NHS 24
BOARD MEETING

29 AUGUST 2024
ITEM NO 10.1
FOR APPROVAL

DUTY OF CANDOUR ANNUAL REPORT 2023/24

Executive Sponsor:
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Lead Officer/Author:
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Action Required
The NHS 24 Board is asked to approve the content Duty of Candour Annual Report 2022/24, and to also approve the publication and onward submission to Scottish Government.

Key Points for this Committee to consider
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).

Governance process
This report was approved by the NHS 24 Clinical Governance Committee.

Strategic alignment and link to overarching NHS Scotland priorities and strategies
- NHS 24 Strategy
- Adherence to the Duty of Candour Procedure (Scotland) Regulations 2018
- Supports the delivery of safe, effective, person-centred care.

Strategic alignment and link to Corporate Delivery Plan activity
- Work collaboratively to support wider primary care reform agenda, supporting increased self-management of care, and offering clinical triage to get people to the right place for the right care.
- Sustain a culture that is values-led, and we can demonstrate makes a difference to staff.

Key Risks
There are no key risks.
Financial Implications
There are no financial implications.

Equality and Diversity

The report supports the Equality & Diversity Agenda. Engagement with patients and their families is in accordance with the expressed preferences of patients/families.

1. RECOMMENDATION

1.1 The NHS 24 Board is asked to approve the content Duty of Candour Annual Report 2022/24, and to also approve the publication and onward submission to Scottish Government.

2. TIMING

2.1 This report covers the reporting period from 1 April 2023 – 31 March 2024.

3. BACKGROUND

3.1 All Health Boards have a duty to provide a Duty of Candour Annual Report outlining the incidences of Duty of Candour.

4. ENGAGEMENT

4.1 The NHS 24 Clinical Governance Committee have approved this Report.

5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications.

6. MEASURABLE BENEFITS

6.1 This report provides assurance of NHS 24's adherence to the Duty of Candour Procedure (Scotland) Regulations 2018.

7. NEXT STEPS

7.1 Following approval publish the report and submit to the Scottish Government.

Duty of Candour Annual Report 2023/24

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 2023 and 31st March 2024.

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 is 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

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

Between 1st April 2023 and 31st March 2024, NHS 24 managed **15** Adverse Events of which **five** activated Duty of Candour. This compared to 11 Adverse Events of which 8 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.

Final Grading	No. of Adverse Events
Category 1	**1**
Category 2	**5**
Category 3	**6**
Near Miss *	**2**
AE Commissioned then closed	**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.

Duty of Candour

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 2023 and 31 March 2024)
A person died	1
A person's treatment increased	0
The structure of a person's body changed	0
A person's sensory, motor or intellectual functions were 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	0
A person needed health treatment in order to prevent other injuries as listed above	4
TOTAL	5

Initial and Final Categorisation of Adverse Events

- **Category I – events that may have contributed to or resulted in permanent harm**, for example unexpected death, intervention required to sustain life (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.

Healthcare Improvement Scotland (HIS) Categories reference:
Learning from adverse events: A national framework (4th Edition)

Following the Procedure

NHS 24 followed the procedure in all **five** cases. NHS 24 contacted the people and/or families affected, offered an apology and offered to meet. In **one** case, the patient did not wish to engage, however was reassured by the review. This patient's care was still progressed as an Adverse Event and identified learning progressed. An offer was made to meet with all patients/families involved, however these were not progressed by them.

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.

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 reports with the relevant person. Reports were provided in plain English with explanations of abbreviations and acronyms where appropriate.

Service Improvements resulting from Duty of Candour Cases

- Amendment to NHS 24 Clinical Process (CP) 99 to reflect “Patients should not have A&E endpoint changed to Primary Care Emergency Centre/Speak to clinician if they have no transport available”. Staff to refer to CP 123. If a patient has no access to transport, then a 1-hour ambulance should be arranged”.
- Update to current application to prevent a call that requires an ambulance to be arranged being closed without populating the Scottish Ambulance Service (SAS) incident number within the NHS 24 patient record. This would mitigate against calls being closed without SAS being contacted to arrange an ambulance.
- One case involved joint working with a partner Health Board to fully understand the patient’s journey of care. Both Boards fully engaged in this process. Learning was identified for NHS 24 in relation to the provision of an anonymised learning summary hosted on the NHS 24 LearnMore24 site. This is a recently implemented learning platform where learning summaries from approved Adverse Events are hosted to ensue NHS 24 gives an opportunity to all staff to learn from the event. The Health Board involved also identified learning in relation to providing clear and detailed documentation.

Meeting with Patients and Families

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

Despite this offer, this year, patients and families did not take the opportunity to meet. In some instances, it was clear the relevant person was reassured by the comprehensive review undertaken and of the detailed findings of the final Adverse Event Report. To date, two reports have been shared with families, one patient did not wish to receive a copy of the finalised approved report and two reports are awaiting final sign off prior to sharing.

Communication with patients and 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. In all cases, patients and families have been reassured by the review of patient care.

Review of Guidance

At the request of the NHS Scotland Scottish Government, NHS 24 was involved in a review of the Duty of Candour Guidance. Updated guidance will be issued during 2024/25.

NHS 24 welcomes this review and will ensure compliance with the revised guidance.