Scottish Parliament Region: Glasgow

Case 200501825: A Medical Practice, Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: GP, Clinical treatment

Overview

The complainant (Mr C) considered that his GP Practice (the Practice) failed to diagnose and treat his illness and he was unhappy that the Practice decided to no longer provide medical treatment to him, his brother and his father.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) the alleged failure to diagnose and treat Mr C's illness (*not upheld*); and

(b) that the decision by the Practice to remove Mr C and his family from their list was wrongly taken (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:

(i) apologise in writing to Mr C, his brother and his father for the failure to follow the appropriate procedures when taking the decision to remove them from the Practice list; and

(ii) review how it takes such decisions in light of The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, and ensure that Practice policy and actions are compliant with this Statutory Instrument.

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

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

Main Investigation Report

Introduction

1. In October 2005 the Ombudsman accepted a complaint from a person who is referred to in this report as Mr C. Mr C was a patient at a GP Practice (the Practice) in the former Argyll and Clyde NHS Board (the Board) area.

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

(a) the alleged failure to diagnose and treat Mr C's illness; and

(b) that the decision by the Practice to remove Mr C and his family from their list was wrongly taken

Investigation

3. After he submitted his complaint I wrote to Mr C asking for all relevant correspondence and documents, which he sent to me. I used this as a basis to make a written enquiry of the Practice and was sent a comprehensive response which included notes on how Mr C's complaint was handled, copies of relevant correspondence and a copy of the Practice's own publications including guidance on *Removal of Patients From List*. I also obtained Mr C's medical records from his new GP Practice. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

4. I obtained advice from the Ombudsman's Medical Adviser (the Adviser), a Consultant in General Practice, on the clinical aspects of the complaint. We examined the papers provided by Mr C, the Practice's complaint file, the Practice's information leaflets and booklets for patients and staff, Mr C's clinical records and the Practice's reply to enquiries which I put to them.

5. In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable, in the circumstances at the time in question. By reasonable, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

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

(a) The alleged failure to diagnose and treat Mr C's illness

7. Mr C had a very rare cancer when he was an infant. This cancer was initially present in his finger but later spread to his lung. The cancer was successfully treated with chemotherapy. The medical condition which is the subject of this complaint is not cancer, but this background is important to Mr C's interpretation and understanding of illness. Mr C was a patient of the Practice at that time, having been registered there since birth.

8. In late 2002 Mr C had an infection of his mouth which healed in approximately six weeks. During this episode of infection he was seen by a locum doctor (Locum 1) at the Practice who prescribed Amoxycillin and noted his past history of cancer on the Practice record.

9. In June 2004 Mr C had a recurrence of the mouth infection and attended the Practice, where he was seen by another locum doctor (Locum 2) and was again prescribed Amoxycillin for what was seen as a fungal infection. The condition continued to cause pain for Mr C and so he returned to the Practice where he was seen by his regular Practice doctor (GP 1) who prescribed Metronidazole and signed Mr C off work for two weeks. A mouth swab was taken and blood tests were carried out and records show that this was in part due to Mr C's previous history of cancer. At this time the Practice first suggested the possibility of a referral to the local Dental Hospital should the symptoms persist. However, the test results were all clear and the condition healed in about six weeks.

10. In October 2004 the infection returned. On 13 October Mr C attended the Practice and saw GP 1 who was of the view that as the blood tests taken in June had been all clear it was not necessary to repeat them. Mr C was prescribed Metronidazole and Ibuprofen and, given the recurrence, GP 1 considered referring Mr C to the Dental Hospital. On 15 October Mr C's father (hereafter referred to as Mr F) telephoned the Practice to request a home visit as Mr C's condition had worsened and he was now in considerable pain. A Practice doctor (GP 2) suggested that Mr C be brought to the surgery for examination, but Mr F reported that Mr C was in too much pain to be brought to the surgery. GP 2 then suggested that Mr C be taken to hospital if he was in significant pain. Mr F and Mr C's brother (hereafter referred to as Mr B) took Mr C to the local Accident and Emergency Unit (A&E) where Mr C was diagnosed with a mouth infection. A&E advised that Mr C continue taking

Metronidazole and in addition prescribed liquid Ibuprofen and Paracetamol. The pain, however, continued and Mr C was taken to the local out-of-hours Emergency Medical Service (EMS) on 16 October 2004 where he was diagnosed with a mouth infection and Difflam was prescribed.

11. On 18 October 2004 Mr C and Mr F attended the Practice where they saw GP 1. Mr F made explicitly clear his unhappiness at the treatment Mr C had received from the Practice, given the recurrence of the infection and the pain Mr C was experiencing. GP 1, who felt that this appointment was intimidating, noted that Mr C's pain was much worse, that his mouth and lips were ulcerated and there was a vesicular eruption on his hands. GP 1 sent an urgent appointment request to the Dental Hospital and Mr C was seen by a Consultant Physician in Oral Medicine at the Dental Hospital that afternoon. The Consultant diagnosed the condition as erythema multiforme (a rash, see Annex 2) and prescribed Prednisolone and emphasised the importance of maintaining an adequate fluid intake. Mr C's condition improved and he attended the Dental Hospital for a number of months to treat and monitor the condition.

12. In his complaint to the Practice Mr C said that he believed the Practice was responsible for 'several cases of misdiagnosis, wrong medication and … refusal to attend a home visit when [Mr C] was in need of urgent medication'. In relation to the third episode of the infection and in particular the visit to the Practice on 18 October 2004, Mr C said that Mr F had asked GP 1 if Mr C's condition was related to cancer (given Mr C's history of cancer as a child, see paragraph 7), to which Mr C alleged GP 1 replied 'I can't honestly look you in the eye and tell you it is not cancer'. Mr C's view on his complaint about the Practice was focused by what he regarded as the quick, accurate and sympathetic treatment he had received from the Dental Hospital.

13. The Practice, in its response to my enquiries, said that Mr C's past medical history was well known and that all doctors treating him would have had access to his medical history. The Practice also said that a possible link with cancer was considered when Mr C was examined and treated but that observations and blood test results meant that cancer was considered to be an unlikely cause for his symptoms.

14. In responding to directly to Mr C about his complaint, a senior partner at the Practice (GP 3) said:

'We were surprised to hear that the diagnosis was erythema multiforme. This is a very rare diagnosis and is an unusual presentation in the mouth. Obviously, at the … Dental Hospital, which is a specialist centre, they do see this condition from time to time and certainly more frequently than we, as general practitioners, do.'

15. The Adviser, a Consultant in General Practice, said that erythema multiforme is a rare illness that would not be easy for a GP to diagnose given that they would not see it frequently. The illness is of a type that recovers of its own accord, whether or not treatment is administered. Therefore, it appeared to the Practice doctors that the antifungal treatment they had prescribed was working, thus reinforcing their belief that Mr C had a fungal illness. The Adviser pointed out that it was of note that not only the Practice doctors, but also A&E and EMS made the same diagnosis of 'mouth infection'. In fact this was strictly accurate as in Mr C's case the erythema multiforme mainly affected the mouth and was an infection.

16. The Adviser went on to say that the Practice GPs, as well as A&E and EMS managed Mr C's illness appropriately in the circumstances. Neither A&E nor EMS felt an immediate referral to hospital was necessary and on 18 October 2004, when Mr C's condition was much worse than before, GP 1 made arrangements for an urgent specialist consultation. The Adviser said that he accepted that the Dental Hospital specialist made the proper diagnosis immediately, but that is the reason for having specialists. The GP's job is to refer patients to them when in doubt as to the diagnosis, or if the patient does not improve with what is thought to be appropriate treatment as in this case.

(a) Conclusion

17. Because Mr C experienced several recurrences of the mouth infection, in particular the October 2004 episode that he described as very painful and distressing for him and his family, I understand why his view was that Practice doctors did not correctly diagnose and treat his illness. However, it is clear to me from Mr C's medical records and the advice from the Adviser that erythema multiforme is a rare condition and that such a diagnosis would not likely be the first conclusion of a GP. The records show that GPs at the Practice, including locum doctors, noted Mr C's symptoms and prescribed what they considered to be appropriate treatment, as corroborated by the actions of A&E and EMS. The records also show that doctors at the Practice took account of Mr C's history of cancer when considering his symptoms and arranging tests and treatment.

When the condition deteriorated in October 2004 GP 1 made an urgent referral to the Dental Hospital. Mr C was seen and diagnosed by a Consultant Physician in Oral Medicine and treatment commenced on the same day. All of this leads me to conclude that although Practice doctors did not diagnose erythema multiforme, they acted appropriately on the basis of the presenting symptoms and could not reasonably have been expected to diagnose such a rare condition. On this basis I do not uphold this complaint.

(b) That the decision by the Practice to remove Mr C and his family from their list was wrongly taken

18. Mr C, in his evidence, has made it clear that the events of 13 to 18 October 2004 were difficult for him and his family. The fact that the Practice did not make a home visit on 15 October 2004 and the deterioration in Mr C's condition led to a heated exchange, described by the Practice as 'vitriolic' (see paragraph 24), between Mr F and GP 1 at the surgery on 18 October 2004. Mr C said that Mr F made clear to GP 1:

> 'how angry and appalled we … were at the treatment we received … and if appropriate actions were not taken … we would take the necessary measures to ensure formal complaints would be made against the GPs involved and that further steps would be taken to make this issue public …'

The Practice have also made clear that GP1 felt that Mr F and Mr C were trying to intimidate him during the exchange on 18 October 2004.

19. Shortly after Mr C's condition of erythema multiforme was diagnosed on 18 October 2004 and treatment commenced, an article appeared in the local newspaper which featured Mr C. The article was critical of the treatment he had received from the Practice. Following this GP 3 wrote to Mr C to encourage him to make a formal complaint. Mr C responded in writing to say that he wanted a meeting to discuss his concerns and that he wanted to:

> 'avoid, if at all possible, any formal paperwork, complaints forms etc, as my family and I have been members of the Practice for many years and our main goal from this meeting is for our questions to be answered and personal assurance further incidents are avoided in the future.'

GP 3 wrote back to Mr C to advise that they would try to arrange a meeting, but that:

> 'it will not be possible for us to comply with your … request to avoid any formal paperwork as, due to the nature of the job that we do, complaints

are always taken very seriously and are fully documented. In this way, we have an accurate account of the concerns raised, the nature and outcome of any meeting and can reflect on matters not only with the doctors involved, but with the wider Practice team.'

Mr C submitted his concerns in writing to the Practice but, due to scheduling problems, a meeting did not take place. The Practice carried out an investigation which involved obtaining accounts of what had happened from the GPs involved in the October 2004 episode, and documenting the chronological sequence of consultations from the initial episode in 2002 through to the October 2004 episode. GP 3 sent a formal written response to Mr C on 3 December 2004.

20. The Practice have told me that

'[Mr C]'s family's relationship with the Practice had been discussed on several occasions during the period of December 2004 to August 2005.'

Between 4 December 2004 and 17 August 2005 there is no evidence of contact between Mr C and the Practice in relation to Mr C's complaint. In the same period Mr C attended the Practice only once, on 21 July 2005, for a consultation with a locum GP (Locum 3) as the erythema multiforme had returned and for which he was prescribed Prednisolone.

21. On 18 August 2005 Mr C, Mr B and Mr F each received a letter from the Practice notifying them that:

'Having allowed considerable time for reflection, the Partners have discussed your relationship with the Practice. They have reached the unanimous decision that the essential bond of trust between Medical Practitioner and Patient has been broken. For this reason we have concluded that your medical care should be provided by another GP Practice.'

22. The Practice information booklet includes a section on 'Your responsibilities as a patient'. This section has a statement that the Practice:

'insist that our staff are treated with respect. It is not acceptable to be rude or offensive to the staff even when you are under stress. Offensive behaviour may lead to us asking you to find another Practice.'

23. The Practice also has a policy document on *Removal of Patients from List*. This includes guidance on removing patients due to the irretrievable breakdown of the doctor – patient relationship. The protocol for dealing with such cases lists the steps to be taken with the patient:

- 'Inform the patient personally that there is a problem, and consider arranging a meeting to discuss matters. If it is decided to inform the patient by letter, the GP should seek advice from the Defence Union before the letter is sent.
- Attempt to explain the nature of the problem to the patient. Doctors will decide who is the most appropriate person to facilitate this discussion.
- Try to elicit the patient's issues and interpretation of the problem.
- Be prepared to negotiate with the patient to resolve the problem where appropriate … '

24. In response to my enquiries the Practice said:

'The MDDUS advised us not to remove [Mr C]'s family from our list until a period of time had passed to allow [Mr C] to reflect on our response to his complaint. The Practice had thought [Mr C]'s family might move their medical care to another GP surgery, since they were obviously extremely dissatisfied with the service we had provided to them.'

The Practice went on to say that:

'The Practice is very much aware that removing patients from the list because they have initiated a complaint is not good medical Practice. Therefore, removing [Mr C]'s family from our patient list was not an easy decision for us. [Mr C]'s family's relationship with the Practice had been discussed on several occasions during the period of December 2004 to August 2005. The reasons for our decision to remove them from the Practice list were as follows:

The angry and vitriolic tone of the consultation … on 18 October 2004 was distressing to the partner concerned [GP 1] …

[Mr C]'s family's decision to take their complaint to the local press rather than take up the offer … to investigate the complaint and attempt to resolve any grievance was taken as a sign that the trust in the Practice had been badly damaged.

The lack of communication from the family following our response to their complaint, despite having been invited to meet to discuss any outstanding issues.

In view of the above the GP Partners decided that the relationship between both parties had been irretrievably broken and it was not conducive to continue to provide medical care to the family. It was with much sadness that the Practice decided that the correct and professional decision was that [Mr C]'s family should be looked after by another GP surgery.'

25. For some time, in the face of an increase in reported incidents of abuse of staff, the NHS has operated a zero tolerance policy in relation to such abuse. In 2003 NHS Scotland ran a Zero Tolerance Campaign, and health boards have policies for the management of violence and aggression. The Campaign Resource Pack noted that:

'It is important that staff and service users are aware of what constitutes 'violent' behaviour. There are many definitions in circulation. The Health and Safety Executive (HSE) define violence as 'Any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment'. The Health at Work PIN [Partnership Information Network] Guidelines expand upon this definition, 'Violence is not restricted to acts of aggression which result in physical harm. It also includes behaviours such as gestures or language that may cause staff to feel afraid, threatened or abused'. It is important to recognise that individuals will view incidents differently. What makes one person afraid or uncomfortable may be perfectly acceptable to someone else. It is necessary therefore to take this 'personal perspective' into account when applying any definitions.'

26. The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 at Schedule 5, Part 2, Section 20 state the procedure to be followed when a GP Practice wishes to remove a patient from their list of patients. In particular, the Regulations state that a Practice may only make a request to the relevant Health Board for the removal of a patient if, within twelve months prior to the date of this request, the Practice has warned the patient that they are at risk of removal and explained to them the reasons for this. There are a number of possible exceptions to this, mainly to do with possible harm to people connected with the Practice. There is also a general exception that, in the opinion of the Practice, it would 'not otherwise be reasonably practical for a warning to be given'. Section 20 of this Statutory Instrument is included at Annex 4.

(b) Conclusion

27. Despite the fact that a meeting could not be arranged between Mr C and Practice staff in November 2004, the Practice conducted an investigation of Mr C's complaint and sent him a response on 3 December 2004. The handling of the complaint is, therefore, not at issue.

28. The fact that Mr C pursued his complaint via the local press rather than directly to the Practice is a matter of concern. Mr C, of course, had the right to do this but in the circumstances I do not believe that it was effective or helpful. This action by Mr C was felt by the Practice to be damaging to their public reputation. It is, therefore, understandable that the Practice cited this as one of the reasons for removing Mr C and his family from the list of patients.

29. The Practice have told me that they discussed the relationship with Mr C and his family on several occasions in the Practice during the period of December 2004 to August 2005. While this may be true, I cannot comment on this as there is no evidence to support this claim. In addition, the gap of nearly nine months from the Practice's response to the complaint to the sending of the letters informing Mr C and his family of removal from the list has not been sufficiently explained. The justification of the advice from the MDDUS as mentioned in paragraph 23 is not sufficient in itself, and is more lacking when taken in tandem with the absence of any warning to Mr C and his family that they might be removed from the list.

30. The Practice has not followed its own guidance as quoted in paragraph 23. Although it is guidance, therefore, unlike statute or regulation is not binding, I have not seen evidence to reasonably explain why the Practice did not follow it. In addition, the Practice do not appear to have followed the provisions of the Statutory Instrument referred to in paragraph 24. While Section 20(4) allows for no warning to be given in certain stated circumstances (see Annex 1), there is no evidence to support such a position in this case. The Practice have said that Mr F used an 'angry and vitriolic tone' during the consultation with GP 1 on 18 October 2004. There is no independent corroboration of this exchange, and, therefore, it cannot be proven. However, even on the assumption that the exchange did take place as described, and even though GP 1 found it intimidating and taking into account the zero tolerance culture in the health service (see paragraph 25), the Practice have not been able to provide reliable evidence to suggest that Mr C, Mr F or Mr B would

pose a risk to the safety of people at the Practice. Neither have the Practice supplied contemporary evidence recording why it was not 'otherwise reasonably practical' for a warning to have been given or, as already noted, how the situation regarding Mr C, Mr F and Mr B was discussed on several occasions in the Practice during the period of December 2004 to August 2005.

31. The Practice, according to their own guidance, should have engaged in discussion with Mr C and his family on the Practice's view that both parties' needs would be better served by Mr C, Mr B and Mr F moving to a different GP Practice. The Statutory Instrument is quite clear that a GP Practice may only request the removal of patients if, within the period of 12 months prior to the date of its request to the Health Board to have them removed, it has warned the patients that they are at risk of removal and explained to them the reasons for this. No warning was given in this case. It is understandable that Mr C and his family were shocked to receive the letters advising of their removal from the Practice list, particularly when the last formal contact in relation to the complaint was almost nine months earlier. On the basis of the evidence I, therefore, uphold Mr C's complaint.

(b) Recommendations

32. The Ombudsman recommends that the GP Practice should:

(i) apologise in writing to Mr C, Mr B and Mr F for the failure to follow the appropriate procedures when taking the decision to remove them from the Practice list; and

(ii) review how it takes such decisions in light of the The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, and ensure that Practice policy and actions are compliant with this Statutory Instrument.

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

24 October 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Practice	Mr C's GP Practice from birth until August 2005
The Board	Argyll and Clyde NHS Board
The Adviser	A medical adviser to the Ombudsman, in this case a Consultant in General Practice
Locum 1	A locum GP who saw Mr C on 31 October 2002
Locum 2	A locum GP who saw Mr C on 18 June 2004
GP 1	Mr C's regular GP
Mr F	The complainant's father
GP 2	The GP who dealt with the home visit request on 15 October 2004
Mr B	The complainant's brother
A&E	Accident and Emergency
EMS	Emergency Medical Services
GP 3	A senior partner at the GP Practice who gave the formal response to Mr C's complaint

Locum 3	A locum GP who saw Mr C on 21 July 2005
MDDUS	The Medical and Dental Defence Union of Scotland

Annex 2

Glossary of terms

Amoxycillin	A commonly used penicillin
Difflam	A non-steroidal anti-inflammatory drug
Erythema multiforme	A rash that is usually mild with only a few spots causing little trouble and clearing up quickly. There can be a more severe type, which is rare, that can be life threatening.
Ibuprofen	A non-steroidal anti-inflammatory drug
Lesion	Abnormal tissue
Locum	A doctor who does the job of another doctor who is ill or on holiday
Metronidazole	An antimicrobial agent
Paracetamol	A common analgesic drug
Prednisolone	A synthetic corticosteroid drug
Vesicular eruption	An outbreak of blisters

Annex 3

List of legislation and policies considered

GP Practice *Removal of Patients from List*

The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004

NHS Scotland Zero Tolerance Campaign Resource Pack

Annex 4

Scottish Statutory Instrument 2004 No. 115
The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004
PART 2

Patients
Removal from the list at the request of the contractor 20. -

(1) Subject to paragraph 21, a contractor which has reasonable grounds for wishing a patient to be removed from its list of patients which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition shall -

(a) notify the Health Board in writing that it wishes to have the patient removed; and

(b) subject to sub-paragraph (2), notify the patient of its specific reasons for requesting removal.

(2) Where, in the reasonable opinion of the contractor -

(a) the circumstances of the removal are such that it is not appropriate for a more specific reason to be given; and

(b) there has been an irrevocable breakdown in the relationship between the patient and the contractor,

the reason given under sub-paragraph (1) may consist of a statement that there has been such a breakdown.

(3) Except in the circumstances described in sub-paragraph (4), a contractor may only request a removal under sub-paragraph (1) if, within the period of twelve months prior to the date of its request to the Health Board, it has warned the patient that the patient is at risk of removal and explained to him the reasons for this.

(4) The circumstances referred to in sub-paragraph (3) are that -

(a) the reason for the removal relates to a change of address;

(b) the contractor has reasonable grounds for believing that the issue of such a warning would -
(i) be harmful to the physical or mental health of the patient; or
(ii) put at risk the safety of the persons specified in sub-paragraph (5); or

(c) it is, in the opinion of the contractor, not otherwise reasonably practicable for a warning to be given.

(5) The persons referred to in sub-paragraph (4) are -
(a) in the case of a contract with an individual medical practitioner, that practitioner;

(b) in the case of a contract with a partnership, a partner in that partnership;

(c) in the case of a contract with a company, a legal and beneficial owner of shares in that company;

(d) a member of the contractor's staff;

(e) a person engaged by the contractor to perform or assist in the performance of services under the contract; or

(f) any other person present -
(i) on the Practice premises, or
(ii) in the place where services are being provided to the patient under the contract.

(6) The contractor shall record in writing -
(a) the date of any warning given in accordance with sub-paragraph (3) and the reasons for giving such a warning as explained to the patient; or

(b) the reason why no such warning was given.

(7) The contractor shall keep a written record of removals under this paragraph which shall include -
(a) the reason for removal given to the patient;

(b) the circumstances of the removal; and

(c) in cases where sub-paragraph (2) applies, the grounds for a more specific reason not being appropriate, and shall make this record available to the Health Board on request.

(8) A removal requested in accordance with sub-paragraph (1) shall, subject to sub-paragraph (9) take effect from -

(a) the date on which the Health Board receives notification of the registration of the person with another provider of essential services (or their equivalent); or

(b) the eighth day after the Health Board receives the notice referred to in sub-paragraph (1)(a), whichever is the sooner.

(9) Where, on the date on which the removal would take effect under sub-paragraph (8), the contractor is treating the patient at intervals of less than 7 days, the contractor shall notify the Health Board in writing of the fact and the removal shall take effect -

(a) on the eighth day after the Health Board receives notification from the contractor that the person no longer needs such treatment; or

(b) on the date on which the Health Board receives notification of the registration of the person with another provider of essential services (or their equivalent), whichever is the sooner.

(10) The Health Board shall notify in writing -

(a) the patient; and

(b) the contractor,

that the patient's name has been or will be removed from the contractor's list of patients on the date referred to in sub-paragraph (8) or (9).