NHS 24

PATIENT EXPERIENCE TEAM

DUTY OF CANDOUR ANNUAL REPORT

2021/22

Created by:

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

July 2022

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 during 2021/22.

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. Should patient care span more than one Health Board, we work together with partners to ensure a comprehensive review of patient care.

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.

3. Duty of Candour Incidents

Between 1st April 2021 and 31st March 2022, NHS 24 initiated 7 incidents in which Duty of Candour was applied. This is the same figure as 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 14 Adverse Event reviews, categorised below:

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

Initial and Final Categorisation of Adverse Events
(HIS Categories ref: A national framework for Scotland April 2015 (2nd Edition)
The following categories should be used to group adverse events.

• **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.

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 2021/2022

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 2021 and 31 March 2022)**
A person died	3
A person's treatment increased	
The structure of a person's body changed	
A person's sensory, motor or intellectual functions was 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	4
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, the parent of a child patient did not engage with us. For the other six cases, NHS 24 contacted the patients and/or families affected and offered an apology. Meeting with families face to face during the reporting period has been impeded due to the COVID-19 Pandemic. However, families were offered the opportunity to meet virtually or to meet with us at a later date once face to face restrictions eased.
In each case, NHS 24 carried out a full review to understand what happened and recommendations were identified. 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 Adverse Event Report with the relevant person. In one case, the relevant person did not wish a copy of the final Adverse Event Report. They advised they were satisfied that a detailed review had been undertaken.

Reports have been produced in plain English. These have been well received by families and positive feedback on our management of Duty of Candour has been received.

5. Information about our policies and procedures

Adverse Events findings are reported through the NHS 24 Clinical Governance reporting structures. NHS 24 has also welcomed the Multi Board Review work and endeavours, where possible, to work closely with partner Health Boards when patient care spans more than one Board.

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. Some key learning is detailed below:

- Training materials and decision support tools to cover acute symptoms and trauma injuries, independent of cause. Further information added to training materials to include 'specifics of mechanism of injury' when considering 'Fall'. This recommendation was actioned in July 2021.

- Learning & Professional Education have updated training materials and e-Learning module to include information on the recognition of early onset diabetes in children.

- Hot Topic (internal communication) issued to staff to fully consider as part of an overall assessment, if a caller has already accessed information on NHS Inform, a quality assured website.

- Clinical Process 01 updated with guidance regarding documentation of supervision where there is more than on episode of supervision required.

- Key Learning points from one case were incorporated into e-Learning materials for future staff and the continuous professional development of current 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.