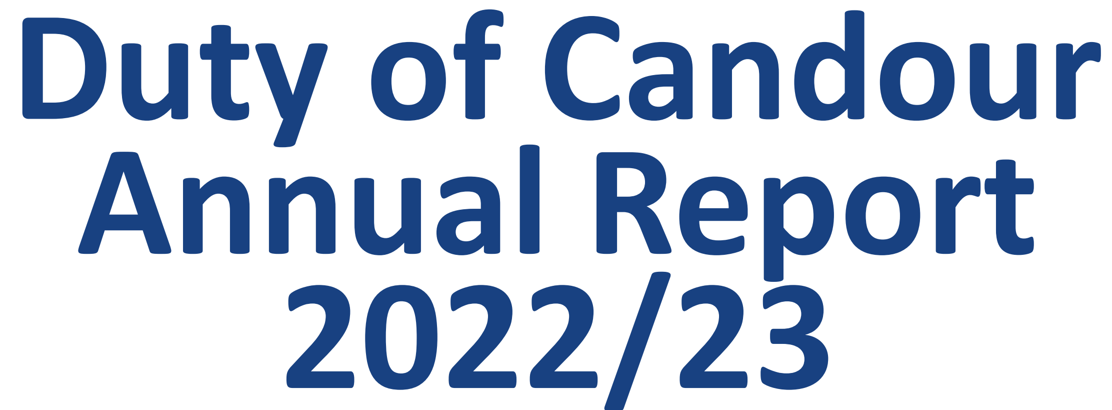

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Introduction and Key Information

All Health and Social Care services in Scotland have a Duty of Candour which is a legal requirement. This means when unintended or unexpected events happen, as defined in the Act, the people affected understand what happened, receive an apology and improvements are made by the organisation.

This report describes how NHS 24 has implemented Duty of Candour between 1st April 2022 and 31st March 2023.

Taking consideration of the role of the NHS 24 111 Unscheduled Care Service, NHS 24 often may only be involved in part of the complete patient journey with patients referred to other services for onward care and/or treatment.

Whilst the impact or outcomes for patients are not always known, where opportunities for learning and improvements are identified through our Adverse Event process, these are addressed.

Policies and Procedures

Adverse Events findings are reported via the NHS 24 Clinical Governance reporting structures.

NHS 24's Adverse Event Process contains information on activating Duty of Candour with accompanying guidance. To support this, staff have access to information on the intranet via our dedicated Duty of Candour page. The NHS Education Scotland Duty of Candour e-Learning module is also available. Information on our responsibilities regarding Duty of Candour are contained within the NHS 24 core induction programme.

Each Adverse Event undergoes a rigorous review to understand what happened and where care provision can be improved. Recommendations are made and improvement plans agreed within defined timescales. NHS 24 understands such Events can be distressing for staff as well as patients and families. Support for staff is available via the line management structure as well as Occupational Health. Staff also have access to the Employee Assistance Programme (EAP).

Duty of Candour Incidents

NHS 24

The decision on whether a case should activate Duty of Candour lies with a Registered Health Professional.

Between 1st April 2022 and 31st March 2023, NHS 24 managed 11 Adverse Events of which eight activated Duty of Candour. Seven Duty of Candour cases were managed the previous year. These were all unintended or unexpected incidents that resulted in death or harm as defined in the Act and did not relate directly to the natural course of an illness or underlying condition.

Of the cases not progressed as Duty of Candour, one was a technical error, one involved a care home patient and one case was categorised as a near miss.

Grading	No. of Adverse Events
Category 1	5
Category 2	-
Category 3	3
Near Miss*	1

***Cases categorised as a 'Near Miss' are: 'Any situation which could have resulted in an incident, but did not, either due to chance or intervention – these do not activate Duty of Candour.**
Two cases have yet to have the Final Grading applied.

Duty of Candour - continued

NHS 24

Through the Adverse Event Review process, NHS 24 key clinical staff determine if there are factors that may have caused or contributed to the event, which helps to identify Duty of Candour incidents.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2022 and 31 March 2023)
A person died	7
A person's treatment increased	-
The structure of a person's body changed	-
A person's sensory, motor or intellectual functions were impaired for 28 days or more	-
A person experienced pain or psychological harm for 28 days or more	-
A person needed health treatment in order to prevent them dying	-
A person needed health treatment in order to prevent other injuries as listed above	1
TOTAL	8

Adverse Event Categories

NHS 24

Initial and Final Categorisation of Adverse Events HIS Categories ref:

A national framework for Scotland December 2019 (4th Edition)

- **Category I – events that may have contributed to or resulted in permanent harm**, for example unexpected death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity (likely to be graded as major or extreme impact on NHSScotland risk assessment matrix.

- **Category II – events that may have contributed to or resulted in temporary harm**, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity (likely to be graded as minor or moderate impact on NHSScotland risk assessment matrix).

- **Category III** – **events that had the potential to cause harm but no harm occurred,** for example near miss events (by either chance or intervention) or low impact events where an error occurred, but no harm resulted (likely to be graded as minor or negligible on NHSScotland risk matrix.

Following the Procedure

NHS 24 followed the procedure in eight cases. NHS 24 contacted the people and/or families affected, offered an apology and offered to meet. In one case, despite best endeavours, one patient did not engage. This patient's care however, was still progressed as an Adverse Event and identified learnings progressed. Of the eight cases, two families took forward the offer of meeting.

In each case, a full review was undertaken to understand what happened and what we could have been done better. Individual and organisational learning was undertaken and subsequent improvement plans have been developed and completed.

NHS 24 prides itself in being an open and transparent organisation and we maintained regular communication, invited questions from patients and families, and have shared the final written report with the relevant person. Reports were provided in plain English with explanations of abbreviations and acronyms where appropriate.

Meeting with Families

NHS 24

In call cases, apart from one patient who did not engage, an offer to meet with senior staff was made.

NHS 24 met with two families in relation to Duty of Candour. Both meetings were held local to the families involved. These were well received with meaningful discussion and assurance offered of actions taken.

Communication with families is a primary focus of our management of Duty of Candour with efforts made to ensure a positive experience of inclusive engagement throughout the process.

What Has Changed as a Result

NHS 24

- Review Clinical Process 99 - Clinical Supervisor Process (Face to face clinical supervision model). Guidance added for clinicians to remain plugged in to calls from the SBAR (Situation, Background, Assessment, Recommendation) handover from the Call Handler to the conclusion of the call and outcome recommendation.
- Operational Process 1701 reviewed by Information Governance Team in collaboration with Service Delivery to enable the organisation to provide immediate clinical support to families who request call recordings, if required.
- Training and Educational materials to be updated to ensure Mental Health Wellbeing Assessment Framework guidance notes are used for every call.
- Review of Mental Health Wellbeing Assessment Framework and MHWAF guidance notes
- Mental Health Wellbeing Assessment Framework guidance notes available in electronic format and available to all staff within the Knowledge Management System
- Extension of 'Protected Pod' environment from 2-4 weeks for Psychological Wellbeing Practitioners

Review of Guidance

A request was received via the Scottish Government for Health Boards to be involved in a review of the Duty of Candour Guidance.

NHS 24 has engaged in this process by the completion of a Survey on our considerations of the effectiveness of the guidance.

Patient Experience and Clinical Governance staff met with the Scottish Government in May 2023 to discuss our experience of working with the Duty of Candour Guidance with a view to informing any proposed changes.

We await the outcome of this review.