NHS 24

PATIENT EXPERIENCE TEAM

DUTY OF CANDOUR ANNUAL REPORT

2020/2021

Created by:

Role	Name	Title
Author	Shona Lawrence	Patient Experience & Liaison Manager
Lead Exec	Maria Docherty	Director of Nursing & Care

If you would like us to consider producing this report in a different format please phone us on 0800 22 44 88. If you have a Textphone dial 18001 0800 22 44 88.

Should you wish any additional detail, please contact:

Patient.Experience@nhs24.scot.nhs.uk

0330 020 4846

CONTENTS	
Page	**Contents**

1. Introduction and Key Information

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.

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.

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.

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

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.

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.

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

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.

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

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?

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 Adverse Event/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.

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.

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.

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

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.

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.

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?

NHS 24 has made, and is 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 Adverse Event 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 curriculum 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

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.

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