Scottish Parliament Region: Glasgow

Cases 200700438 & 200800535: NHS 24 and Greater Glasgow and Clyde NHS Board – Acute Services Division

Summary of Investigation

Category

Health: Out-of-hours; general medical services

Overview

The Ombudsman received a complaint from a member of the public (Mrs C). Mrs C complained that her husband (Mr C) had not received the appropriate treatment further to a telephone call to the out-of-hours emergency medical services provided jointly between the NHS 24 and Greater Glasgow and Clyde NHS Board (the Board), during which time it is stated by the family they had been unable to get the service to accept their description of Mr C's illness. He had been out early in the evening and returned home complaining of a headache. Initially, Mr C had been advised to take medication available in the house, rest and let NHS 24 know if there was no improvement. He was admitted to the Southern General Hospital the following morning and died eight days later of subarachnoid haemorrhage. Mrs C complained that there was a delay of 12 hours without treatment for her husband.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) NHS 24 failed to provide proper care and treatment to Mr C (*upheld*); and

(b) the Board failed to provide proper care and treatment to Mr C (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) NHS 24 provide an apology to Mrs C and her family for the delay in transferring the necessary clinical details to the correct out-of-hours service;

(ii) NHS 24 conduct an evaluation into a review of the improvements introduced by NHS 24 as a result of this complaint;

(iii) NHS 24 ensure call handlers' basic training is developed enough to ensure staff are able to determine how to manage information they are given when a call is made from a service user, and the mechanism to transfer

vital clinical information between services is reviewed to avoid mistakes in transmission arising;

(iv) NHS 24 ensure the algorithms are fit for purpose in so far as they are able to capture the appropriate detailed information to assist the nurses to make the appropriate decisions;

(v) the Board provide an apology to Mrs C and her family for the delay in picking up on the clinical symptoms described by Mr C and his family;

(vi) the Board undertake a further review of the triage doctor's clinical practice in order to ensure their understanding of the signs and symptoms of a subarachnoid haemorrhage; and

(vii) the Board ensure the triage doctor reflects on the lessons of the case, shares it with his appraiser during his next appraisal and is aware of the possibilities of rare diagnoses such as subarachnoid haemorrhage for future work.

NHS 24 and the Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 10 May 2007, the Ombudsman received a complaint from a member of the public (Mrs C) whose husband (Mr C) had died following a subarachnoid haemorrhage (a kind of stroke where there is a bleed from one of the blood vessels running over the brain), on 9 April 2006 after being admitted to the Southern General Hospital (the Hospital) on the morning of Sunday 2 April 2006. Mrs C complained that her request for help for her husband from the out-of-hours medical services was not attended to for 12 hours prior to his admission to the Hospital. Mrs C's daughter (Ms C) raised her mother's complaint initially with NHS 24 (NHS 24) and the issues relating to Greater Glasgow and Clyde NHS Board (the Board) were forwarded to them by NHS 24 to look into the aspect of the complaint that related to their services. Mrs C remained unhappy with the responses she received and through a support worker within her local Citizens Advice Bureau, brought her complaint to the Ombudsman.

2. Whilst the complaint does refer to two separate Boards, the issue of complaints are closely related around one episode of care and, therefore, it has been addressed within one report taking into account the responses made by both Boards involved in Mr C's care during the evening of Saturday 1 and Sunday 2 April 2006.

3. The complaints from Mrs C which I have investigated are that:

(a) NHS 24 failed to provide proper care and treatment to Mr C; and

(b) the Board failed to provide proper care and treatment to Mr C.

Investigation

4. As part of the investigation into this complaint I have received information about the assessment carried out by the Board's Glasgow Emergency Medical Services (GEMS) over the telephone and a note of the visit made by the visiting GP (Doctor 1) during the following morning, which determined Mr C's admission to the Hospital. I have reviewed the clinical recordings of the information shared over the telephone between NHS 24 and Mr C and his family. I have received clinical advice regarding this complaint from an adviser to the Ombudsman (the Adviser).

5. Ms C complained to NHS 24 on 2 September 2006 and they shared the complaint with the Board in order for the Board to address the aspects of the complaint that related to their part of the out-of-hours service which had been provided by them. NHS 24 replied to Ms C, acting on behalf of her mother, on 20 October 2006 and the Board responded on 26 October 2006. The Board responded to my investigation enquiries on 22 January 2008 providing details of the complaint relating to the Board's triage doctor (Doctor 2).

6. On 11 February 2008 NHS 24 responded to my enquiries and provided a summary of the calls that were made by the family during the evening of Saturday 1 April and Sunday 2 April 2006. I have also heard the audio recording of the calls made. NHS 24 had a computer based record of the calls that had been made and this information was passed to the Board for Doctor 2 to make the required telephone call to Mr C and his family.

7. In the response to the complaint, NHS 24 let the family know they had considered, at the time, that a house visit by a doctor was not appropriate and that a doctor would telephone them.

8. The Board later contact that morning with Mr C's family resulted in Doctor 1 being asked to visit, which facilitated the admission to the Hospital during the following day. The concerns about the telephone call between Doctor 2 in GEMS and Mr C and his family was a matter for the Board to consider.

9. The family remained unhappy with the responses they received prompting them to complain to the Ombudsman.

10. On 2 September 2006, Ms C complained on her mother's behalf of a lack of professional attention during the early morning of 2 April 2006, and was concerned that Mr C's death would have been prevented had he been seen sooner. In order to get medical assistance for Mr C the family had contacted NHS 24 in the early hours of Sunday 2 April 2006. Mrs C explained that Mr C suddenly became ill after his return home from a meal. His symptoms were a sudden pain in his head, crying in pain, sweating and colour draining from his face. A further call to NHS 24 approximately half hour later led Mrs C to be told to give Mr C a couple of paracetamol and she was asked if Mr C could be taken to the Primary Care Emergency Centre. A short period later, a relative called the service concerned that Mr C had suffered a 'haemorrhage of some sort'.

The family called NHS 24 again at 02:23 and were then told Doctor 2 would telephone the house at 03:00. Doctor 2 made the triage telephone call as arranged from GEMS and advised further paracetamol to be taken. He spoke to both Mrs C and Mr C and carried out a telephone assessment of the symptoms experienced by Mr C and seen by Mrs C. Further to this the family called again at 08:50. They were advised a house call would be made. Doctor 1 visited Mr C at 09:40 on Sunday 2 April 2006.

11. NHS 24's record of the events of the evening of 1 April and 2 April 2006 are similar in that the first telephone call was received by NHS 24 at 00:09 from Mrs C. Mrs C was advised a nurse advisor (the Nurse) would call her back as soon as one was available.

12. At 00:38 Mrs C called again and was again told the Nurse would call back.

13. At 00:50 a further call was received by NHS 24 from Mrs C's sister looking for a time when the Nurse would be calling. She was told that the Nurse was trying to make contact at that point.

14. NHS 24 has a record of a call being made to the family by the Nurse at 00:48 and speaking to Mrs C, Mr C and Mrs C's sister. They record that a full clinical assessment was carried out over the telephone and it was agreed that a doctor would be asked to telephone the family to provide a further assessment.

15. NHS 24 have let me know that this information is usually recorded and passed to the appropriate local out-of-hours service. On this occasion, it transpired that the information was initially sent to the wrong out-of-hours service and only correctly sent on after the error was identified within NHS 24. It was forwarded at 02:27, corresponding with the time Mrs C's sister called NHS 24 again, that being the fourth call to NHS 24. This resulted in the Board being advised of the requirement for the call and it was duly made at 03:00 on 2 April 2006.

16. NHS 24 has identified that this delay was an oversight that was picked up at the same time Mrs C's sister contacted the service again at 02:27 and they have asked me to pass their apologies to the family for this delay. This is discussed below in paragraph 30 and paragraph 31.

17. At 03:00 Doctor 2 telephoned Mr C and had access to onscreen information prepared by NHS 24. This information contained details about the questions that had been asked of Mr C. As part of the assessment, the telephone call was recorded by Doctor 2. He wrote:

> '3am – spoke to [Mrs C], has headaches and abdo pain, Had 2 whiskys earlier, no vomiting or diarrhoea, pain all over to neck and head, symptoms for 2 days. Able to move neck, no stiffness IMP – muscular headache
> Advice to take paracetamol, one more dose and phone back if no relief.'

The recording of the telephone call also records the doctor saying to Mr C:

> '… then you don't have to worry it is nothing to do with a brain tumour or anything …'

Doctor 2 determined that a house visit was not required and that available medication should be used with advice to call again if symptoms did not improve.

18. At 08:50 Mrs C called NHS 24 saying Mr C had not improved at all and was told Doctor 1 would visit within two hours. Doctor 1 made a house visit at 09:40 and from the symptoms described and the presenting history made a tentative diagnosis of a subarachnoid haemorrhage. He arranged for admission to the Hospital. He was later asked about the conversation he had at the house. In a letter dated 31 October 2006, Doctor 1 confirmed he would not have suggested Doctor 2, carrying out the telephone triage at 03:00, on 2 April 2006 should have made a house visit. Doctor 1 agreed he expressed concern at his colleague's response earlier on that day.

19. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, NHS 24 and the Board were given an opportunity to comment on a draft of this report.

(a) NHS 24 failed to provide proper care and treatment to Mr C; and (b) The Board failed to provide proper care and treatment to Mr C

20. On Saturday 1 April 2006 Mr C was out with his family for part of the evening, when he arrived home he complained of a headache and his family decided to call the out-of-hours services in NHS 24 for advice. After a number of calls made between Mr C's family and NHS 24, including both the centrally located part of the out-of-hours service, and GEMS, the local part of the service

(see paragraph 1 and paragraph 4), Mr C was admitted to the Hospital where he remained until he died on 9 April 2006. The first contact between NHS 24 and the family was recorded at 00:09 (see paragraph 11) and the ambulance became available to convey Mr C to the Hospital a little after midday on Sunday 2 April 2006, resulting in the family's experience of a 12-hour wait before Mr C began to get the treatment he needed in the Hospital.

21. In her complaint, Ms C wrote that Doctor 1, who visited the house, was shocked that the previous contact with Doctor 2 had not resulted in a house call and only paracetamol had been suggested. Doctor 1 called an ambulance to take Mr C to the Hospital and he was admitted.

22. On 13 November 2006 Ms C indicated the family's ongoing unhappiness with the resolution of their complaint. On Friday 22 December 2006, NHS 24 and the Board met with Mrs C and her family to try to assist further in the resolution of their continued unhappiness regarding the care provided to Mr C and the handling of the telephone call made by Doctor 2 during the early hours of 2 April 2006.

23. The response from NHS 24 outlined the improvements they intended to make as a result of the complaint that had been raised. They accepted there had been delays in the care provided to Mr C and lessons would be learned. They indicated the staff involved in 'call handling' during that evening were undertaking further training and their call handling skills were being monitored to ensure improvements had been made, and this was part of their personal development plans.

24. The concerns raised about Doctor 2 were referred appropriately to the Board for further consideration. They responded to the family about the concerns they had regarding the handling of the telephone call by Doctor 2 who had telephoned the family in the early hours of 2 April 2006. The Board considered that a full history had been taken by Doctor 2 from Mrs C and her husband over the telephone. They reported Doctor 2 had been taking information specifically about the symptoms and advised accordingly. They, however, accepted that more symptoms were emerging than had been apparent during the telephone conversation.

25. The Board have said:

'… may well have been a more serious reason for the headache at the time than was apparent during the telephone conversation',

The Board went on to say:

'… it may be that a face-to-face consultation would have led to [Mr C] being admitted to hospital, but it is impossible to be sure of this'.

26. The Board considered the telephone consultation had been handled in such a way to make sure there was no potential serious cause for the headache at that particular time.

27. The Adviser reviewed the care provided to Mr C before he was admitted to the Hospital on 2 April 2006. In the advice provided to me, the Adviser noted the clinical information available and heard the recordings of the calls made to Mr C and his family and read a written note of the telephone triage call held at 03:00 on 2 April 2006. He also had a copy of the complaint correspondence relating to this complaint. He has advised that there were significant issues of inadequate assessment and delays. He has considered there was significant delay in the care provided on that occasion. Further to listening to the audio recording of the calls between NHS 24 and the family, the Adviser has said staff failed to realise they were dealing with a man who was significantly unwell. The Adviser has commented that whilst there were delays in the arrangements of forwarding care, there is a record of an initial bleed and a further re-bleed. He has indicated that in the time between initial contact to actual admission, it is probably unlikely that there would have been any different outcome for Mr C. However, he is critical of the delay as he considers this contributed to the distress experienced by the family during that very difficult time. The Adviser has said Doctor 2 may have been able to arrive at a diagnosis of subarachnoid haemorrhage. The Adviser said the symptoms described, and description of onset was clear in presentation, Doctor 2 should have considered this as a diagnosis based on the information he had and there is no clear evidence he did so on this occasion.

28. The Adviser has indicated that the development of algorithms, those being a computer based system designed to work through problems using a step by step guide, for use in such settings as an on call medical service, must be robust. They should be clear to use and have the precise questions to elicit the information required to lead as close to a diagnosis as possible for the caller

and the call handlers. It is important, in his view; the process is supported by a very comprehensive set of options to refer to, and he has suggested the algorithms in use are reviewed to ensure their appropriateness. The Adviser was concerned about the mistake made in transferring the information between the central service and the locally based service (see paragraph 15).

29. NHS 24 reported having made service improvements as a result of this complaint. In relation to the improvements made in the call handling arrangements within NHS 24, the Adviser has indicated this is a welcome improvement. He has, however, indicated that a review of the basic training for staff delivering front line duties would be advisable.

(a) Conclusion

30. It is clear there were opportunities missed to take into account all the symptoms described by Mr C and his family during the onset of his illness at home. Whilst the Adviser does not consider the outcome would have been different for Mr C, he does consider there might have been a reduction in the stress for the family at the time, notwithstanding the very sad outcome for the family on this occasion and the loss of Mr C. NHS 24 have indicated they learned lessons as a result of this complaint and made some improvements and have also made apologies to the family which the Ombudsman welcomes. I have made further recommendations and these will be followed up in order to ensure lessons have been learned to avoid a repeat of this in the future. NHS 24 failed to forward information timeously to the Board and further to that, I uphold this complaint against NHS 24.

(a) Recommendations

31. The Ombudsman recommends that NHS 24:

(i) provides an apology to Mrs C and her family for the delay in transferring the necessary clinical details to the correct out-of-hours service;

(ii) conducts an evaluation into a review of the improvements introduced by NHS 24 as a result of this complaint;

(iii) ensures call handlers' basic training is developed enough to ensure staff are able to determine how to manage information they are given when a call is made from a service user, and that the mechanism to transfer vital clinical information between services is reviewed to avoid mistakes in transmission arising; and

(iv) ensures the algorithms are fit for purpose in so far as they are able to capture the appropriate detailed information to assist the call handlers to make the appropriate decisions.

(b) Conclusion

32. The Board did not pick up on the clinical symptoms as described by Mr C and his family during the telephone triage call made at 03:00 on 2 April 2006. The Adviser has indicated there was enough information to arrive at a diagnosis of a subarachnoid haemorrhage and this should have been followed through. It cannot be said that any earlier intervention would have resulted in a different outcome for Mr C, the Adviser being of the view this is not likely, but the level of distress for Mr C and his family was heightened as a result of this delay. I uphold this aspect of the complaint.

(b) Recommendations

33. The Ombudsman recommends that the Board:

(i) provides an apology to Mrs C and her family for the delay in picking up on the clinical symptoms described by Mr C and his family;

(ii) undertakes further review of Doctor 2's clinical practice in order to ensure their understanding of the signs and symptoms of a subarachnoid haemorrhage; and

(iii) ensures Doctor 2 reflects on the lessons of the case, shares it with his appraiser during his next appraisal and is aware of the possibilities of rare diagnoses such as subarachnoid haemorrhage for future work.

34. NHS 24 and the Board have accepted the recommendations made within this report and some work on those recommendations has begun. The Ombudsman asks that NHS 24 and the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Hospital	Southern General Hospital
Ms C	Mrs C's daughter
The Board	Greater Glasgow and Clyde NHS Board
GEMS	Glasgow Emergency Medical Services (now referred to as Greater Glasgow and Clyde, Out of Hours Service)
Doctor 1	The visiting GP (the Board)
The Adviser	Medical adviser to the Ombudsman
Doctor 2	The triage doctor (the Board)
The Nurse	The nurse advisor (NHS 24)

Annex 2

Glossary of terms

Abdo	Abdomen
Algorithm	A computer based system designed to work through problems using a step by step guide
Paracetamol	Analgesia
Subarachnoid haemorrhage	A kind of stroke where there is a bleed from one of the blood vessels running over the brain
Triage	Telephone clinical assessment service which screens service requirements