Home to check if the patient had attended for an x-ray. It was as a result of this that the GP contacted the hospital to arrange an appointment. I commend the Practice for taking this action and ensuring the patient attended for an x-ray, especially given the patient was not under its care at that time. Had the GP not done so it is likely the x-ray would have been delayed further.

Issue 2: Whether the GP appropriately communicated to the complainant the reasons why the patient was removed from the family home.

Detail of Complaint

38. The complainant believed the GP should have informed him that she completed and submitted to social services an APP1 Adult Protection report about the patient's welfare at home. He said the way the GP handled the situation caused both him and the patient to suffer unnecessarily.

Evidence Considered

Policies

39. I considered the following policies:
    - Safeguarding Policy
    - Northern Trust Safeguarding Policy

Practice's response to investigation enquiries

40. The Practice stated it was the GP's understanding that following her submission of the APP1 form on 21 December 2021, it was the Social Worker's responsibility to follow up with the complainant. The GP spoke with a representative from the Trust on 22 December 2021 about the subject of notifying the complainant of the safeguarding concern. The representative told the GP they would escalate the matter.

41. The Practice stated that while the complainant *'was not expressly informed that [the GP] had submitted an APP1 form, the fact that there were safeguarding concerns about [the patient] was discussed with the complainant'*. It discussed these concerns with the complainant both during a telephone call and in person on 24 December 2021. During the telephone call, the GP informed the complainant that the patient *'had pressure sores on her bottom, poor mobility and a lack of supportive structures in place to support [the patient] in her activities of daily living at home'*. The GP also explained to the complainant that an MDT was involved in the decision to admit the patient to the Home for a period of time for assessment.

Relevant Practice records

42. I considered the following records:
    - GP Records
    - Record of telephone call with complainant on 24 December 2021

Relevant Independent Professional Advice

43. In relation to the communication of the submission of the APP1 Adult Protection Report, the IPA advised it is the role of the GP to '*respond to the concerns raised by the district nursing team and the GP to see the way the patient was being looked after*'. Therefore, '*it was right*' for the GP to '*refer the case to the learning disability safeguarding team on the 22nd December*'.

44. The IPA advised it was the Adult Safeguarding Team's responsibility to '*assess the situation and then decide on what action needed to be taken under the referral pathway*'.

45. The IPA advised that the records evidence that on 22 December 2022, the social worker told the GP that the social work team would speak to the complainant '*to explain that the patient was going to be admitted to a Nursing Home following an MDT meeting*'.

Analysis and Findings

46. The Practice submitted an APP1 form to the Trust on 21 December 2021. The Adult Safeguarding Policy states '*GPs and other allied health professionals…have a key role in the identification of risks and harm and ensuring appropriate referral to the HSC Trust for a further assessment of needs and/or risks*'. The Northern Trust Safeguarding Policy states that if you suspect someone to be at risk '*contact the Northern Trust Adult Protection Safeguarding Team*'. The records evidence that the Practice acted in line with the requirements outlined in both policies.

47. The Adult Safeguarding Policy further states it is the Trust's safeguarding team who carry out the investigation and risk assessment to decide on next steps. The guidance does not outline any responsibility for GP Practices. I am therefore satisfied there was no requirement within either policy for the Practice to take additional action following its referral to the team, including notifying the complainant about the referral.

48. Based on the guidance outlined, I accept the IPA's advice that '*it would be the Adult safeguarding team to assess the situation and then decide on what action needed to be taken under the referral pathway'*. I also accept the IPA's advice that it was not the GP's role to communicate to the complainant about the submission of the APP1 form, but to respond to concerns raised and '*to see the way the patient was being looked after*'.

49. The Practice said its GP spoke to a representative from the Trust on 22 December 2021. The GP's contemporaneous note of the conversation evidenced that they told the representative they expected the social worker to notify the complainant about the safeguarding concern. The representative agreed to escalate the matter within the Trust. Based on this note, I consider it reasonable for the Practice to have expected the Trust to take this forward and notify the complainant of the concern raised.

50. I appreciate the complainant was not informed about the APP1 referral until after he raised his complaint. However, based on the guidance and evidence available, I am satisfied it was not the Practice's responsibility to notify him about the concern raised. Therefore, I have not identified any failure in this regard. As such, I do not uphold this issue of complaint.

CONCLUSION

51. I received a complaint about care and treatment Braid Family Practice (the Practice) provided to the patient during the period 23 December 2021 to 12 February 2022. The complainant also raised a concern that the Practice did not notify him that it submitted an APP1 form to the Trust.

52. I did not identify a failure in care and treatment of the patient for the reasons outlined in this report. I also did not identify any maladministration in the Practice's communication with the complainant. I therefore do not uphold the complaint.

53. It is clear from my reading of the records how involved the complainant was in the patient's care. I hope this report goes some way to address his concerns. I have learned the patient sadly passed away shortly after the events in this complaint. I offer through this report my condolences to the complainant for the loss of his sister.

SEAN MARTIN
Deputy Ombudsman
MARCH 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.