SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201403377, NHS 24
Sector: Health
Subject: Out-of-hours services and NHS 24; clinical treatment; diagnosis

Summary

Mrs C complained about her late mother (Ms A)'s interaction with NHS 24, in particular their main out-of-hours telephone service, the Unscheduled Care Service (UCS), and Breathing Space, which is a confidential telephone service for people experiencing low mood, anxiety or depression, and also part of NHS 24.

Ms A suffered from anxiety and depression. One week after attempting suicide, she telephoned Mrs C and told her she needed help as she could not cope. Mrs C called NHS 24, describing Ms A as a risk to herself, and an NHS 24 call handler rang Ms A directly. Ms A was extremely distressed during the call. She told the call handler that she might harm herself again and that she wanted to be taken away under mental health legislation. The call was initially classified as 'serious and urgent' but, when no nurse was available to speak to Ms A, a senior nurse advised the call handler to downgrade the call, which set a three hour call back from a nurse practitioner. They also offered Ms A assistance from Breathing Space whilst she waited for the call back, which she accepted. The Breathing Space adviser (the BSA) spoke and did breathing exercises with Ms A, but she was still tearful when the call ended. A nurse practitioner called Ms A around two hours later but there was no answer and the call was closed. Mrs C called the police a few days later as she had been unable to contact Ms A. They forced entry to Ms A's home and found that she had completed suicide. It is understood that she died from an overdose of medication.

In investigating Mrs C's complaints, I took independent advice from a nursing adviser, a mental health adviser and a GP adviser with experience of NHS 24 and out-of-hours work.

Mrs C said that the classification of Ms A's call meant that a suicidal woman needing immediate help instead received a three hour call back. NHS 24's own investigation report noted that it was unclear why the call was downgraded, and that there seemed to have been a disregard of mental health concerns by the senior nurse. They also found that following the transfer to Breathing Space,

the call should have been closed down within the UCS. The advice I received was that, given the information taken by the call handler, contact with Ms A should not have been broken. Allocating a three hour call back and leaving the call open after transferring to Breathing Space was not reasonable and, therefore, I upheld this complaint.

Mrs C complained that the BSA had not used Applied Suicide Intervention Skills Training (ASIST) during the call with Ms A and took no action to help her. NHS 24 said that ASIST techniques were not used as the BSA knew that a nurse practitioner would be calling Ms A to make a full clinical assessment of her symptoms. My mental health adviser said that this explanation was not reasonable as the BSA knew about Ms A's suicide attempt yet did not explore sufficiently the risk of suicide during the call. My adviser said that the support offered by the BSA was ineffective. The call recording showed that Ms A became increasingly distressed and my adviser commented that they would have expected the BSA to continue speaking with Ms A until her distress had reduced, instead of ending the call. I found that Breathing Space did not offer a reasonable service to Ms A so I upheld this complaint and made several recommendations.

Mrs C also complained that there was only one attempt to call Ms A back before closing the call, and that NHS 24 did not contact Ms A's GP. My investigation found that NHS 24's procedure is to attempt to call patients up to two times before closing the call, unless there is a particular clinical concern. However, there was enough evidence from Ms A's call to indicate a 'particular clinical concern' and I considered that further action should have been taken, including sharing information with Ms A's GP. Therefore, I upheld this complaint.

This significant case has raised concerns about how effectively mental health crises are managed by the UCS. The initial call handling is geared towards physical problems and gathering personal information. However, the advice I have received highlighted that, for people experiencing mental health difficulties, this is ineffective and can exacerbate their symptoms. More needs to be done to ensure that mental health is not treated with any less urgency than physical health, so I made a number of additional recommendations to address my wider concerns.

Redress and recommendations

The Ombudsman recommends that NHS 24:		*Completion date*
(i)	apologise to Mrs C for the allocation of a three hour call back;	18 November 2015
(ii)	ensure that this complaint is included for discussion at the next appraisal of the Senior Nurse;	18 November 2015
(iii)	ensure that all relevant staff are aware of the guidance on transferring calls to Breathing Space to avoid incorrect advice being offered to call handlers in future;	18 November 2015
(iv)	apologise to Mrs C for the way this call was handled by Breathing Space;	18 November 2015
(v)	ensure that the findings of this report are discussed with the BSA for learning;	16 December 2015
(vi)	ensure that Breathing Space staff are aware of when to use ASIST techniques;	18 November 2015
(vii)	ensure that all Breathing Space staff are aware of the process to escalate calls;	18 November 2015
(viii)	apologise to Mrs C for the failure to take appropriate action when Ms A could not be reached;	18 November 2015
(ix)	ensure that this complaint is included for discussion at the next appraisal of the Nurse Practitioner;	18 November 2015
(x)	report to us on the implementation schedule of the new Patient Contact Management system system;	18 November 2015 and then again when the system goes live
(xi)	review their guidance for all staff on the management of suicidal thoughts and common mental health problems;	16 December 2015
(xii)	review their procedures for triaging mental health difficulties, such as panic and depression, for patients who present in crisis; and	18 November 2015
(xiii)	review the questions used in the initial contact process to take mental health into account.	18 November 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils,

housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (Mrs C) complained to the Ombudsman about her late mother (Ms A)'s interaction with NHS 24 and Breathing Space.

2. NHS 24's out-of-hours telephony service, the Unscheduled Care Service (UCS), provides people in Scotland with access to advice and information on health matters. The UCS can be used by the public if their doctors' surgery is closed and they are too ill to wait until it re-opens. Calls are initially dealt with by trained call handlers who ask questions about the caller's location and reasons for contacting the service. This is then used to direct the call to a suitable health professional, such as a nurse practitioner. The health professional will then talk to the caller about their symptoms and advise what care they think is needed. This might include self-treatment at home, seeing an out-of-hours doctor, or, in some cases, they might call an ambulance.

3. Breathing Space are part of NHS 24 and provide a confidential out-of-hours telephone service for people who are experiencing low mood, anxiety or depression. They offer advice and someone to listen, as well as signposting callers on where to seek help in their local area.

4. Breathing Space are one of a number of services that NHS 24 have responsibility for and while they are separate from the main UCS, they are part of the overall suite of services that NHS 24 provide.

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

(a) NHS 24's three hour classification of their call back to Ms A on 16 March 2014 was unreasonable; (*upheld*);
(b) Breathing Space's handling of their conversation with her on 16 March 2014 was unreasonable; (*upheld*); and
(c) NHS 24's actions in relation to their call back on 16 March 2014 were unreasonable; (*upheld*).

Investigation

6. In order to investigate Mrs C's complaint, my complaints reviewer considered all the information provided by Mrs C and NHS 24. Further enquiries were made with NHS 24 which they responded to. Independent advice was also obtained from a nursing adviser (Adviser 1); a mental health adviser (Adviser 2); and a general practitioner (GP) with NHS 24 and out-of-hours experience (Adviser 3). In this case, we have decided to issue a public

report on Mrs C's complaints due to the significant personal injustice she and Ms A suffered. We were also concerned that this case highlighted potential systemic failures around the management of mental health crises by NHS 24.

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

Background

8. At the time of these events, Mrs C was resident elsewhere in the United Kingdom and Ms A was living alone in Scotland. Ms A suffered from anxiety and depression. She also had issues with alcohol but Mrs C has advised that Ms A had not drank for some two months at that time. In the week prior to her contact with NHS 24, Ms A had taken an overdose that resulted in her being taken into hospital.

9. On Sunday 16 March 2014, Ms A contacted Mrs C and told her she needed help as she could not cope and was unable to move her legs, eat, or sleep. Mrs C called a hospital to get advice from their mental health team and was informed she should call NHS 24 for assistance. At 16:48 on 16 March 2014, Mrs C rang NHS 24 and explained that she was concerned for Ms A's welfare. She described Ms A as a risk to herself and explained that she was a recovering alcoholic who had taken an overdose of her prescription medication the week before. Mrs C said that her mother was now finding it very difficult to cope and suffering with anxiety. She reiterated that Ms A was a risk to herself. The call was disconnected at 16:55 due to an issue with Mrs C's telephone. After several attempts to contact Mrs C, all of which diverted to voice-mail, the NHS 24 call handler (the Call Handler) rang Ms A directly at 16:59.

10. Ms A was extremely distressed during the call. She told the Call Handler that she was very anxious and had tried to take her own life during previous week. Ms A said that could not look after herself, could not cook, clean, or pay her bills and had a court case pending. When the Call Handler asked her if she felt like she might want to harm herself again, Ms A said yes and that she wanted to be taken away under mental health legislation. Ms A was having difficulty breathing and the Call Handler attempted to get a nurse to speak to her.

11. The Call Handler initially routed the call as 'serious and urgent'. No nurse practitioner was available and the Call Handler was prompted by an automated message to contact a senior nurse for guidance. The Call Handler explained to the senior nurse (the Senior Nurse) that Ms A was in distress, had pains in her chest, had attempted suicide last week and felt that she might try again. Following a question from the Senior Nurse, the Call Handler asked Ms A if she was planning to hurt herself at that time. She replied 'no' but was clearly distressed and then said 'maybe' when the Call Handler probed further. The Call Handler told the Senior Nurse that Ms A had replied 'maybe' to the question. The Senior Nurse advised the Call Handler to set the call for a three hour call back from a nurse practitioner and in the interim, offer her assistance from Breathing Space. The Senior Nurse also advised that Ms A should be advised to call NHS 24 back if she felt unsafe whilst waiting for the call back.

12. The Call Handler advised Ms A that she would receive a call back later that day but not that this would be within three hours. The Call Handler explained to Ms A how she could get back in touch with NHS 24 if she needed and gave a brief overview of Breathing Space. Ms A agreed to speak with Breathing Space and the call was transferred.

13. The Breathing Space adviser (the BSA) spoke with Ms A who advised that she was very anxious and disclosed that she had attempted suicide a week ago. The BSA spoke to Ms A and also conducted breathing exercises but she still remained tearful. The call ended at 17:32.

14. Meanwhile, the call had been placed in a queue at 17:15 for call back from a nurse practitioner within three hours. Ms A was called at 19:38 by a nurse practitioner (the Nurse Practitioner) but there was no reply. A message was left advising Ms A to call back if she still required assistance and the call was closed.

15. Mrs C called the police on 21 March 2014 as she had been unable to contact Ms A for four days. They forced entry to her home and found Ms A in the bathroom. It is understood that Ms A died on the morning of 18 March 2014 as a result of an overdose of medication. Mrs C has advised that during their investigation, the police discovered that on 17 March 2014, her mother bought two packets of paracetamol. It is understood she returned home and took an overdose of her prescription medication fluoxetine (a medicine used in the treatment of depression and other conditions) and the paracetamol.

16. Mrs C first raised concerns verbally on 24 March 2014 regarding the way Ms A's contact with NHS 24 was handled. Following correspondence and a meeting with Mrs C on 4 July 2014, a written response was provided on 15 July 2014. Mrs C remained dissatisfied with the explanations provided and wrote to NHS 24 again on 25 July 2014. A further meeting took place on 20 October 2014 during which Mrs C advised that she intended to bring her complaints to the SPSO.

(a) NHS 24's three hour classification of their call back to Ms A on 16 March 2014 was unreasonable

Concerns raised by Mrs C

17. Mrs C complained that the Senior Nurse set the call for Ms A as a priority three which meant that a suicidal woman that needed immediate help would receive a call back within three hours.

NHS 24's response

18. During the meeting with Mrs C on 4 July 2014, NHS 24 advised that the Senior Nurse who had provided advice to the Call Handler considered it safe for a return call to be made within three hours and that this was a clinical judgement on the basis of the information available at the time of the call.

19. In their written response of 15 July 2014, NHS 24 confirmed that after taking details of Ms A symptoms, no nurse practitioners were immediately available and the Call Handler placed the call in the clinical queue for a three hour call back after taking advice from the Senior Nurse. They went on to say that their investigation had shown that the Call Handler had advised Ms A of the timeframe for the call back and explained the service that Breathing Space provide. NHS 24 told Mrs C that Ms A agreed for the call to be transferred.

20. NHS 24 considered that all NHS 24 staff managed the call with Ms A in a professional and sensitive manner at all times, showing empathy and understanding. However, they went on to advise that as a direct result of their investigation, it was clear that following the transfer to Breathing Space, the call should have been closed down within the UCS. NHS 24 considered that the BSA would then have been able to utilise all relevant skills required to assist in managing Ms A's care. They advised that if it had been determined that Ms A required a full clinical assessment, the BSA would then have had the ability to

actively pass the call back to the UCS. NHS 24 apologised that this did not happen.

21. NHS 24 confirmed that as a result of Mrs C's complaint, a review had been undertaken, resulting in the revision of their process to ensure that when a call is accepted for transfer internally within NHS 24, it is only ever open within one service and is closed by the transferring service. NHS 24 considered that this would ensure that calls are managed in their entirety by one service at a time.

22. In response to an enquiry from my complaints reviewer, NHS 24 advised that as a result of their investigation of this complaint, steps had been taken to reinforce the process to frontline staff for the transfer of patients/callers from the UCS to Breathing Space. They advised that their Clinical Process 1 – the Call Handler Process – had been updated as a result.

23. In their own clinical investigation report dated 24 March 2014, NHS 24 noted that it was unclear why the call was re-triaged to a three hour call back and that the Senior Nurse needed to reflect on her rationale for downgrading the call. It also noted that there appeared to have been a disregard of mental health concerns on the part of the Senior Nurse.

Relevant procedure

24. NHS 24's Clinical Process 72 sets out guidance on the transfer of calls to Breathing Space. At the time of these events, the system process that was in place confirms that the call record with the UCS should be closed once the call has been transferred.

Medical advice

25. Adviser 1 was asked to comment on whether it was reasonable to allocate Ms A a three hour call back. Adviser 1 found that the Call Handler had given sufficient consideration to the risk involved in Ms A's case as the call had initially been graded as 'serious and urgent'. It was noted that as a nurse practitioner was not available to speak with Ms A immediately, the Call Handler had appropriately sought advice from the Senior Nurse. Although Adviser 1 considered that it was reasonable to transfer the call to Breathing Space as they have appropriately trained advisers, they said that the three hour call back was not reasonable.

26. Adviser 1 commented that, given the detailed information taken by the Call Handler, contact with Ms A should not have been broken. They went on to advise that the ownership of the call should have been transferred to Breathing Space and closed down on the UCS side. Adviser 1 said that it would be expected that the trained BSA would take the appropriate action following their intervention, which may have included transferring the call back to the UCS.

27. In conclusion on this point, Adviser 1 commented that the decision to assign a three hour call back, with Breathing Space intervention until then, caused problems with Ms A's patient journey. They found that as the BSA was aware that Ms A would be getting a call back from an NHS 24 nurse practitioner, further action had not been initiated.

(a) Decision

28. NHS 24 have accepted that it was not appropriate to allocate a three hour call back, leaving the call live and queued with the core UCS, before transferring Ms A to Breathing Space.

29. The advice I have received is that it was reasonable to transfer the call to Breathing Space in the circumstances of the case, as they are a service with trained advisers to support people dealing with conditions such as anxiety. In line with NHS 24's own clinical process 72, the call should have been closed down following the transfer, allowing Breathing Space to take full control. This did not happen and appears to have had an adverse impact on how the call was managed within Breathing Space.

30. I do not consider the advice provided by the Senior Nurse to the Call Handler to be reasonable and agree with NHS 24's original clinical investigation report on the downgrading of the call. Adviser 1 highlighted that contact with Ms A should not have been broken and queuing the call for a three hour call back, even with interim intervention from Breathing Space, was likely to result in a period where contact with Ms A was lost. I note from the call recording provided by NHS 24 that the BSA actually referred to terminating their call with Ms A to ensure that the nurse practitioner call back could be received.

31. While the Call Handler Process has been updated to reinforce awareness of the need to close down the UCS call when transferring to Breathing Space, the decision to leave the call open and add it to the three hour call back queue was taken by the Senior Nurse, not the Call Handler. As such, I am concerned

that not all the relevant NHS 24 staff are aware of the guidance laid out in Clinical Process 72 and the amendment made to Clinical Process 1 following NHS 24's review may not go far enough towards preventing a recurrence of such an error in future.

32. I do not consider that the classification of the call on 16 March 2014 as a three hour call back was reasonable in the circumstance and in view of this finding, I uphold this complaint.

33. I acknowledge that NHS 24 have already apologised to Mrs C in part and that their processes have been reviewed as a result of this complaint, however, I have made the following recommendations to address my remaining concerns.

(a) Recommendations

34. I recommend that the NHS 24:	*Completion date*
(i) apologise to Mrs C for the allocation of a three hour call back;	18 November 2015
(ii) ensure that this complaint is included for discussion at the next appraisal of the Senior Nurse; and	18 November 2015
(iii) ensure that all relevant staff are aware of the guidance on transferring calls to Breathing Space to avoid incorrect advice being offered to call handlers in future.	18 November 2015

(b) Breathing Space's handling of their conversation with her on 16 March 2014 was unreasonable

Concerns raised by Mrs C

35. Mrs C complained that the BSA who spoke with Ms A had not used Applied Suicide Intervention Skills Training (ASIST) training during the call despite the circumstances. Mrs C was also concerned that numerous questions were asked of Ms A in quick succession and that despite making the BSA aware that she was ill and wanted to be taken to hospital, no action was taken to help her.

NHS 24's response

36. During the meeting of 4 July 2014, NHS 24 confirmed that the BSA was trained in ASIST. NHS 24 advised Mrs C in their written response that the BSA provided support to Ms A in the form of breathing guidance to try to reduce her anxiety level. They advised Mrs C that ASIST techniques were not used as the

BSA was aware that Ms A was awaiting a return call from an NHS 24 nurse practitioner to undertake a full clinical assessment of her symptoms.

37. During the meeting of 20 October 2014, Mrs C was advised that given the information available, it was considered that Breathing Space handled the call sensitively and that if it was felt that urgent care was required for a patient, then calls are transferred for clinical assessment by an NHS 24 nurse practitioner.

Medical advice

38. Adviser 2 noted that Breathing Space is not a clinical or medical service but will offer listening, support, advice and information.

39. Adviser 2 was asked to comment on whether it was reasonable that the BSA had not used ASIST techniques when dealing with Ms A, given that she had disclosed a recent suicide attempt and advised that she wanted to be hospitalised. They advised that this was not reasonable. Adviser 2 noted that NHS 24 had confirmed that the BSA was ASIST trained but did not consider their explanation as to why suicide prevention/assessment strategies were not employed to be reasonable. There was evidence of a recent suicide attempt and Adviser 2 did not consider that risk had been explored sufficiently during the call.

40. Adviser 2 found that the support offered by the BSA was of a non-specific nature in that it did not follow a particular therapeutic model or framework. It was noted that NHS 24 had confirmed that the transferring of the call to Breathing Space was a 'holding' intervention. Adviser 2 did not consider the action taken by Breathing Space to be effective for the problem that Ms A presented with. They advised was it evident from the call recording that Ms A was becoming increasingly distressed and that breathing techniques were ineffective for her. Adviser 2 found that it would have been preferable had the BSA escalated their concerns about Ms A, however, this did not happen.

41. Adviser 2 found that the questioning used was not evidence based and was not effective. They considered that the assessment of risk was unsatisfactory and that the conversation had strayed into unhelpful small talk at points. Adviser 2 commented that there was evidence that Ms A was distressed and hyperventilating during her interaction with Breathing Space but that the call had been ended while she remained distressed. They advised that this was

unreasonable and commented that they would have expected the BSA to continue to speak with Ms A until her distress had reduced.

42. In relation to the breathing exercises that were carried out during the call, Adviser 2 explained that these are commonly employed to assist with hyperventilation which is experienced during high anxiety or panic states. Adviser 2 went on to advise that a common problem with techniques such as these is 'rebound panic' where the breathing exercises induce rapid breathing and exacerbate panic due to the person misinterpreting physical symptoms brought on by the imbalance of carbon dioxide and oxygen in their system. Adviser 2 considered that this had happened during Ms A's call with Breathing Space. They noted that the BSA appeared to have detected this and stopped the breathing exercises during the call but later returned to them.

43. Adviser 2 commented that breathing techniques can be helpful, particularly the exercise that that the BSA had used when dealing with Ms A, and that they are a recognised intervention. However, Adviser 2 found that Ms A had been highly distressed when trying to apply the techniques which can impact on their effectiveness. They also explained that such techniques can be difficult to instruct over the telephone, particularly when someone is very distressed. Although the breathing exercises appeared to have heightened Ms A's distress, Adviser 2 considered it reasonable to attempt to use them.

44. Taking the fact that Ms A had been queued for a nurse practitioner call back with the UCS, Adviser 2 was asked to comment on what other action it would have been reasonable for the BSA to take. Adviser 2 considered there to have been sufficient evidence during the call to suggest that Ms A was experiencing depression, anxiety and suicidal thoughts. They commented that it was unclear why a police welfare check or referral to the local mental health crisis team was not considered. Adviser 2 explained that a police welfare check is prompted where there are concerns about the welfare or safety of an individual and officers will attend at the property to check on their welfare. Adviser 2 commented that it would have been reasonable for NHS 24's services to escalate the call to the local mental health duty workers, accident and emergency or mental health crisis team, however, they found no evidence that this was attempted.

(b) Decision

45. As previously referred to, the decision to leave Ms A queued for a call back from an NHS 24 nurse practitioner while she was transferred to Breathing Space appears to have had a negative impact on the way the call was handled.

46. The advice I have received is that many areas of the call with Breathing Space were lacking and consequently, a reasonable service was not offered to Ms A. The advice highlighted that much of the questioning used during the call was unhelpful and it is clear that Ms A remained distressed when the call was ended. I do not consider that it was reasonable to have broken contact with Ms A in the circumstances.

47. I note NHS 24's position that ASIST techniques were not used because Ms A was queued for a nurse practitioner call back. While I appreciate that there was confusion over the ownership of the call, I do not consider this to be a reasonable approach. The advice I have received is clear that the risks posed were not explored sufficiently during the call, despite there being evidence of a recent suicide attempt.

48. I am concerned that while there were clear indications that Ms A was experiencing depression, anxiety and suicidal thoughts, there is no evidence that the potential risks to her welfare were appropriately considered by Breathing Space. Even when taking the fact that a nurse practitioner call back was awaited in to account, the advice received is that it would have been reasonable to take steps to escalate the call. I understand that this would have involved transferring the call back to NHS 24 and will return to issue of escalation later in the report.

49. In view of the findings outlined here, I uphold this complaint.

(b) Recommendations

50. I recommend that the NHS 24:	*Completion date*
(i) apologise to Mrs C for the way this call was handled by Breathing Space;	18 November 2015
(ii) ensure that the findings of this report are discussed with the BSA for learning;	16 December 2015
(iii) ensure that Breathing Space staff are aware of when to use ASIST techniques; and	18 November 2015

(iv)	ensure that all Breathing Space staff are aware of the process to escalate calls.	18 November 2015

(c) NHS 24's actions in relation to their call back on 16 March 2014 were unreasonable

Concerns raised by Mrs C

51. Mrs C complained that when the NHS 24 Nurse Practitioner called back within the three hour period, Ms A had turned her telephone off and that the call had then been closed, even though Ms A had been suicidal. She was concerned that there was no attempt to call her back again and that no fax had been sent to Ms A's GP the following day to notify them of NHS 24's contact with their patient.

NHS 24's response

52. NHS 24 advised Mrs C that, as per the three hour call back arrangement, an attempt was made by the Nurse Practitioner to contact Ms A at 19:38 on 16 March 2014. They confirmed that no reply was received and a voice-mail message was left advising Ms A to contact NHS 24, if she felt it was still necessary.

53. During the meeting of 20 October 2014, Mrs C advised NHS 24 that she felt it was poor professional judgement on the part of the Nurse Practitioner to close the call. NHS 24 advised her that the process in place directs that a patient is called back once and that the NHS 24 nurse practitioner did not act incorrectly.

54. In response to an enquiry from my complaints reviewer, NHS 24 advised that as there had been no clinical assessment of Ms A during this contact with their service, no information was available to send to her GP in this connection. They advised that Breathing Space do not routinely provide information to GPs. NHS 24 explained that when a clinical assessment is undertaken of a patient displaying symptoms, the detail of the contact and any advice provided is routinely sent to the person's GP to ensure that patient care communication is provided.

55. NHS 24 went on to advise that a new Patient Contact Management (PCM) system is currently under development and testing. They explained that this is designed to ensure that all contact with NHS 24's UCS will automatically generate a notification to the patient's own GP, whether or not the person has

been clinically assessed. NHS 24 advised that in future, when they are unable to contact a patient to carry out an assessment, a daily notification will be sent to their GP to advise of this. They anticipate that this system will be implemented by the end of 2015.

56. Also in response to my complaints reviewer's enquiry, NHS 24 advised that the decision to close the call was made following full consideration of any clinical risk by the Nurse Practitioner on the basis of the information available. They confirmed that no police involvement was requested by NHS 24 for Ms A and the Nurse Practitioner considered that there was sufficient information to make a risk based assessment that no further action was required at the time of her contact with their service.

Relevant procedure

57. NHS 24's clinical process 60 provides guidance on the 'no reply' procedure for all their staff. This process applies to calls where there has already been an attempted call back which has been unsuccessful. The process states that patients will receive up to two call back attempts and after this, unless there is a particular clinical concern, their call will be closed off.

Medical advice

58. Adviser 1 noted that the NHS 24 clinical process 60 covers their no reply process and is marked for use by all staff. They noted that this states that patients will receive up to two call back attempts after which, unless there is a particular clinical concern, their call will be closed.

59. They commented that regardless of clinical process, a clinician such as a nurse practitioner should exercise their own clinical judgement. Adviser 1 found that Ms A was a risk to herself and sufficiently detailed information had been taken by the Call Handler and relayed to the Senior Nurse to indicate a 'particular clinical concern'. They considered that on this basis, further action should have been taken and that a police welfare check may have been appropriate.

60. Adviser 3 considered the explanation provided by NHS 24 in relation to why no information was shared with Ms A's GP to be unreasonable. They found that concerning information (Ms A's disclosure that she felt suicidal; could not keep herself safe; and request for hospital admission) was available and recorded on NHS 24 systems. Adviser 3 considered that in was unreasonable

to suggest that this information was not shared with the GP because it was gathered by an NHS 24 call handler, rather than a clinician.

(c) Decision

61. There is no evidence in the information provided by NHS 24 to suggest that more than one attempt was made to call back Ms A before the decision was taken by the Nurse Practitioner to close the call. The advice I have received is that further action should have been taken as sufficient information had been recorded to make Ms A a 'particular clinical concern'. There was clear evidence on the record of the risk that Ms A posed and I do not consider that the assessment of this risk was reasonable.

62. Similarly, I do not consider that it was reasonable that the information gathered by the call handler was not shared with Ms A's GP. The advice I have received is that this was significant, concerning information and that it is unreasonable that this was not provided to the GP on the basis that it was obtained by a call handler, rather than a nurse or other clinical member of staff.

63. I note that NHS 24 are in the process of implementing a new PCM system that will share all information from contact with their UCS with GPs, rather than only that obtained during a clinical assessment. This is positive news but I remain concerned by the interim arrangements before this system goes live.

64. In light of these findings, I uphold this complaint.

(c) Recommendations

65. I recommend that the NHS 24:	*Completion date*
(i) apologise to Mrs C for the failure to take appropriate action when Ms A could not be reached;	18 November 2015
(ii) ensure that this complaint is included for discussion at the next appraisal of the Nurse Practitioner; and	18 November 2015
(iii) report to us on the implementation schedule of the new PCM system.	18 November 2015 and then again when system goes live

(d) Other Issues

66. The investigation of this significant case has highlighted a number of other issues that require attention but do not fall directly under the individual complaints listed above. I have detailed my findings on these matters below.

Medical advice

67. Adviser 2 noted that during the call with NHS 24, Ms A presented with symptoms consistent with panic attacks as she was clearly hyperventilating; was worried that something bad would happen; was worried that she could not cope; reported 'jelly legs', numbness in the legs and physical shaking. Adviser 2 explained that individuals suffering with panic attacks generally misinterpret the physical symptoms as a sign of another illness, such as a heart attack or stroke. They considered that the focus from NHS 24 on chest pain while Ms A was in a panicked state appeared to have added to her catastrophic thinking. Adviser 2 found that, during the initial call, Ms A experienced an increase in panic and anxiety and a reduction in her ability to concentrate. They found this was evidenced by her hyperventilation during the call and that she found writing down a telephone number that was offered to her very difficult. Adviser 2 also referred to Ms A's request to be 'sectioned' during the call and considered that it was very clear that she wanted help.

68. Adviser 2 found that the emphasis during the initial call with the UCS was focussed on information such as location of the patient and physical health. It was noted that this was undertaken mainly by the Call Handler rather than a clinician and that the advice that had been given to the Call Handler by clinical staff was poor considering the high level of distress that Ms A was experiencing. Adviser 2 considered that mental health questions could be included in this process. They suggested that a shortened version of the patient health questionnaire could potentially be used, as is recommended in depression guidelines by the National Institute for Health Care and Excellence (NICE) in England.

69. Adviser 2 found that the Call Handler who initially spoke to Ms A had managed the call very well. However, Adviser 2 considered that due to the specialist nature of Ms A's mental health difficulties and the urgency involved, a clinician should have intervened and assessed her sooner. Adviser 2 commented that the Call Handler had effectively been left to manage the call with no qualified mental health or nursing support. Referring back to the advice

given previously, Adviser 2 considered that at the least, Ms A should have been kept on the telephone until she could be properly assessed.

NHS 24 response

70. After receiving this advice, my complaints reviewer made further enquiries with NHS 24 regarding their management of mental health calls. NHS 24 advised that as well as their own expertise, their clinicians have a wide range of decision support tools available to them to effectively manage calls from patients who have mental health symptoms. They advised that NHS 24 have dedicated mental health nurse practitioners who are available to process such calls.

71. They went on to explain that NHS 24 frontline staff receive mental health awareness training and this is consolidated through the use of practice scenarios during induction training. It was also advised that additional electronic educational resources are available to support staff in their management of such calls.

72. Returning to the issue of escalating calls, NHS 24 were asked whether they have a mechanism in place to refer patients to their local mental health crisis team and if this had been considered for Ms A. They confirmed that NHS 24 have, in agreement with the local NHS boards, mechanisms in place to refer patients to their local mental health crisis team and/or local out-of-hours GP. They explained that there are variations in the method of onward referral due to local differences but that they ensured that all patients are referred appropriately. They did not advise whether this was considered for Ms A.

Consideration

73. The mental health advice received in relation to this case has raised concerns about how effectively mental health crises are managed by the UCS. Perhaps understandably, the initial UCS call handling process is geared towards physical problems and the gathering of personal information, however, the advice I have received highlighted that this approach is ineffective and can exacerbate the symptoms that people experiencing mental health difficulties are having.

74. I agree that the Call Handler approached their interaction with Ms A well, displaying understanding and empathy, however, I found that other parts of Ms A's patient journey lacked proper consideration of her mental state and the

risk that this placed her in. Mrs C has made comment to NHS 24 that Ms A would have been treated differently had her symptoms been physical, such as a chest pain suggestive of a heart attack, and that it is not reasonable to treat someone who has said they are suicidal differently. I agree that more needs to be done to ensure that mental health is not treated with any less urgency than physical health.

75. Taking this into account, I have a number of additional recommendations to address my wider concerns.

(d) Recommendations

76. I recommend that the NHS 24:

		Completion date
(i)	review their guidance for all staff on the management of suicidal thoughts and common mental health problems;	16 December 2015
(ii)	review their procedures for triaging mental health difficulties, such as panic and depression, for patients who present in crisis; and	18 November 2015
(iii)	review the questions used in the initial contact process to take mental health into account.	18 November 2015

77. NHS 24 have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. NHS 24 are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Ms A	the aggrieved
the UCS	the Unscheduled Care Service
Adviser 1	a senior nurse
Adviser 2	a mental health adviser
Adviser 3	a general practitioner
GP	general practitioner
the Call Handler	an NHS 24 call handler
the Senior Nurse	a senior NHS 24 nurse
the Nurse Practitioner	an NHS 24 nurse practitioner
the BSA	a Breathing Space adviser
ASIST	Applied Suicide Intervention Skills Training
PCM system	Patient Contact Management System

Glossary of terms

Applied Suicide Intervention Skills Training (ASIST)	a two day course on the provision of suicide first aid
Breathing Space	a confidential out-of-hours telephone service for people who are experiencing low mood, anxiety or depression
NHS 24 Clinical Processes	NHS 24's suite of guidance
fluoxetine	a medicine used in the treatment of depression and other conditions
Unscheduled Care Service (UCS)	NHS 24's core out-of-hours telephone care service

Annex 3

List of legislation and policies considered

NHS 24 Clinical Process 1, Call Hander Process

NHS 24 Clinical Process 60, No Reply Process – For All Staff

NHS 24 Clinical Process 72, Transferring Calls to Breathing Space