NHS Borders

Meeting:	**Clinical Governance Committee**
Meeting date:	**Wednesday 09 November 2022**
Title:	**Duty of Candour**
Responsible Executive/Non-Executive:	**Lynn McCallum, Medical Director**
Report Author:	**Laura Jones, Director of Quality Improvement** **Joanne Forrest, Clinical Risk Coordinator**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to provide the Clinical Governance Committee with an update on NHS Borders' current position in relation to the organisational Duty of Candour (DoC) and the work in progress to ensure the duty is reliably applied across all clinical areas. This paper contains the content for NHS Borders Annual Duty of Candour Report to be shared with the Scottish Government.

2.2 Background

On 01 April 2018 the statutory Organisational Duty of Candour legislation came into force. The purpose of this organisational duty of candour is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event which has resulted in death or harm (as defined in the act). The requirements of this legislation are that people involved in an event understand what has happened, receive an apology and that the organisation learns from the events.

2.3 Assessment

The attached NHS Borders Duty of Candour Annual Report provides a detailed review of the application of DoC in 2021/2022.

2.3.1 Quality/ Patient Care

This report is aligned to the NHS Borders and national patient safety programme.

2.3.2 Workforce

Services and activities are provided within agreed resources and staffing parameters

2.3.3 Financial

Services and activities are provided within agreed resources and staffing parameters.

2.3.4 Risk Assessment/Management

Systems, processes and procedures need to be strengthen to ensure NHS Borders will be able to fulfil their obligation to implement the requirements of the Duty of Candour as set out by the Scottish Government.

2.3.5 Equality and Diversity, including health inequalities

In compliance.

2.3.6 Other impacts

None noted.

2.3.7 Communication, involvement, engagement and consultation

The content of the report has been considered by a range of stakeholders in NHS Borders and advice sought from regional and national colleagues. The annual report will be available through the NHS Borders public website for information.

2.3.8 Route to the Meeting

The content of this paper is reported to Clinical Boards, Clinical Governance Groups and to the Board Clinical Committee.

The paper has been approved by Laura Jones, Head of clinical Governance & Quality.

2.4 Recommendation

This paper has been brought to the Clinical Governance Committee for

- **Awareness and Discussion**

The Clinical Governance Committee is asked to note the paper and the actions underway to embed the Duty of Candour across NHS Borders.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 – NHS Borders Duty of Candour Annual Report 2020/21

4 Glossary

Appendix 1

Duty of Candour Annual Report

1 April 2021 – 31 March 2022

Report Prepared by:	
Joanne Forrest	Clinical Risk Coordinator
Report Approved by:	
Julie Campbell	Quality Improvement Facilitator: Patient Safety
Laura Jones	Director of Quality and Improvement
Lynn McCallum	Medical Director
Report Date:	
15 December 2022	

Information about the NHS Board

NHS Borders provides a wide range of healthcare services through numerous locations throughout the Scottish Borders. NHS Borders incorporates an acute hospital (BGH) together with 4 Community Hospitals and 5 Mental Health units. Our purpose is to improve the health of our population and deliver healthcare services that meet the needs of the Borders community.

The organisational Duty of Candour (DoC) legislation has been in place since April 2018 when the Scottish Government introduced statutory organisational Duty of Candour legislation in Scotland.

NHS Borders

NHS Borders is one of the smaller health boards in Scotland with a population of 115,000 across rural and urban communities. We employ approximately 3,500 staff and have one main acute hospital, 4 community hospitals and 5 mental health units. Safe Patient Care is paramount within NHS Borders and our Corporate Objectives.

Number and Nature of Duty of Candour incidents

For the period 1 April 2021 to 31 March 2022 there were 31 adverse events which activated the organisational DoC. These are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

There are two significant adverse events during this time period which may have activated the duty of candour, however, until the investigations have been finalised, we are unable to confirm at this present time. Therefore, this report is based on the confirmed numbers of activated DoC and may be revised on completion of the reviews.

Table 1 demonstrates the breakdown of incidents which activated the DoC:

Nature of unexpected or unintended incident where Duty of Candour applies	**Number**
A person died	3
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	25
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	0
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	1
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	1

To what extent did NHS Borders carry out the duty of candour procedure?

The correct procedure was carried out in all instances in relation to Management Reviews and Significant Adverse Events Reviews. In relation to one Management Review the patient and next of kin were contacted, however, did not wish to have any part in the review process, this was still counted as compliance. For one case the clinical team recall providing an apology but there is no formal documentation to evidence this was enacted. Due to COVID-19 pandemic it was not in some cases appropriate to offer a further meeting.

There were 20 Level 2 Pressure Damage graded 3, 4, suspected deep tissue injury and ungradable pressure ulcers reported as developed whilst in our care. Following the completion of a pressure ulcer investigation tool we identified some areas where not all elements of the standard of care were delivered in a way we would expect. It is difficult to confirm in all instances if this would have mitigated the pressure damage. In 11 out of the 20 identified cases the requirements of the DoC procedure were met. In the remaining 9 cases we were unable to determine to what extent the requirements of the act had been met due to no documentation recorded within the patient case notes.

Clarity was sought from the Adverse Event Networking Group and Scottish Government to ensure all Boards are consistent in what they are reporting in relation to the Duty of Candour. There appears to be a wide variation in relation to reviews and when the DoC has been activated across the Boards and Boards intend to collaborate over the coming year to achieve greater consistency in application of the duty.

Information about our policies and procedures

All adverse events within NHS Borders are reported through Datix, adverse event reporting system. Each adverse event is reviewed to understand what happened and the level of review required. The level of review depends on the severity of the event. Through our adverse event management process we can identify adverse events that trigger the duty of candour procedure and ensure the appropriate review is carried out. From the recommendations of the review an improvement plan is developed and actions taken forward by the relevant management teams to incorporate these improvement plans into their governance groups to ensure actions are taken forward and lessons are learnt.

Our Adverse Event Management Policy incorporates the DoC legislation. In addition, a Significant Adverse Event and DoC Guidance document has been produced to support Lead Reviewers with a specific section detailing ‘Involving patient, relative and representatives and applying the DoC’. There is also a section for Lead Reviewers in relation to supporting staff through the review process offering support through our line management structure as well as our Wellbeing Service.

A number of other processes have been embedded to ensure that NHS Borders deliver what is required in relation to the DoC. For Significant Adverse Event Reviews and Management Reviews a Lead Reviewer guidance document has been developed including short bite sized Lead Reviewer training films together. In addition, a Significant Adverse Event Toolkit has been developed and an NHS Education Scotland DoC eLearning module is available. A DoC support tool is also embedded within our Datix system to support staff when completing an adverse event.

Additional training and advice is readily available to Lead Reviewers together with first and final approvers by the Patient Safety team.

The Patient Safety Team meet weekly to validate adverse events this includes DoC.

COVID-19 Pandemic

NHS Borders together with communication from other Health Boards via the National Adverse Event Network meeting confirmed they are facing similar challenges in relation to commissioning and the completion of reviews in the appropriate timeframes together with workload capacity for staff to support with SAE reviews. NHS Borders has sought external Lead Reviewers to support SAER's.

As part of the significant adverse event process all reviews are monitored daily. In the event where reviews were commissioned later than anticipated due to identifying a Lead Reviewer that had capacity to support, patient / families were written to, to advise and apologise for the delay.

The Patient / families were offered face to face meetings with the Lead Reviewer(s), ensuring national social distancing guidelines were followed, to discuss the SAER process and if they wished to be involved in the review by providing questions together with offering a meeting when the report was finalised to share the findings of the investigation. If a patient / family were unable to meet face to face a telephone / video link meeting were offered as an alternative.

Hospital outbreaks related to COVID-19 were managed and reviewed by the Infection Control and Prevention Team (IPCT). The IPCT reviewed the minutes of all Incident Management Teams formed to oversee the management of COVID-19 outbreaks and could not identify failings in personal protective equipment or infection control practice which were directly attributable to specific cases.

Mortality Reviews were undertaken for all patients who died with COVID-19 whilst in hospital. This included 5 confirmed COVID-19 deaths which resulted from hospital outbreaks during 2021/22. The mortality review of these cases did not identify any harm that would activate the DoC.

Learning for the future

Educational sessions have been arranged to educate the relevant staff in leading a review which will include the DoC process. Small bite sized films are readily available for all staff supporting investigations / reviews and enacting the duty of candour.

Recommendations are made as part of the adverse event review and the relevant management teams incorporate these improvement plans into their governance groups to ensure actions are taken forward.

A standardised approach from the Scottish Government to ensure all NHS Boards are submitting the agreed dataset to ensure all Boards are reporting the same.