NHS 24

NHS 24 BOARD	19 AUGUST 2021 BD (2021 22) 003 FOR APPROVAL
DUTY OF CANDOUR ANNUAL REPORT 2020/21	
Executive Sponsor:	Executive Director for Nursing and Care
Lead Officer/Author:	Patient Experience Manager
Action Required	The Board is asked to: a) Approve the Duty of Candour Annual Report; b) Note the revised Duty of Candour Guidance.
• **Key Points**	• The Annual Report details key activities and developments relating to Adverse Event cases managed under the Duty of Candour legislation from 1 April 2020 - 31 March 2021. • Following completion of the Adverse Event Review, it was considered timely to review the Duty of Candour Guidance.
Governance Process	• The Annual Report was presented to the National Clinical Governance Group on 29 July 2021 and Clinical Governance Committee on 12 August 2021. • The Guidance has been shared and discussed at NHS 24's Regional Clinical Governance Groups, approved by the National Clinical Governance Group on 29 July 2021 and presented to the Clinical Governance Committee on 12 August 2021.
Timing	There are no issues in relation to the timing of this report.
Strategic alignment and link to overarching NHS Scotland priorities and strategies	Supports delivery of NHS 24 strategic objectives of demonstrating the NHS Scotland Quality Ambitions in continuous improvement of care that is Safe, Effective and Person-Centred.
Financial Implications	There are no financial implications associated with this paper.
Equality and Diversity	The report supports the Equality and Diversity agenda.

1. RECOMMENDATION

1.1. The Board is asked to approve the NHS 24 Duty of Candour Annual Report and note the updated Duty of Candour Guidance for NHS 24.

2. TIMING

2.1. There are no issues in relation to the timing of this report.

3. BACKGROUND

3.1. There is a legal requirement on NHS Boards to complete an Annual Report.

4. ENGAGEMENT

4.1. In compiling the information contained within the report, the Patient Experience Manager has engaged the Clinical Governance Team including the Head of Clinical Governance & Quality Improvement.

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NHS 24
PATIENT EXPERIENCE TEAM

DUTY OF CANDOUR
ANNUAL REPORT
2020/2021

Created by:

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1. Introduction and Key Information

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

1.2 Organisations are required to provide an Annual Report in relation to Duty of Candour. This report describes how NHS 24 has implemented Duty of Candour between 1st April 2020 and 31st March 2021.

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

1.4 Whilst the impact or outcomes for patients are not always known, where opportunities for learning and improvements are identified through our Adverse Event process, following feedback from other Health and Social Care Services, or from patients and families, these are addressed.

2. NHS 24

2.1 NHS 24 is the national provider of digital and telephone-based health and care services for Scotland by providing the public with access to information, care and advice through multiple channels including telephone, web and online.

2.2 NHS 24 works in collaboration with our Health Board partners, the public and our people to co-design services using technology and a digital first approach to sustainable service development and delivery.

2.3 NHS 24 has promoted Duty of Candour internally thereby ensuring a good understanding by key senior clinical staff of the requirements of the Act. This process is facilitated by the Patient Experience & Liaison Manager. To date, 159 staff have completed the Duty of Candour e-Learning materials and these will be promoted in the coming quarter to ensure staff awareness of the Procedure.

3. Duty of Candour Incidents

3.1 Between 1st April 2020 and 31st March 2021, NHS 24 initiated 7 incidents in which Duty of Candour was applied. This is a decrease from 11 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.

3.2 NHS 24 identified these incidents through our Adverse Event management process.

3.3 Over the time period for this report, NHS 24 undertook 16 Adverse Event reviews, categorised below:

Grading	No. of Adverse Events
Category 1	5
Category 2	1
Category 3	7
Near Miss*	3

*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.

3.4 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. The decision on whether a case should activate Duty of Candour lies with NHS 24's Associate Medical Directors.

Incidences of Duty of Candour 2020/2021

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 2020 and 31 March 2021)
A person died	4
A person's treatment increased	1
The structure of a person's body changed	1
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries as listed above	0
TOTAL	**7**

4. To what extent did NHS 24 follow the Duty of Candour procedure?

4.1 NHS 24 followed the procedure in six cases. In one case, despite best endeavours by senior clinical staff, one patient's Next of Kin was unable to be identified, therefore family engagement was not possible. This patient' care however was still progressed as an AE/Duty of Candour case and identified learnings progressed. For the other six cases, NHS 24 contacted the people and/or families affected, apologised to them, and offered to meet with them. This year, the impact of COVID-19 has meant that early face to face meetings were impeded and some meetings to discuss final reports are also

delayed. It is hoped, with the easing of COVID-19 restrictions, face to face meetings can be arranged in the near future.

4.2 In each case, NHS 24 carried out a full review to understand what happened and what we could have done better. Individual and organisational learning was undertaken and subsequent improvement plans have been developed and completed.

4.3 NHS 24 prides itself in being an open and transparent organisation and throughout our dealings with patients and families, we maintained regular communication, invited questions from those involved, and have shared the final written report with the relevant person. Reports have been produced in plain English with explanations of abbreviations and acronyms where appropriate. These have been well received by families and positive feedback on our management of Duty of Candour has been received.

4.4 This year, to ensure a person-centred approach to the management of a specific Duty of Candour case, translation services in the form of language line and written translation services were utilised. In this case, joint working was also evident with a partner Heath Board to ensure a comprehensive Adverse Event Report was provided.

5. Information about our policies and procedures

5.1 Adverse Events findings are reported through the NHS 24 Clinical Governance reporting structures as set out in the adverse event management process. During this year, NHS 24 has undertaken a review of its Adverse Event Process.

5.2 NHS 24's Adverse Event Process contains a section on activating Duty of Candour with accompanying guidance. This ensures that Duty of Candour status is considered in all cases. To support this, staff have access to information on the intranet via our dedicated Duty of Candour page. All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module, which is also available on the organisation's intranet. Duty of Candour Information on Duty of Candour and our responsibilities in this regard are contained within the NHS 24 core induction programme delivered to all new frontline staff.

5.3 Each adverse event undergoes a rigorous review to understand what happened and where care provision in the future can be improved. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made, and local management teams develop improvement plans to meet these recommendations within defined timescales. Additional training is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event. NHS 24 understands that adverse events can be distressing for staff as well as the patients and families involved. Support is available for all staff through the line management structure as well as through Occupational Health. Staff have access to the Employee Assistance Programme and can seek support from trained counsellors.

6. What has changed as a result?

6.1 NHS 24 has made, and are considering, a number of changes following review of Adverse Events which activated Duty of Candour. NHS 24 continually reviews its processes and clinical decision support materials to ensure clinical content is evidence based and relevant. Our aim is to improve the patient journey, learn from feedback from service users and partners and to ensure all learning from Adverse Events is progressed and evidenced.

- Recommendation that NHS 24 revise the inbound telephone messaging options to consider having an option at this point for translation services. This is currently being impact assessed and engagement will take place with service users and the public in relation to this change.
- In one AE case, the expert opinion of a Consultant Urologist was sought. Work is ongoing to formalise such requests to ensure consistency.
- Guidance reviewed in relation to the keyword 'unknown'. This now reflects revised keyword of 'clinical supervision'.
- In relation to calls to the 111 service, NHS 24 has formalised a national training curricula with associated re-validation timelines for Senior Charge Nurse to prioritise and manage the 'Holding Area' and to provide safety-netting when requested to do so.
- NHS 24 is working closely with the Scottish Government and Public Health Scotland in relation to constantly reviewing and updating the COVID-19 protocol utilised by staff.

7. Other information

7.1 NHS 24 continues to welcome opportunities to learn and improve. Feedback from service users and partner Health Boards allows us the opportunity to do so. NHS 24 has recently reviewed and approved a revised Adverse Event process to ensure this is as effective as possible. It was considered timely therefore to revise the Duty of Candour Guidance to assist staff in their decision making in relation to when Duty of Candour should be activated.

7.2 NHS 24 will submit this report to Scottish Ministers and this will be available on the NHS 24 website and the Intranet.

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Organisational Duty of Candour Guidance

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What is Duty of Candour?

The organisational Duty of Candour provisions of the **Health (Tobacco, Nicotine etc, and Care) (Scotland) Act 2016** (The Act) and **The Duty of Candour Procedure (Scotland) Regulations 2018** set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an **unintended** or **unexpected incident** that results in the death or harm (or additional treatment is required to prevent injury that would result in death or harm).

Duty of Candour underpins and supports NHS 24's commitment to the values of openness, honesty and learning which is vital to the provision of safe, effective and person centred care.

Candour promotes responsibility for developing safer systems; better engages staff in improving services; and creates greater trust in people who use our services. The focus of the Duty of Candour legislation is to ensure that organisations inform those affected that an unintended or unexpected incident has occurred; apologise; involve them in meetings about the incident; review what happened with a view to identifying areas for improvement; and learn from the incident (taking account of the views of relevant persons). Organisations must ensure that support is in place for their employees and for others who may also be affected by unintended or unexpected incidents.

The responsible person

The "responsible person "in terms of the Act is the Health Board. The Director of Nursing & Care has overall responsibility for the delivery of Duty of Candour within NHS 24 in conjunction with Executive Leads. Heads of Clinical Services and Associate Medical Directors have a key responsibility to identify and ensure that Duty of Candour events are managed in line with legislation.

The Patient Experience Team is responsible for monitoring and reporting on implementation of Duty of Candour.

When must the Duty of Candour procedure be activated?

Organisations (as responsible persons) must activate the Duty of Candour procedure as soon as reasonably practicable after becoming aware that:

An unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person;

(a) that incident appears to have resulted in or could result in any of the outcomes mentioned below; and

(b) that outcome relates directly to the incident rather than to the **natural course** of the person's **illness or underlying condition**.

The relevant outcomes are as follows:

A. The death of the person
B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) (“severe harm”).
C. Harm which is not severe harm but which results in one or more of the following criteria:
- An increase in the person’s treatment;
- changes in the structure of the person’s body;
- the shortening of the life expectancy of the person;
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days;
- The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.

D. The person requires treatment by a registered health professional in order to prevent:
- The death of the person, or
- Any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in **B or C.**

The view of the registered health professional

A registered health professional must give their view on the incident and its relationship to the occurrence of death or harm and pre-existing illnesses or underlying conditions.

NHS 24 should ensure that the registered health professional is not someone who was involved in the incident. The requirement is for someone not involved in the incident to provide a view to inform a decision about activating the Duty of Candour Procedure (which includes a review process)

The registered health professional is required to provide the responsible person with their view on the following:

- Based on the background information provided, does it appear that this incident is directly linked to the death or harm described?
- Could the natural course of the person’s illness or underlying condition have resulted in death or harm described?

How do we identify cases and activate Duty of Candour?

It is expected that all Adverse Events will be considered to fall under the scope of Duty of Candour.

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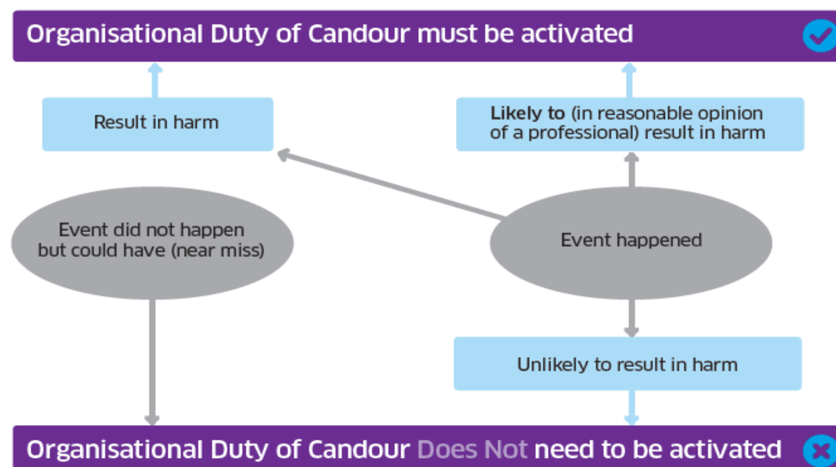
NB: The person declaring Duty of Candour must not be directly involved in the patient’s care.

What is the procedure start date?

The procedure start date is the date that NHS 24 receives confirmation from a registered health professional that, in their reasonable opinion, an unintended or unexpected incident appears to have resulted in, or could result in, an outcome listed above and that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

What does 'could result' mean and how is that decision to be made?

If the registered health professional thinks that it is unlikely that harm did occur, then the Duty of Candour procedure need not be activated for that incident



Are there any other ways we could identify Duty of Candour cases?

All feedback will be monitored for potential Duty of Candour and these will be highlighted to the relevant HOCS/AMD for confirmation in line with the current procedure for raising an Adverse Event.

Potential cases may also arise through whistleblowing procedures. Any potential case must be escalated to the HOCS/AMD. The Clinical Governance Leads can provide advice.

The relevant person

The relevant person is the patient, or where the person has died, or is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided, a person acting on behalf of that person.

Notification

The Duty of Candour legislation states that notification should be as soon as reasonably practicable but it should be considered as good practice to notify the relevant person **within 10 working days** of the procedure start date.

This notification can be by various methods including telephone, face to face, by letter etc. It is important to remember that where a Duty of Candour procedure start date is more than a month after the incident, the NHS 24 must provide the 'relevant person' with an explanation of why this is:

The following should be considered:

- Who from NHS 24 is already in contact with the relevant person?
- What discussions or information exchange has already taken place?
- What is the relevant person's current understanding of the incident and NHS 24's response to this?
- Where the conversation takes place?
- Who should be part of and who should lead that conversation?
- What support should be available to the relevant person during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the relevant person?
  If the relevant person is unable to participate in the discussion who should be involved on their behalf? (e.g. because the incident was fatal or the patient lacks capacity or the patient wishes to nominate someone to do it for them)

The notification must include:

- **an account of the incident to the extent that NHS 24 is aware of the facts at the date the notification is provided;**
- **an explanation of the actions that NHS 24 will take as part of the procedure;**
- **in the case where the procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for the delay in starting the procedure.**

Communication with relevant person

NHS 24 should take reasonable steps to find out the relevant person's preferred method of communication. We should also take reasonable steps to ensure that communication with the relevant person is in a manner that they can understand.

It is recognised that in some instances communication channels may not exist or preferences are unknown. Contact by telephone in the first instance may be necessary to establish the relevant person's preferred method of communication and to begin dialogue on what steps might need to be taken in following the Duty of Candour procedure.

If unable to contact the relevant person or the relevant person does not wish to speak with a representative, the attempts made to contact them need to be included as part of NHS 24's written record of following the Duty of Candour procedure.

NHS 24 need not provide information where relevant persons have indicated that they do not wish to receive it.

The Regulations do not permit or require the organisation to disclose any information that would prejudice any criminal investigation or prosecution or contravene any restriction on disclosure arising by virtue of an enactment or rule of law.

NHS 24 will act in accordance with the European Convention of Human Rights, and any other relevant law such as the Data Protection Act 1998.

Implications of a compensation claim

What are the implications if a claim for compensation is made once the decision to follow the Duty of Candour procedure is made?

If a relevant person intimates they are considering making a claim, the Duty of Candour procedure should continue. If a relevant person makes a claim then some elements of the Duty of Candour procedure may need to be paused until the legal process reaches a conclusion. For example, internal reviews could still proceed and NHS 24 should still try to identify any potential improvement and learning actions. Cases should be escalated to the Director of Nursing and Care for advice and, where appropriate, escalated to the Central Legal Office.

Apology

In addition to any apology provided at the time of the incident, as part of the Duty of Candour procedure, NHS 24 must offer the relevant person a written apology (this can be by electronic communication if that is the relevant person's preferred means of communication) in respect of the incident.

There may still be misconceptions and misunderstanding that the provision of an apology equates to an admission of liability. This is not the case. In Section 23(1) of the Act states that "an 'apology' means a statement of sorrow or regret in respect of the unintended or unexpected incident." The Act sets out that "an apology" does not of itself amount to an admission of negligence or a breach of a statutory duty.

Meeting

The relevant person must be invited to attend a meeting and be given the opportunity to ask questions in advance. Reasonable steps should be taken to ensure that the meeting is accessible to the relevant person, having regard to their needs, for example, linguistic needs or reasonable adjustments that may be required for someone who has a disability. In some circumstances, it may be necessary to have an interpreter or an advocate present.

A quiet room should be used, free from distraction and where the meeting will not be interrupted. At the meeting, NHS 24's representative should speak to the relevant person in the same way as they would want someone in the same situation to communicate with them or a member of their own family. The relevant person should be spoken to in plain English, without the use of jargon, and the representative should check to see if they have understood what they have been told.

The meeting must include:

- a verbal account of the incident;
- an explanation of any further steps that will be taken by NHS 24 to investigate the circumstances which it considers led or contributed to the incident;
- an opportunity for the relevant person to ask questions about the incident;
- an opportunity for the relevant person to express their views about the incident; and
- the provision of information to the relevant person about any legal, regulatory or review procedures that are being followed in respect of the incident in addition to the procedure.

Following some unexpected or unintended incidents there may be several review processes operating in parallel. This can be confusing for people. To try to lessen this confusion, meetings with relevant persons must include details of other procedures which are being followed including their differing scope and focus.

In circumstances where there is concern, for example, that an unintended or unexpected incident was contributed to by factors influencing the capability of an employee it may be helpful for them to know that in addition to the systems review that is in operation, a separate process has been put in place to identify whether an employee may benefit from support.

After the meeting, the relevant person should be provided with:

- a note of the meeting;

- contact details of an individual member of staff acting on behalf NHS 24 who the relevant person may contact in respect of the procedure

It should be agreed with the relevant person what the note of the meeting will include. This does not need to be a verbatim account of the discussion but could include when and where the meeting took place, a record of the apology and actions and timescales that were agreed.

If the relevant person does not wish to or is unable to attend the meeting, NHS 24 must still provide them with the information set out above (other than a note of the meeting) if the relevant person wishes it.

When more than one organisation is involved

Where more than one organisation needs to be involved in the Duty of Candour procedure

The Duty of Candour procedure is the legal responsibility of the organisation who provided the service where the incident occurred. Other health and social care providers may have been involved in the provision of care and services, **but they are not responsible persons (organisations) in respect of that incident.**

It is often the case that a range of organisations are involved in the episode of treatment or care where the unexpected or unintended incident occurred. Although they are not responsible persons in terms of the legislation, they may need to become involved in providing information as part of a review or in providing support for relevant persons coping with the personal impact of death or harm arising from the unintended or unexpected incidents.

In rare circumstances, several responsible persons may each decide to activate the Duty of Candour procedure for multiple incidents. In such circumstances, responsible persons should seek to communicate with each other, emphasising co-operation and ensuring a co-ordinated approach in their communication with the relevant person.

Where more than one organisation needs to be involved in the Duty of Candour review, all parties are expected to co-operate fully throughout the Duty of Candour procedure and share lessons learned and necessary actions identified by the procedure.

Where this is the case, the relevant person must be informed as part of the notification process, that the organisation where the incident occurred is the responsible person, as defined by the legislation, who will carry out the procedure.

The Review

NHS 24 must carry out a review of the circumstances which they consider led or contributed to the unintended or unexpected incident**.** The legislation does not specify the manner in which the review is undertaken, however within NHS 24 this will be an Adverse Event review.

Best practice in reviewing unintended or unexpected incidents that have resulted in death of harm require that a whole system and human factors approach is adopted. The NHS 24 approach focuses on systems analysis; the identification of contributory factors and the investigation of human factors.

In the case where the review is not completed within 3 months.

Where the review is not completed within 3 months of the procedure start date, NHS 24 will provide the relevant person with an explanation of the reason for the delay in completing the review.

In carrying out the review, NHS 24 will seek the views of the relevant person and take account of any views expressed. This will be best implemented through the development of a supportive relationship with the relevant person and arrangements that ensure review processes consider the views of the relevant person and are able to demonstrate the way in which these views (which are likely to reflect what matters most to them) have been taken account of.

The Written Report

NHS 24 are required to prepare a written report of the review, which must include:

- a description of the manner in which the review was carried out;
- a statement of any actions to be taken by NHS 24 for the purpose of improving service quality and sharing learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services; and
- a list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.

This provides an opportunity to demonstrate that the views of relevant persons have been considered and that a review has been conducted that has focused on systems analysis that takes account of best practice in review and investigation of human factors.

The legal requirement to include details of the dates when each element of the Duty of Candour procedure took place is included to provide an overview of the process within NHS 24 from the point that we decide to activate the Duty of Candour procedure to the point the review is concluded.

Where possible, written reports on reviews should be written in a manner that minimises the need for extensive redaction.

NHS 24 must offer to send the relevant person:

A copy of the written report of the review:

- details of any further information about actions taken for the purpose of improving the quality of the service provided by NHS 24 and;
- details of any services or support which may be able to provide assistance or support the relevant person, taking into account their needs

It is important to think about how the report of the review is written if it is to be shared with 'relevant person'. It should not contain jargon or acronyms, which are difficult to understand. It should be clear and unambiguous.

The review report should include information on the actions that are to be taken to make improvements in systems and processes influencing the quality of care delivery. The actions taken to share learning with other organisations (such as those who might have similar organisational processes to the ones that formed the basis of the review) should be outlined in the written review report.

NHS 24 must keep a written record for each Duty of Candour incident including a copy of documents or correspondence relating to the application of the Duty of Candour procedure to the incident. These will be retained in accordance with relevant local policies and procedures.

Reporting and monitoring

The Act sets out that NHS 24 must prepare an annual report, as soon as reasonably practicable after the end of the financial year.

The report must include:

- information about the number and nature of incidents to which the Duty of Candour procedure has applied
- an assessment of the extent to which NHS 24 carried out the Duty of Candour;
- information about NHS 24's policies and procedures in relation to the Duty of Candour, including information about procedures for identifying and reporting incidents, and support available to staff and to persons affected by incidents;
- information about any changes to NHS 24's policies and procedures as a result of incidents to which the Duty of Candour has applied; and
- such other information as the responsible person thinks fit.

The report must not mention the name of any individual, or contain any information that could identify any individual involved in the event.

The report will be published on NHS 24's website.

When NHS 24 has published a report, they must notify:

- Healthcare Improvement Scotland.

Healthcare Improvement Scotland, may, for the purpose of monitoring compliance with the Duty of Candour provisions, serve a notice on an organisation, requiring them to provide information about any of the matters listed in the Reporting and Monitoring section above as specified in the notice, and that information is to be provided within the time specified in the notice. As a result, they may publish a report on the organisation's compliance.

Training and support

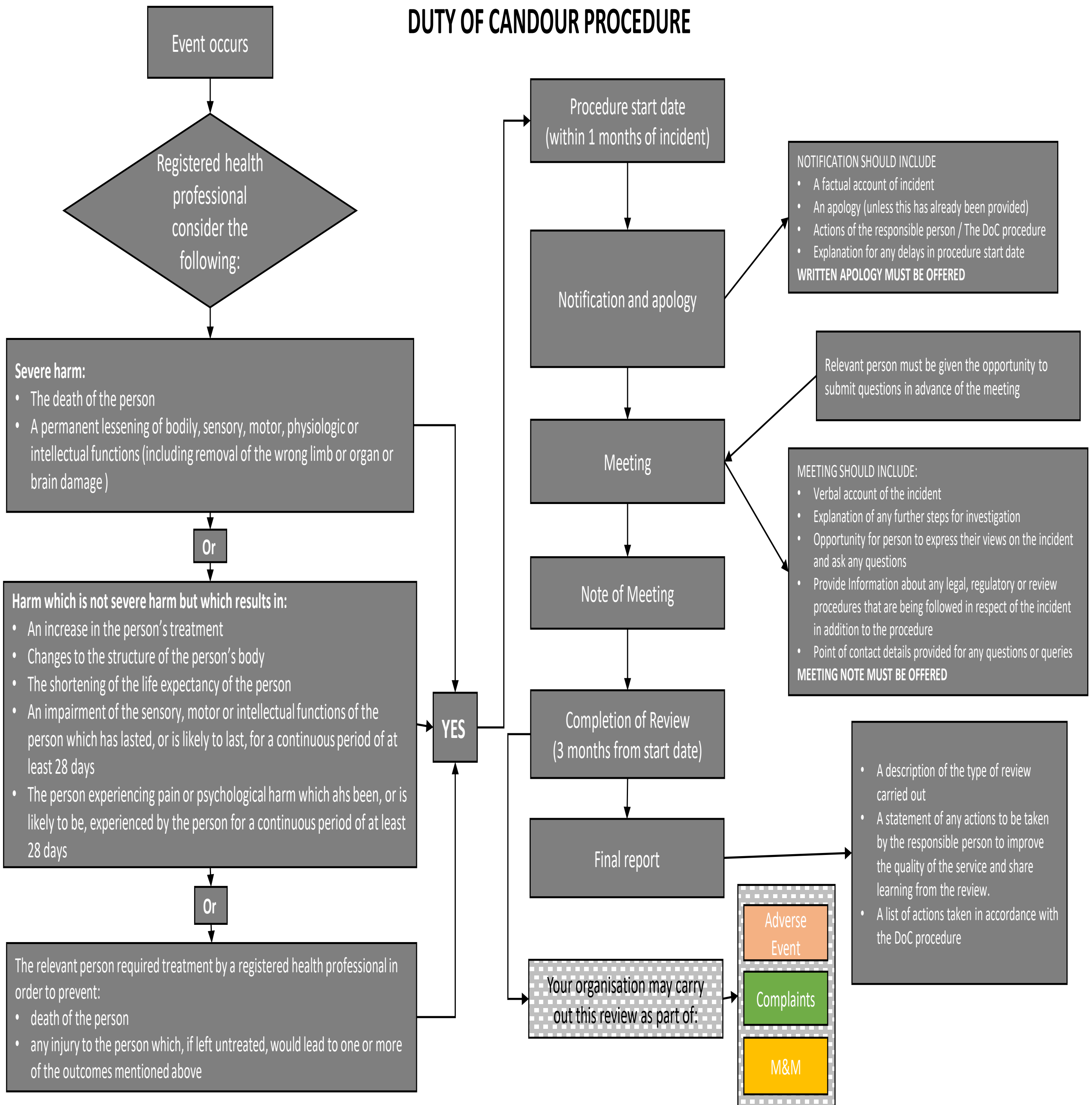
NHS 24 must ensure that relevant staff are aware of the Duty of Candour procedure.

An e-Learning resource is available on NHS 24 e-learning system and relevant staff are required to complete the module

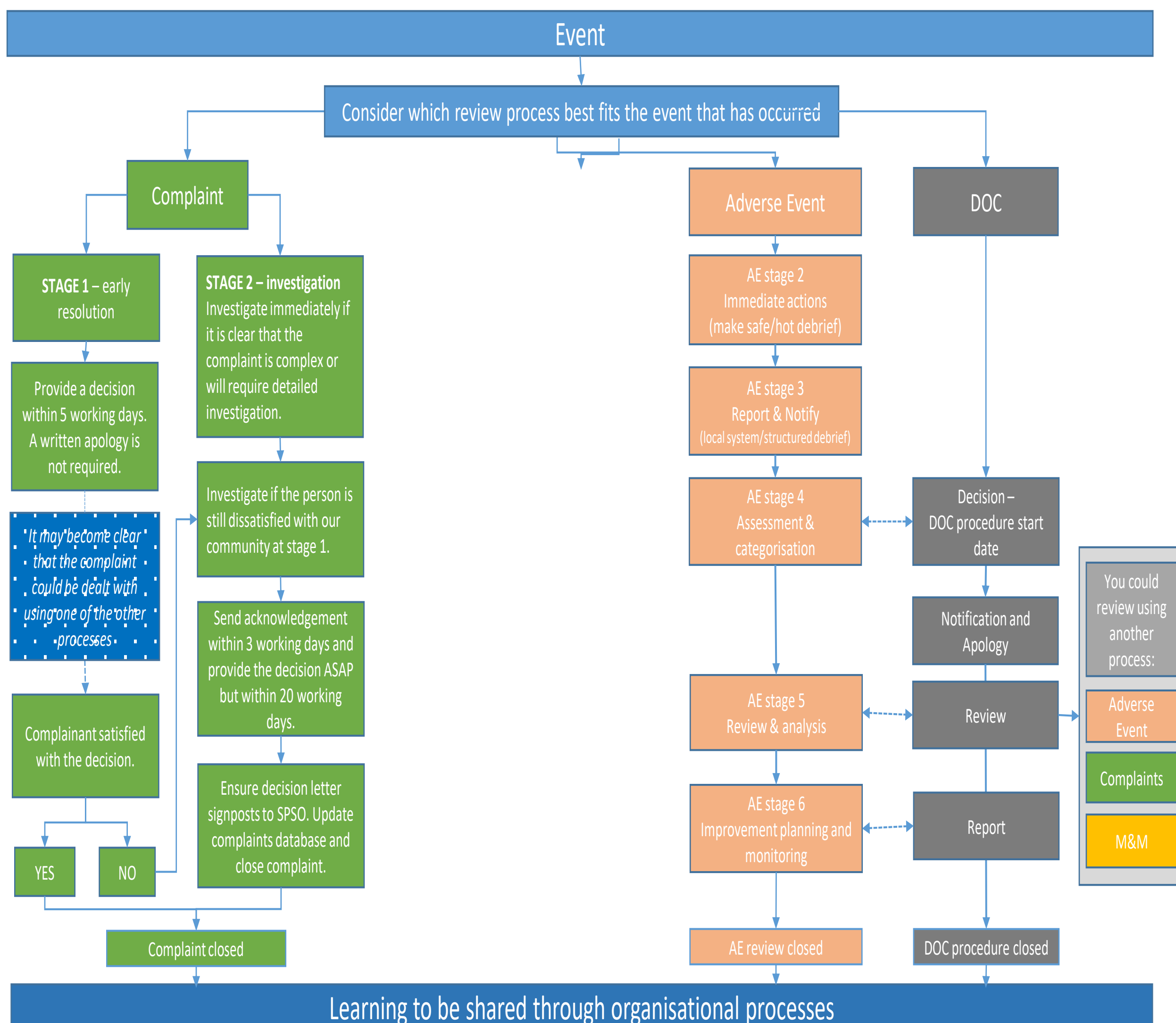
Factsheets and other resources are available via the staff intranet and within all Centres.

Through meetings and discussion with relevant persons, NHS 24 determines the impact of the unintended or unexpected event on the staff member's health and wellbeing. NHS 24 provides any of the staff who were involved in the incident with details of any services or support of which the organisation is aware which may be able to provide assistance or support to staff, taking into account the circumstances relating to the incident; and the staff member's needs. This may take the form of debriefing or direct support.

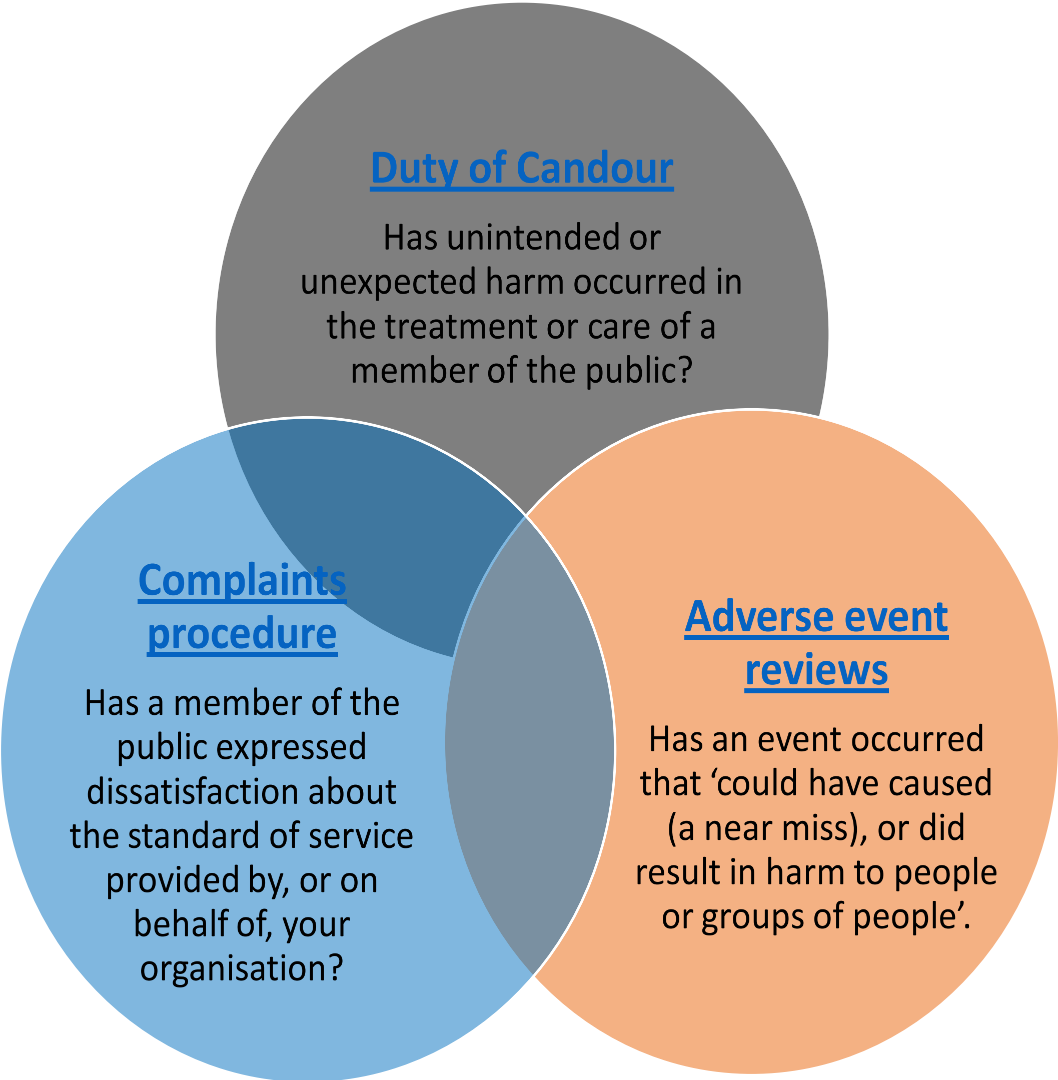
Appendix 1 – Duty of Candour Procedure



Appendix 2 – Event



Appendix 3 – Deciding on which review procedure best fits an incident



Appendix 4 – Making an apology

For the purposes of the Act, an "apology" means a statement of sorrow or regret in respect of the unintended or unexpected incident that caused harm or death. The Act sets out that an apology or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty.

The Four Rs are an easy way to remember how we can get this right:

Reflect - stop and think about the situation

Regret - give a sincere and meaningful apology

Reason - if you know, explain why something has happened or not happened and if you don't know, say that you will find out

Remedy - what actions you are going to take to ensure that this won't happen again and that the organisation learns from the incident.

An apology is not an admission of liability.

What is a meaningful apology?

An apology is often the first step in putting things right and can help to repair a damaged relationship and restore dignity and trust. To make an apology meaningful you should:

- Acknowledge what has gone wrong.
- Clearly describe what has gone wrong to show you understand what has happened and the impact for the person affected.
- Accept responsibility or the responsibility of your organisation for the harm done
- Explain why the harm happened.
- Assure the individual and/or their family of the steps you or your organisation have taken, or will be taking to make sure the harm does not happen again (where possible).
- Make amends and put things right where you can

How should I make an apology?

Your apology should be based on the individual circumstances.

- The timing of the apology is very important and should be done without delay.
- To make the apology meaningful do not distance yourself from the apology or let there be any doubt that you or your organisation accepts any wrongdoing.
- The language you use should be clear, plain and direct.
- Your apology should not question the extent of harm suffered by the person affected.
- Your apology should not minimise the incident.
- It is very important that you apologise to the right person or people.

Who should apologise?

The Act states that the responsibility for the apology rests with the responsible person – this is the organisation delivering the service. Within each organisation there will be individuals with delegated responsibility for ensuring that the organisational duties (in this case providing an apology on behalf of the organisation) are met (recognising that there are likely to have been individuals who have provided individual apologies).

For an apology to be effective it needs to be sincere. Sometimes you may need to apologise for an event which is not of your doing - indeed the organisationally focused apology required by the duty of candour procedure will involve this. Sometimes it is the official organisational recognition of the event that will be important to the individual and/or their family.

The timing of a more formal apology is at the discretion of the responsible person but best practice would be to also apologise immediately the event comes to light. When making your apology you should not worry about who is to blame or what has gone wrong but merely apologise for the event occurring.

Appendix 5 – Adults with incapacity and following a death

THE RELEVANT PERSON:
ADULTS WITH INCAPACITY AND FOLLOWING A DEATH

In carrying out the duty of candour procedure the onus is for the health, care, or social work provider, in their role as appropriate person, to determine who should act on behalf of a relevant person who lacks capacity or who has died, taking into account any existing arrangements that are in place as regard to power of attorney or guardianship and seeking legal advice as appropriate. The following paragraphs provide information on Power Of Attorney; Guardianship and Next-of-Kin.

Power of Attorney

A power of attorney is a way of giving someone else permission to make decisions about your money and property as well as your health and personal welfare. It usually sets out what you would want to happen in the future if you could no longer look after your own affairs. In some circumstances you can choose for it to start immediately. As a power of attorney gives legal authority for someone else to act on your behalf, it is important to take advice from a solicitor.

The Attorney

A power of attorney is a written document, usually drawn up by a solicitor, which gives the name of the person - the attorney - you would like to help make decisions and take actions on your behalf. More than one person can be named. The attorney should be someone you trust, such as a family member or friend, or your solicitor. The powers the attorney would have are written down along with when he or she would begin acting for you. Attorneys have a duty to keep records of their actions. If you have only one attorney named and he or she is no longer able to act for you, a new power of attorney must be drawn up.

Who Needs a Power of Attorney?

Everyone should consider asking a solicitor to prepare a power of attorney. With some people, their capacity to look after their affairs is impaired gradually, for instance, as they grow older. But sudden accidents and illnesses can happen to anyone. A doctor can assess whether or not a person is incapable.

What is the difference between a power of attorney and a guardianship?

Both fulfil the same function - allowing one person to act on behalf of another, to look after their financial and/or welfare matters. The difference is that a power of attorney can only be granted from an individual who can understand and explain their wishes whereas a guardianship applies when a person does not have capacity to make decisions on their own behalf. A guardianship is applied for through the courts (and can take up to six months to be granted) whereas a power of attorney is drawn up by a solicitor.

A guardianship is for a fixed period of time (unless a good reason can be shown why it should be longer) whereas a power of attorney stays in force unless revoked by the person granting the power of attorney or death.

Next-of-Kin

The term next-of-kin has no legal definition in Scotland. An individual can nominate any other individual as their next-of-kin. There is no requirement for the nominated person to be a blood relative or spouse, although it is normally the case. Someone who has no close family (or who has little or no contact with their surviving family members) may decide to list someone outside their family as their next of kin, for instance a friend or a neighbour. The nominated person must agree to the nomination, otherwise it is invalid. The status of next-of-kin confers no legal rights and has no special responsibilities.

In the context of healthcare, patients are often asked to nominate a next-of-kin when registering with their general practitioner, or alternatively on admission to hospital. Hospitals will then notify the next-of-kin that the patient has been admitted or if there is any change in their condition. If the patient is unconscious or otherwise unable to state their next-of-kin, hospitals will usually list their nearest relative, though there are no specific rules. Doctors should attempt to seek the views of the next-of-kin when considering decision making for unconscious patients or those who lack capacity.

Appendix 6 – Duty of Candour Timeline

Trigger DoC procedure as soon as recognised as all steps follow this date.
NOTE: it may not be date of event

<table>
<tr><th>Timeframe</th><th>Action</th></tr>
<tr><td>▼
As soon as reasonably practicable and not more than **10 working days** of the DoC procedure start date. If the date is more than a month after the incident, NHS 24 must provide the 'relevant person' with an explanation of is the delay.</td><td>**Notification**
• An apology given to the relevant person/representative by the relevant senior person - This notification can be by various methods including telephone, face to face, by letter etc.
• Explain event has triggered inclusion in the DoC process what that means and that there will be a review.
The notification must include:
• an account of the incident to the extent that the NHS 24 is aware of the facts at the date the notification is provided;
• an explanation of the actions that NHS 24 will take as part of the procedure; and
• in the case where the procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for the delay in starting the procedure.

Arrange a meeting with the relevant person/representative to be held within one month of the adverse event.

The relevant person/representative should be given the opportunity to ask questions in advance of the meeting date.

RECORD DoC COMMENCED ON RESPOND– this record is to be kept for 7 years.</td></tr>
<tr><td>▼
Within 1 month</td><td>**Meeting**
• a verbal account of the incident;
• an explanation of any further steps that will be taken by NHS 24 to investigate the circumstances which it considers led or contributed to the incident;
• an opportunity for the relevant person to ask questions about the incident; an opportunity for the relevant person to express their views about the incident; and the provision of information to the relevant person about any legal, regulatory or review procedures that are being followed in respect of the incident in addition to the procedure

After the meeting the relevant person should be provided with:
• a written account/note of this meeting within **5 working days.**
• contact details of an individual member of staff acting on behalf of NHS 24 who the relevant person may contact in respect of the procedure

In addition to any apology provided at the time of the incident, as part of the Duty of Candour procedure NHS 24 must offer the relevant person/representative a written apology in respect of the incident and NHS 24 must provide an apology if the relevant person wishes it.</td></tr>
</table>

Timeframe	Action
	The written apology should be personal and provided at an appropriate time during the duty of candour procedure, taking account of the facts and circumstances in relation to the particular incident. If the relevant person does not wish to or is unable to attend the meeting, NHS 24 should still provide them with the information set out above (other than a note of the meeting) if the relevant person wishes it.
▼ **Within 3 months** Where the review is not completed within **3 months** of the procedure start date, NHS 24 will provide the relevant person with an explanation of the reason for the delay in completing the review	**Written report** NHS 24 will offer to share the report with the relevant person/person acting on their behalf. If they agree to receive the report it should be sent within **10 working days** of their reply. If not an explanation should be provided. All other relevant documentation relating to the review must be included in the report **The written report of the review will include**: • a description of the manner in which the review was carried out; • a review the circumstances that led or contributed to the adverse event • the views and answer any questions from the representative/ relevant person acting on their behalf. • a statement of any actions to be taken by NHS 24 for the purpose of improving service quality and sharing learning with other persons or organisations in order to support continuous improvement in the quality of service provided. • a list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.
Staff support	**Employees needs will form part of the review** • Where learning has been identified for the staff member, this will be carried out by their line manager and completed within the required timescales. • through meetings and discussion with relevant persons, NHS 24 will determine the impact of the unintended or unexpected event on the staff member's health and wellbeing. • Staff will be provided with details of services or support which may be able to provide assistance or support to them, taking into account the circumstances relating to the incident; and the staff member's needs.