Duty of Candour Annual Report 2023/24

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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 1.3 million and employs around 41,000 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 period 1 April 2023 and 31 March 2024.

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?

At the time of writing this report, 22 incidents were identified which triggered Duty of Candour for the period 1st April 2023 and 31st March 2024. 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.

It is recognised that investigations are still ongoing when this report is produced, and until reviews are concluded, it is not possible to determine if events are duty of candour. The Duty of Candour Annual Report 2023-2024 therefore has an Addendum produced later in the year, which includes details of any additional duty of candour adverse events, and an update on those events not yet concluded.

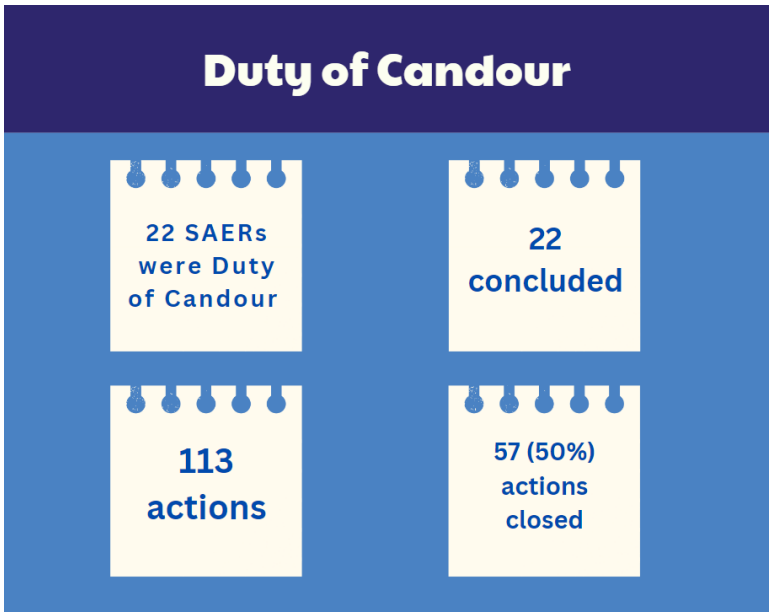
A breakdown of the 22 incidents identified at this stage is provided below.

Type of unexpected or unintended incident	Number of times this happened
A person died	3
A person's treatment increased	16
A person's life expectancy shortened	1
The structure of a person's body changed	1
A person experienced pain or psychological harm for 28 days or more	1
Total	22

3 To what extent did NHSGGC follow the DOC procedures?

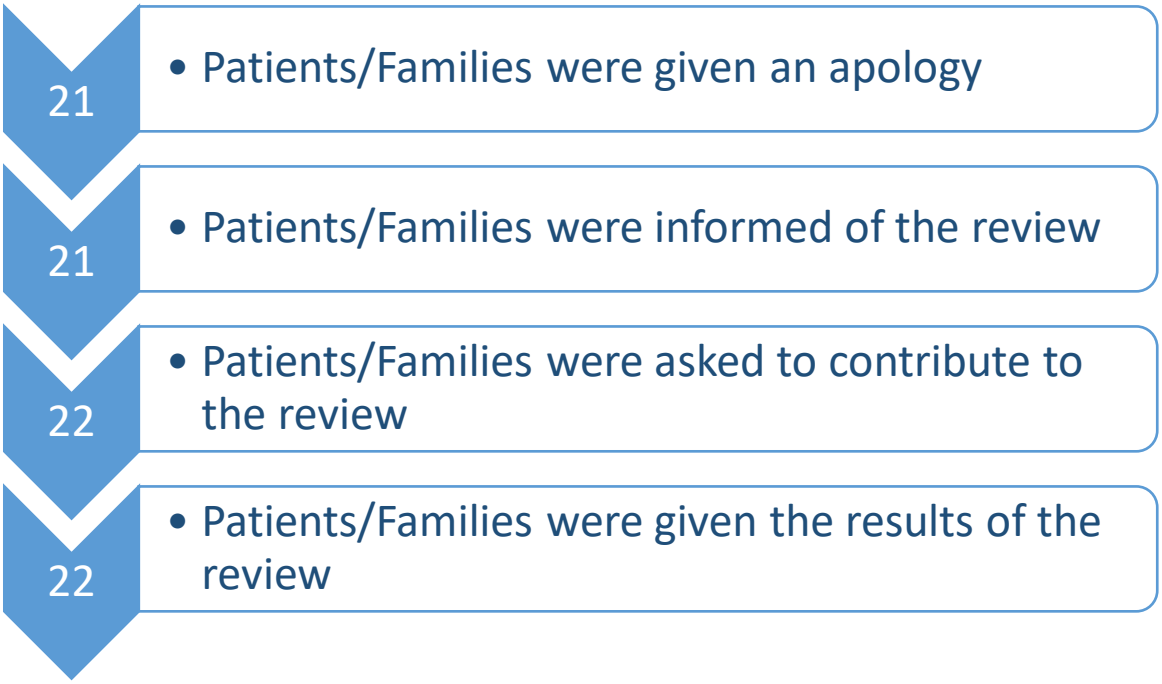
A Significant adverse event (SAE) review has been commissioned for all 22 Duty of Candour incidents. At the time of writing, all 22 reviews have been concluded.

The 22 completed SAE reviews have generated 113 actions. The diagram below summarises the progress of SAE investigations for Duty of Candour incidents to date.



The 22 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



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.

The Duty of Candour Policy is due for review at September 2024. Prior to the review NHSGGC will complete an audit of duty of candour compliance and ensure results are incorporated into the revised policy.

Duty of Candour Update from 2022/23

As highlighted earlier, the Duty of Candour Annual Report has an Addendum produced later in the year, which includes details of any additional duty of candour adverse events identified for the reporting period, and an update on those not yet concluded when the report was written (this is due to ongoing investigations when the report is drafted).

Updated figures for 2022/23

Date	Number of Duty of Candour Event Reviews Concluded
June 2023	29
November 2023	76
June 2024	162

At the time of writing this report, the data for 2022/23 was re-run to close off this period and identified 162 events from closed SAER reports. The 162 completed investigations were assessed for compliance with the regulations, which identified:

- 155 patients/families received an apology. In 1 case disclosure would have been deemed to cause harm; in 5 cases the patient had no contact with family or the service were unable to contact family and in 1 case the apology was pending the SAER review.

- 155 patients/families were involved in the investigation. In 2 cases there was a clinical decision made to not involve patients/ families in the investigation; in 5 cases the patient/relative requested not to have contact or the service were unable to contact family.

- The report was shared with 150 patients/families and once again reasons for not sharing were in 2 cases disclosure would have been deemed to cause harm; in 8 cases the patient had no contact with family or the service were unable to contact family and in 2 case the patient subsequently passed away.

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:

- An aftercare document/summary with information for all patients being discharged from hospital with an indwelling catheter within the Emergency Department of Queen Elizabeth University Hospital. This has been developed from documents already in place within Clyde Sector. This document will also be shared with NOK/Carers where appropriate.

- The Combined Care Assurance Audit Tool (CCAAT) Peer audit commenced in September 2023 within Renfrewshire HSCP which will give assurance and

governance around documentation. Staff are discussing audits and outcomes with team leads.

- The referral pathway between Alcohol and Drugs Recovery Service to Acute Addictions Service in Glasgow City HSCP – North East has been reviewed. In Glasgow City HSCP – North West the Alcohol and Drugs Recovery Service RAG Guidance and Standard Operating Procedure has been updated to reflect expectations if patient Did Not Attend (DNAs) appointments.

- An incident occurred involving a specimen leaving one hospital but was 'missing' when it was checked at a second hospital. The ED department produced a standard operating procedure document for the packaging and transfer of amputated tissue. The document was introduced into all ED within NHSGGC. Tissue must be packed for transport in a way that prevents cross contamination if a specimen leaks. As far as possible, the tissue should be kept within a leak-proof container and be separate to the documentation on the patient and tissue type record. Tissue containers should be ordered through Procurement/PECOS. This will be supported by an information leaflet produced by the ED department for patients / relatives detailing guidance on the transport of the amputated tissue.