Duty of Candour Annual Report 2022/23

NHS GREATER GLASGOW & CLYDE	Custodian: Director of Clinical and Care Governance
Issue date: December 2023	Status: Final
Version: Final	Data run: June 2023. Addendum update November 2023

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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 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 2022 and 31 March 2023.

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 35 incidents which occurred between 1st April 2022 and 31st March 2023. 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.

The Duty of Candour Annual Report 2022-2023 will have an Addendum produced later in the year which will include details of any additional duty of candour adverse events and those not yet concluded, 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.

Type of unexpected or unintended incident	Number of times this happened
A person died	9
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
A persons treatment increased	23
The structure of a person's body changed	1

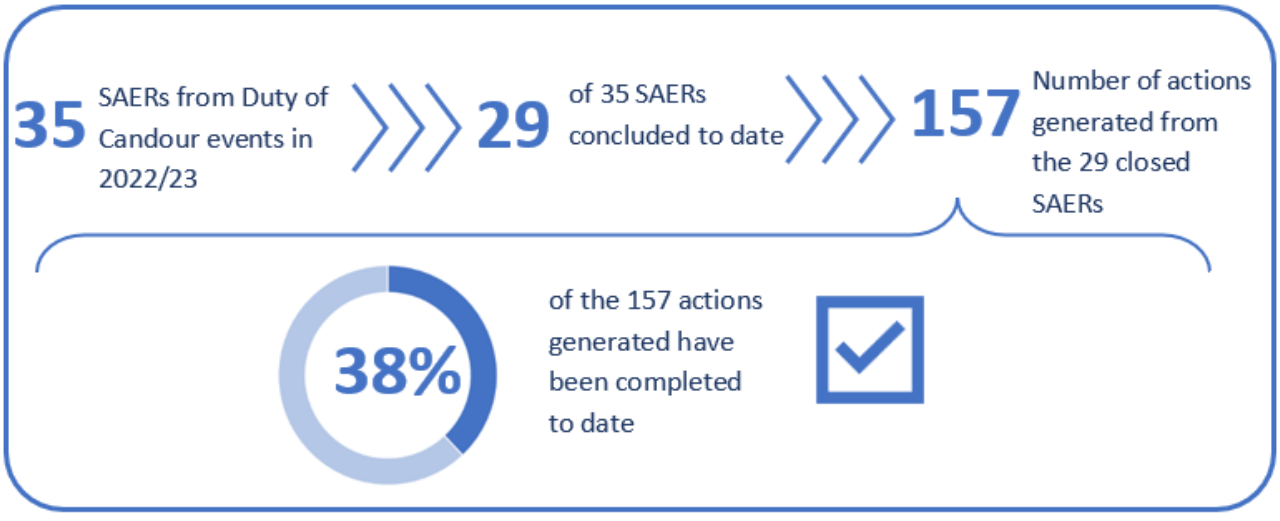
Type of unexpected or unintended incident	Number of times this happened
A person's life expectancy shortened	0
A persons sensory, motor, or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	35

3 To what extent did NHSGGC follow the DOC procedures?

A Significant adverse event (SAE) review has been commissioned for all 35 Duty of Candour incidents. At the time of writing, 29 of these reviews have concluded.

The 29 completed SAE reviews have generated 157 actions. Please see diagram below for further details.

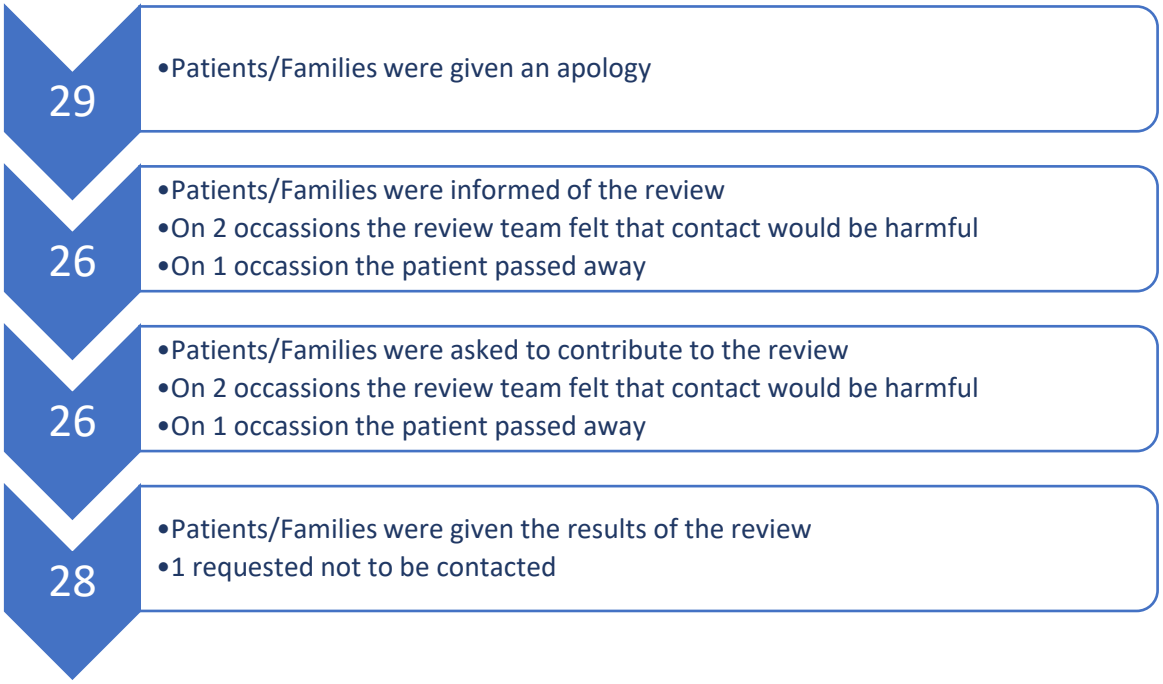
This summarises the progress of SAE investigations for Duty of Candour incidents to date.



The 29 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 2021/22

The 2021/22 Duty of Candour annual report with addendum update, reported 41 incidents within the reporting period that triggered Duty of Candour. At the time of writing the 2021/22 Duty of Candour annual report, 38 of these incidents had been closed. Since the report was published a further 44 incidents have now been closed therefore the total number of duty of candour events dated 2021/22 was 82. This was due to investigations which were still ongoing at the time of compiling the annual report and the further addendum report.

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 incident occurred involving specimens which had been sent to the pathology lab for analysis. There was no mention of a small separate deep margin specimen on the form and it was not marked on the cork board. It's thought that the specimen was accidentally discarded at the time the pins used to hold specimens to the cork board were put into the sharps bin for H&S reasons.

  Each specimen should be listed on the form to ensure the laboratory are able to match them up when processing, this is applicable to all specimens. It would also allow Pathology to catch any missing tissue at various points at the process if an accidental discard were to happen.

  More information on this has been added to the Pathology User Manual which is available on the Pathology website.

- An incident occurred involving the implantation of an unsterile device. There is a robust SOP in existence, however it was acknowledged the staff had assumed that the implants received would be sterilised prior to arriving within the department.

  The process of requesting, procuring and subsequently receiving implants into theatre departments required to be reviewed in order to have traceability, and the request paperwork to include a "sterile" check box.

  The on loan request form now contains-STERILE check box.

- An incident occurred in endoscopy whereby a patient suffered bowel perforations. The review highlighted that there was no standardised protocol for bowel preparation, this has now been standardised across NHS GGC.

6 Duty of Candour Addendum Update Dec 2023

It was agreed that the Duty of Candour Annual Report 2022-2023 would include an update addendum produced to include detail of any additional duty of candour adverse events and those not yet concluded.

At November 2023 the figures increased from the 35 reported to a total of 76 Duty of Candour incidents between 1st April 2022 and 31st March 2023. 75 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	23
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	3
A persons treatment increased	45
The structure of a person's body changed	2
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
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	0
Total	75

The 75 completed investigations were assessed to ensure an apology was provided, patients and/or relatives were informed and invited to participate in the review and copies of the final report were shared.

75 patients/families received an apology. In 2 cases there was a clinical decision made to not involve patients/ families in the investigation, 73 patients/families were involved in the investigation. The report was shared with 75 patients/families.