Duty of Candour Annual Report 2020/21

NHS GREATER GLASGOW & CLYDE	Custodian: Director of Clinical and Care Governance
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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 1.14 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 we 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 2020 and 31 March 2021.

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 we fully meet our own policy principle. The reasons for not involving included events where there was no contact with family or the investigation relates to an internal process unrelated to the patient care or outcome.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations 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 review reports which means there may be more duty of candour incidents which are not able to be declared 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 Divisional Clinical Governance Groups and Board Clinical Governance Forum.

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

Between 1 April 2020 and 31 March 2021 there were 42 incidents where the duty of candour applied. 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.

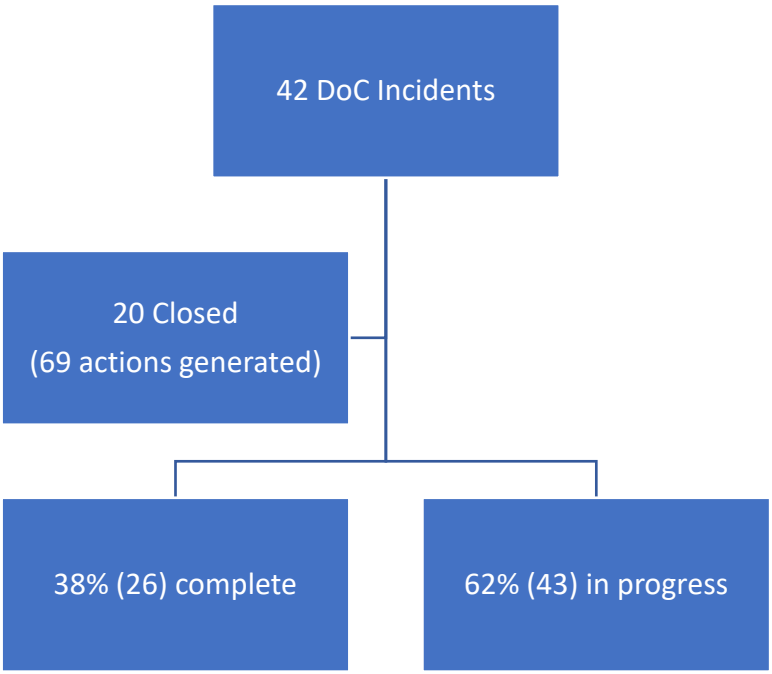
Type of unexpected or unintended incident	Number of times this happened
A person died	12
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A persons treatment increased	26
The structure of a person's body changed	1
A person's life expectancy shortened	2
A persons sensory, motor, or intellectual functions was impaired for 28 days or more	0

Type of unexpected or unintended incident	Number of times this happened
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 needing health treatment in order to prevent other injuries as listed above	1
Total	42

3 To what extent did NHSGGC follow the DOC procedures?

A Significant adverse event (SAE) investigation has been commissioned for all 42 Duty of Candour incidents. At the time of writing, 20 of these investigations have concluded.

The 20 completed SAE investigations have generated **69** actions. Please see diagram below for further details.

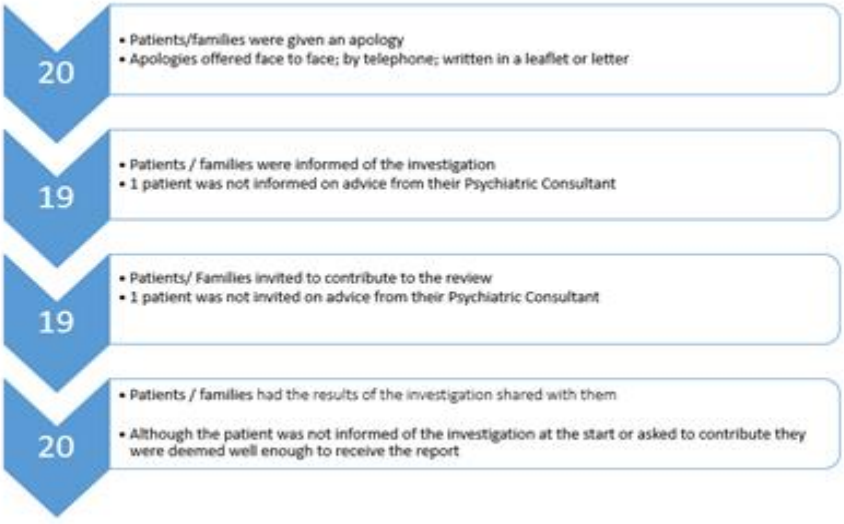


The twenty significant adverse events that have concluded were assessed for compliance with the following elements of the regulations.

- Apology given
- Patient or Relative informed of the investigation

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

Full compliance was achieved for all concluded incidents.



4 Information about our policies and procedures

In accordance with the 2020/21 Internal Audit Plan, the Board's arrangements for ensuring compliance with the Duty of Candour was reviewed, including training and guidance provided to staff. The review concluded with an audit rating of minor improvement required.

Findings of the internal audit:
NHSGGC has clear policies and processes in place that support compliance with Duty of Candour legislation. We confirmed through sample testing that Duty of Candour investigations had been consistently carried out by appropriate specialist teams, with each investigation culminating in a summary report outlining the key issues raised and recommendations for improvement. We have identified a few 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 investigations.

NHSGGC Duty of Candour Policy was first published in April 2018. The policy was due for review in 2021 and as part of this review we took cognisance of both national and local learning and ensured that the recommendations which pertained to duty of candour in the Oversight Board Final Report, published in March 2021 were addressed.

NHSGGC have reviewed its Duty of Candour Policy and associated information and guidance on the intranet site. The policy includes links to virtual training sessions which will become mandatory for role specific staff. The implementation plan for the revised policy includes virtual awareness raising sessions. The revised policy not only includes a flowchart on how to activate duty of candour but also includes a link to examples provided by Healthcare Improvement Scotland. The clinical risk team provide advice and support to the services on the role of the duty when a review is taking place, as well as providing regular reports which monitor the duty of candour process.

The national research of the annual reports from 2018/19 highlighted the need to include support for staff. Although staff leaflets and support through management structures are available, the issue has been raised through the national adverse event network for further development.

Every duty of candour event is reviewed and includes an offer for patients and/or families to be involved in the process. Each patient/family is given a contact name and number to support them through the review process. Once the report has concluded patients and/or family are offered a meeting or copy of report to share and discuss the recommendations.

A revised NHSGGC Duty of Candour Policy was approved by the Corporate Management Team on the 2 September 2021.

5 What has changed as a result?

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

New Nursing care plan, has been developed, within HDU. This care plan includes a section for confirming that labels have been applied to the patient's tubes/drains and that the surgeons have included a labelled diagram in their Operation notes. There is also a section to verify that the nurse has read and understood the Operation note

- A review highlighted a patient safety risk when handing over patient care from one shift to another. An incomplete handover was a contributing factor in an electrolyte imbalance in a patient being missed as the patient did not have bloods taken. A quality improvement project was carried out which resulted in the NEWBIE handover sheet being developed as an aide memoir.

Following a significant event a review was carried out which highlighted a number of issues. These issues include requesting and escalating ambulances, nursing staff induction and skill mix; and the introduction of the national early warning score (NEWS) system.

NHSGGC have also introduced a template and generic email account to receive feedback from patients and families on the process. The feedback will be monitored and suggested changes to the process considered and improved where possible.

6 COVID 19 Pandemic

NHS Boards were advised in April 2020 that Duty of Candour procedures would continue but noted there may be delays in the process.

In April 2020 Clinical Risk contacted all lead reviewers and commissioners to determine how to progress the open SAERs during the 1st wave of the COVID-19 pandemic. 95% of the reviews continued, with extra support made available from Clinical Risk. The remaining SAERs were unable to be concluded due to the pressures on the service area at that time. These were suspended and restarted once the service pressure allowed. The patients/ families of the suspended SAERs were notified of the decision in line with the Boards obligations under Duty of Candour legislation.

At the time of writing this report there has been one Duty of Candour event directly attributable to COVID-19.

NHSGGC has continued to involve families in the investigation 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.