Duty of Candour Annual Report 2021/22

NHS GREATER GLASGOW & CLYDE	Custodian: Director of Clinical and Care Governance
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Table of Contents

1 Introduction 3
2 How many incidents happened to which Duty of Candour Applies? 4
3 To what extent did NHSGGC follow the DOC procedures? 5
4 Information about our policies and procedures 7
5 What has changed as a result? 7
6 COVID 19 Pandemic 8
7 Duty of Candour Addendum Update Dec 2022 9

1 Introduction

NHS Greater Glasgow and Clyde (NHSGGC) is one of 14 regional NHS Boards in Scotland. The Board provides strategic leadership and performance management for the entire local NHS system in the Greater Glasgow and Clyde area and ensures that services are delivered effectively and efficiently. Responsible for the provision and management of the whole range of health services in this area including hospitals and General Practice, NHSGGC works alongside partnership organisations including Local Authorities and the voluntary sector. NHSGGC serves a population of 1.14 million and employs around 39,000 staff – it is the largest NHS organisation in Scotland and one of the largest in the UK.

The statutory 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 death or harm (or additional treatment is required to prevent injury that would result in death or harm). The Duty of Candour (DoC) legislation became active from the 1st April 2018.

Organisations are required to apologise and to meaningfully involve patients and families in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

An important part of this duty is that NHSGGC provide an annual report about how the duty of candour is implemented in our services. This report describes how NHSGGC has operated the duty of candour during the time between 1 April 2021 and 31 March 2022.

The statutory organisational duty of candour has been developed to be in close alignment with the requirements of the professional duties of candour.

Duty of Candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short- and long-term effects of what has happened.

The organisation records and reviews whenever the patient or family was not informed to ensure NHSGGC fully meet the policy principles.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns. The legislation requires that NHSGGC must also publish a Duty of Candour annual report.

NHSGGC identify through a significant adverse event review process if there were factors that may have caused or contributed to an unintended incident, which helps identify duty of candour incidents. There can be delays however in completing the reviews which means there may be more duty of candour incidents which are not able to be reported at this time.

There have been additional codes added to the electronic incident reporting system (Datix) to allow an annual report to be created for Duty of Candour events. The compliance with Duty of Candour is monitored via the Clinical Risk reports that are submitted to the Acute; Mental Health and Partnership Clinical Governance Forums.

2 How many incidents happened to which Duty of Candour Applies?

There were 23 incidents which occurred between 1st April 2021 and 31st March 2022. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition. There are a further 3 events identified as duty of candour through the complaints process which will be investigated through the Significant Adverse Event process.

Type of unexpected or unintended incident	Number of times this happened
A person died	6
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A persons treatment increased	12
The structure of a person's body changed	0
A person's life expectancy shortened	0
A persons 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	2

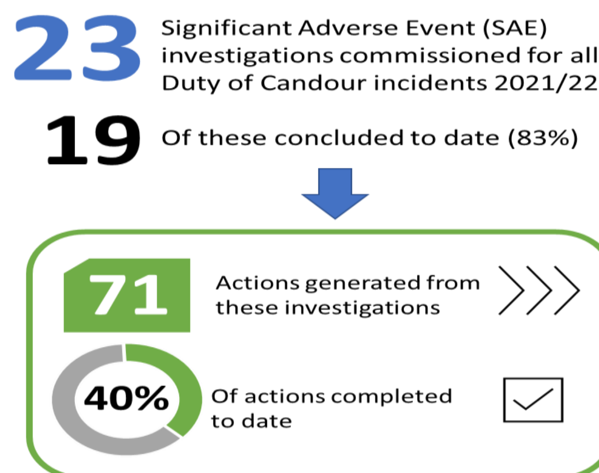
Type of unexpected or unintended incident	Number of times this happened
A person needed health treatment in order to prevent them dying	2
A person needing health treatment in order to prevent other injuries as listed above	0
Total	23

3 To what extent did NHSGGC follow the DOC procedures?

A Significant adverse event (SAE) review has been commissioned for all 23 Duty of Candour incidents. At the time of writing, 19 of these reviews have concluded.

The 19 completed SAE reviews have generated **71** actions. Please see diagram below for further details.

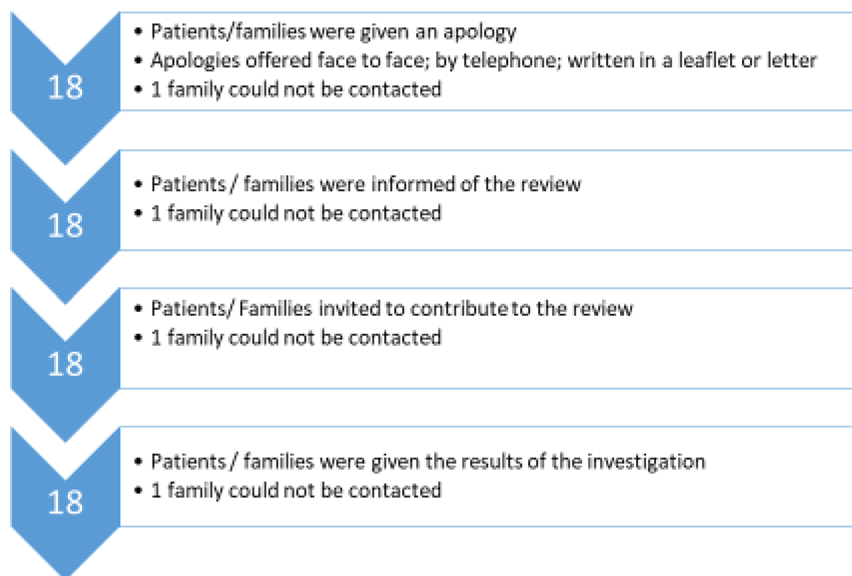
This summarises the progress of SAE investigations for Duty of Candour incidents to date.



The 19 significant adverse events that have concluded were assessed for compliance with the following elements of the regulations.

- Apology given
- Patient or Relative informed of the review
- Patient or Relative invited to participate in review
- Patient or Relative informed of the results of the review

Full compliance with duty of candour was achieved for all concluded reviews.



The 2020/21 Duty of Candour annual report, reported 42 incidents within the reporting period that triggered Duty of Candour. At the time of writing the report, 20 of these incidents had been closed. Since the 2020/21 Duty of Candour Annual Report was published a further 14 incidents have been closed. Full compliance with duty of candour was achieved for the 12 incidents closed since the last report.

- 2 concluded that Duty of Candour should not be triggered.
- 4 was that a person died
- 8 patients had their treatment increased.

The remaining 8 reviews from 2020/21 are underway. The Duty of Candour Annual Report 2021-2022 will have an Addendum produced later in the year which will include detail of any additional duty of candour adverse events and those not yet concluded. An addendum will be compiled and produced for this report, this is due to investigations still ongoing that are potential duty of candour events, but until these are concluded the required information to determine if they are duty of candour, is not available until this time.

Staff within NHSGGC were impacted by the circumstances surrounding COVID-19, where there were limitations on the amount of time clinical staff were able to provide and participate in significant adverse events reviews, resulting in delays in completion times for these reviews. We have identified improvement actions to support ongoing compliance with the legislation and enhance internal policies and procedures. These relate mainly to improving compliance with the required timescales for both initiating and concluding Duty of Candour reviews.

4 Information about our policies and procedures

The Board maintains a policy on Duty of Candour which is informed by the requirements set out in The Duty of Candour procedure, and regulations in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) implemented in April 2018.

NHSGGC Duty of Candour Policy was reviewed in 2021 and the following changes came into effect from October 2021:

- Change of language from patient safety event to unintended/unexpected incident.
- Link to Scottish Government guidance providing advice on different reporting procedures for health and social work.
- Healthcare Improvement Scotland examples provided.
- A scope section was added in line with NHSGGC policy development framework.

A recommendation in the Queen Elizabeth University Hospitals/NHS Greater Glasgow and Clyde Oversight Board was made in relation to Duty of Candour. Specific work was undertaken with the Infection Prevention and Control Team to develop an agreed process for the consideration of duty of candour within an incident management process. Following testing an agreed process was developed and is included within the Infection Prevention & Control Team (IPCT) Incident Management Process Framework.

5 What has changed as a result?

There have been a number of changes following the reviews of the duty of candour events. The list below highlights a selection of learning being applied to improve care:

- Local improvements have been implemented within the Public Dental Service after an event. Contributory factors identified include poor clinical handover, a lack of confidence in challenging the treatment plan provided by a senior member of staff, and limited access to clinical notes. The first improvement is an update to the induction for Core Trainee (CT) dentists. The induction process now includes difficult discussions with senior staff, as well as guidance on the Duty of Candour process. The second improvement relates to dentists' preparation and communication prior to treating a patient. This includes allocating adequate time to review clinical records prior to treatment and providing a full handover if another dentist is asked to provide care to a patient they have not seen previously.
- As a result of a fall the bedrail guidance in use across Acute Services was adapted and implemented across community services.
- Board-wide actions have been implemented relating to the care of children with complex needs. These improvements include:
    - Lead Health Professional (LHP) introduced to co-ordinate healthcare plans and contribute to multi-agency process (e.g. Child Protection), where required.

- Children's Health Services Complex Care Management Protocol introduced which includes the use of TAC (Team around the Child) meetings across all areas of Health.
    - Assessment of Care toolkit implemented for all agencies to help assess and support families where neglect is a concern.
    - Child protection discussion and the use of significant events within a child's chronology now a standard practice within supervision and caseload management for Allied Health Professionals (AHPs).
    - The 'Was Not Brought' Policy developed and implemented which replaced the 'Unseen Child/Young Person' Policy.
- A Standard Operating Procedure for signing off blood results in the Emergency Department has been written and instituted within the department in the South Sector after a patient was discharged with a raised troponin.

6 COVID 19 Pandemic

At the time of writing this report there has been two Duty of Candour events with COVID-19 identified as a contributory factor which occurred between 1st April 2021 and 31st March 2022.

NHSGGC has continued to involve families in the reviews process using different means due to the pandemic. Examples of this are telephone conversations or virtual interviews. On occasion face to face meetings using social distancing continued where requested by the patient and/or family.

7 Duty of Candour Addendum Update Dec 2022

As reported in the Duty of Candour Annual Report staff within NHSGGC were impacted by the circumstances surrounding COVID-19, where there were limitations on the amount of time clinical staff were able to provide and participate in significant adverse events reviews, resulting in delays in completion times for these reviews.

As a result it was agreed that the Duty of Candour Annual Report 2021-2022 would include this Addendum produced in December 2022 to include details of any additional duty of candour adverse events and those not yet concluded.

At October 2022 the figures increased from the 23 reported to a total of 41 Duty of Candour incidents between 1st April 2021 and 31st March 2022. 38 of these investigations are complete and the types of incidents are listed below.

Type of unexpected or unintended incident	Number of times this happened
A person died	14
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A persons treatment increased	18
The structure of a person's body changed	0
A person's life expectancy shortened	0
A persons 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	3
A person needed health treatment in order to prevent them dying	2
A person needing health treatment in order to prevent other injuries as listed above	0
Total	38

The 38 completed investigations were assessed to ensure and apology was provided, patients and/or relatives were informed and invited to participate in the review and copies of the final report were shared.

Of the 38 completed investigations full compliance was met in 37 cases. In 1 case there was no family to contact and the report was not shared.