NHS Borders

Meeting:	**Clinical Governance Committee**
Meeting date:	**9 November 2023**
Title:	**Duty of Candour**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality Improvement**
Report Author:	**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 2022/2023.

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 strengthened 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 Climate Change

None noted.

2.3.7 Other impacts

None noted.

2.3.8 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.

2.3.9 Route to the Meeting

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

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 2022/23

Appendix 1

Duty of Candour Annual Report

1 April 2022 – 31 March 2023

Report Prepared by:	
Joanne Forrest	Clinical Risk Coordinator
Report Approved by:	
Julie Campbell	Lead Nurse – Patient Safety and Care Assurance
Laura Jones	Director of Quality and Improvement
Report Date:	
3 October 2023	

About NHS Borders

NHS Borders provides a wide range of healthcare services through numerous locations throughout the Scottish Borders and is one of the smaller health boards in Scotland with a population of 115,000 across rural and urban communities. NHS Borders employs approximately 3,500 staff and has one main acute hospital, 4 community hospitals, 5 mental health units, a wide range of community teams and independent contractors. Our purpose is to improve the health of our population and deliver healthcare services that meet the needs of the Borders community. The safety of patients and staff is of critical importance to NHS Borders.

Adverse Events

During the reporting period of 1 April 2022 to 31 March 2023 there were 5,073 adverse events or near miss records reported on the NHS Borders Adverse Event Reporting System (Datix). On final evaluation there were 39 adverse events which activated the organisational Duty of Candour (DoC). These were 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.

Table 1 demonstrates the grading of the adverse events together with the reviews carried out:

Table 1:

	Grading of Adverse Event:				
Review carried out:	**Extreme**	**Major**	**Moderate**	**Near Miss**	**Total**
Duty of Candour Report			3		3
Management Review		2	2	1	5
Pressure Ulcer Investigation Tool		22	2		24
Significant Adverse Event Review (SAER)	6	1			7
Total	**6**	**25**	**7**	**1**	**39**

Two SAER's commissioned within this timeframe remain under investigation and until finalised we are unable to confirm if the DoC has been activated. Therefore, this report is based on the confirmed numbers of activated DoC and may be revised on completion of the reviews.

Table 2 shows the number and rationale of the 39 adverse events that met the criteria to activate the statutory DoC procedure:

Table 2:

Nature of unexpected or unintended incident where Duty of Candour applies	**Number**
The death of a person	5
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	28
Changes to the structure of the person's body	3
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	0
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	2
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0

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.

The Pressure Ulcer Investigation Tool was used to review 24 adverse events. 21 of these were directly in relation to 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 16 out of the 21 identified cases the requirements of the DoC procedure were met. In the remaining 5 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.

When undertaking the Level 3 DoC reports all patients / next of kin were contacted, full explanation and apology provided.

NHS Borders Policies and Procedures

All adverse events within NHS Borders are reported through Datix, adverse event reporting system. There are a series of process measures in place to ensure adverse event records have an accurate final decision regarding duty of candour. Each adverse event is reviewed to understand what happened, ensuring that the adverse event is appropriately graded and if required the appropriate review is undertaken. The level of review depends on the severity of the event. Through our adverse event management process, NHS Borders can identify adverse events that trigger the duty of candour procedure. From the recommendations of the review an improvement plan is developed, and actions are taken forward by the relevant management teams within their governance groups ensuring actions are taken forward and lessons are learnt.

There is a weekly Adverse Event checking meeting that includes Topic Specialists from the Patient Safety Team, Risk Team and Health and Safety Team validating adverse events and ensuring next steps are followed in relation to the Adverse Event Management Policy.

Our Adverse Event Management Policy incorporates the DoC legislation. In addition, a Significant Adverse Event Guidance (including DoC) has been produced to support Lead Reviewers with a specific section detailing 'Involving patient, relative and representatives and applying the Duty of Candour (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 Traumatic Events Staff Support Pathway is also being constructed to support staff. NHS Borders acknowledges that staff can be exposed to difficult or traumatic situations as part of their work and are committed to supporting staff wellbeing across the organisation.

In relation to SAERs and Management Reviews the Patient Safety Team facilitates Lead Reviewer training covering the DoC this is delivered via group sessions as well as offering 1:1 training if required. Short bite sized Lead Reviewer training films have also been produced. The NHS Education Scotland DoC eLearning module link is also promoted within the training.

Several other processes have been embedded to ensure that NHS Borders deliver what is required in relation to the DoC. All staff have the opportunity to receive training on adverse event management and implementation of the DoC so that they understand when it applies and how to trigger the duty. Facilitation tools and guidance are available to all staff via the organisational intranet.

Throughout 2022/23 NHS Borders continues to face similar challenges in relation to commissioning and completing reviews in the appropriate timeframe due to challenges staff are continually facing post pandemic. 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 that a review is commissioned later than anticipated due to identifying the capacity of a Lead Reviewer patient / families were advised of the delay with an apology.

Learning for the Future

There have been several discussions within the national Adverse Event Networking Group in relation to what appears to be a wide variation of the reporting requirements for the annual DoC report. A meeting was arranged with the Scottish Government due to the Organisational DoC non-statutory guidance requiring renewal. Boards advised that a standardised approach with an agreed dataset would be beneficial to provide assurance that all NHS Boards are reporting consistently.