Agenda Item 9

Duty of Candour Annual Report 2019 - 2020

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Falkirk IJB Clinical and Care Governance Committee

27 November 2020

Duty of Candour Annual Report 2019 - 2020

For Noting

1. Executive Summary

1.1 All health and social care services in Scotland have a Duty of Candour, which came into effect on 1 April 2018. This is a legal requirement which means that, when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened and receive an apology, and that organisations learn how to improve for the future.

1.2 An important part of this duty is that we provide an annual report about how the Duty of Candour is implemented in our services.

1.3 The report presents the Duty of Candour Annual Reports for NHS Forth Valley (appendix 1) and Social Work Adult Services (appendix 2).

2. Recommendations

The Clinical and Care Governance Committee is asked to:

2.1 note this report

2.2 note the intention for officers to consider the future report format for Duty of Candour reports that covers HSCP services.

3. Background

3.1 A new 'Duty of Candour' came into force on 1 April 2018 as set out in Part 2 of The Health (Tobacco Nicotine etc and Care) (Scotland) Act 2016. The Duty of Candour Procedure (Scotland) Regulations 2018 and Guidance from Scottish Government were issued on 28 March 2018.

3.2 The duty is essentially triggered by two circumstances:

- An unexpected or unintended incident occurs in connection with a health, care or social work service intervention that results in death or serious harm to a person
- A registered health professional not involved in the incident determines that the harm in question was caused by the incident and not some underlying cause.

3.3 When the duty is triggered the care provider has certain responsibilities to:

- record the incident as a duty of candour event
- notify the person affected or a person acting on their behalf
- apologise to that person, offer to meet with them to give further information about the incident and support available
- give the person an opportunity to ask questions in advance of that meeting and an opportunity to give their own views of the incident which should be recorded
- investigate the incident and set out findings and actions to be taken in a written report, a copy of which must be given to the person
- prepare annual reports on Duty of Candour Events within the organisation.

4. Duty of Candour Annual Reports

4.1 Both NHS Forth Valley and Social Work Adult Services are committed to achieving openness and transparency without blame in the provision of health and social care services. The duty of candour reports reflects the commitment to place people at the heart of health and social care services. When death or harm occurs the focus must be on personal contact with those affected, support and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement. The organisational duty of candour is vital to the provision of safe, person centred and effective health and social care.

NHS Forth Valley

4.2 Attached at appendix 1 is the Forth Valley Annual Duty of Candour report for 2019/2020. There were 6 incidents where the Duty of Candour applied. There was a pause on some investigations during this time period due to the impact of COVID-19. These were unintended or unexpected incidents that resulted in harm or death. NHS Forth Valley identified these incidents through our Adverse Event Management Process.

Social Work Adult Services (SWAS)

4.3 SWAS Annual Duty of Candour report is attached at appendix 2. There have been no occasions where the Duty of Candour procedure was implemented.

4.4 Committee is asked to note the intention for officers to consider the future report format for Duty of Candour reports that covers HSCP services.

5. Conclusions

5.1 This report provides a summary of the NHS and Falkirk HSCP SWAS Duty of Candour Reports provided in Appendices 1 and 2.

Resource Implications
There are no resource implications arising from the report.

Impact on IJB Outcomes and Priorities
The preparation of Annual Duty of Candour reports ensure the Strategic Plan priorities and outcomes are met.

Directions
There is no new Direction or amendment required.

Legal & Risk Implications
By preparing Annual Duty of Candour reports we are compliant with the legislative requirement.

Consultation
No consultation was required to develop the report.

Equalities Assessment
There are no equalities impacts arising from the report.

6. Report Authors

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7. List of Background Papers

n/a

8. Appendices

Appendix 1:	NHS Duty of Candour Annual Report 1 April 2019 – 31 March 2020
Appendix 2:	Falkirk HSCP SWAS Duty of Candour Report 2019-2020

Appendix 1

NHS FORTH VALLEY

Duty of Candour Annual Report

1st April 2019 to 31st March 2020

DUTY OF CANDOUR REPORT

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that, when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened and receive an apology, and that organisations learn how to improve for the future.

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 NHS Forth Valley has operated the Duty of Candour during the time between 1st April 2019 and 31st March 2020. We hope that you find this report useful.

1. About NHS Forth Valley

NHS Forth Valley is one of the fourteen regions of NHS Scotland and serves a population of more than 300,000. It provides healthcare services in the Clackmannanshire, Falkirk and Stirling council areas. Our aim is to provide high quality care for every person who uses our services and, where possible, to help people receive care at home or in a homely setting.

2. How many incidents happened to which the Duty of Candour applies?

Between 1st April 2019 and 31st March 2020, there were 6 incidents where the Duty of Candour applied, of which 3 are still underway. This is, in part, due to the need to pause some investigations due to the impact of Covid-19. These were unintended or unexpected incidents that resulted in harm or death as defined by the Act and they did not relate directly to the natural course of someone's illness or underlying condition(s) although, in one case, this was difficult to confirm. In two cases an external reviewer was invited to join the Review Team.

NHS Forth Valley identified these incidents through our adverse event management process. Over the time period for this report, we carried out 6 significant adverse event reviews. We identified, through the adverse and significant adverse events process, if there were factors that may have caused or contributed to the event, which helps to identify Duty of Candour incidents (see Table 1 below).

Table1: Number of Times Unexpected or Unintended Incidents occurred between 1st April 2019 and 31st March 2020

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition(s))	Number of times this happened (between 1st 2018 and 31st March 2019)
A person died	6*
A person incurred permanent lessening of bodily, sensory, motor, psychological or intellectual functions	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition(s))	Number of times this happened (between 1st 2018 and 31st March 2019)
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions 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 needed health treatment in order to prevent other injuries as above	0
TOTAL	**6***

A stillbirth occurred prior to one of the deaths however no causative link was identified between the two. It is also recognised that the families of those who died would also have experienced significant emotional pain and psychological distress.

3. To what extent did NHS Forth Valley follow the Duty of Candour procedure?

NHS Forth Valley followed the correct procedure in all 6 cases. This means that we informed the people affected, apologised to them and offered to meet with them. Due to Covid-19, it was not always possible to meet face-to-face however 'Near Me' technology was also used to hold virtual meetings.

We always offer to share the final report with the patient and/or family. In each case, we reviewed what happened, what went wrong and what we could have done better. Individual and organisational learning has been undertaken and subsequent action and improvement plans have been developed and completed.

4. Information about our policies and procedures

Every adverse event is reported through the NHS Forth Valley clinical governance reporting structures as set out in our adverse event management process and, through this, we can identify incidents that trigger the Duty of Candour procedure. Our Management of Adverse and Significant Adverse Events policy contains a section on Duty of Candour and there are guidance documents available on the NHS Forth Valley intranet.

All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module. In our last report. NHS Forth Valley documented that over 700

staff had completed this to date (31th March 2019). LearnPro training records show that 234 staff had completed the modules during this reporting period.

Staff receive training on adverse event management as part of their induction. Additional support is available for those members of staff who review adverse and significant adverse events and for those who are key points of contact with people who have been affected by such events.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review and local management teams develop action and improvement plans to meet these recommendations.

NHS Forth Valley understands that adverse events can be distressing for staff as well as those affected by the event. Support is available for all staff through the line management structure as well as through Occupational Health.

5. What has changed as a result?

NHS Forth Valley has made a number of changes following review of the Duty of Candour events. There are 6 significant changes that we wish to highlight:

- The Emergency Department now has a Clinical Nurse Educator in post to facilitate the learning from adverse and significant adverse events. Particular emphasis will be placed on the use of PEWS charts and the frequency of observations.
- NHS Forth Valley went live with Trakcare in April 2019. The master patient index (MPI) is currently in transition from the previous systems to Trakcare and, in time, Trakcare will hold the complete MPI.
- There has been a focus on neonatal and paediatric education and training with respect to the Difficult Airway Guideline as well as intubation and the use of laryngeal mask airways. This will incorporate practical teaching sessions including simulation and airway scenarios. In addition, Consultants will be asked to log their neonatal intubations and, where this is not meeting a minimum number of 2 per year, will be mandated to provide practical evidence of ongoing training.
- Forth Valley Royal Hospital has an extended in-house programme of human factors training which is being advertised throughout the organisation.
- The Emergency Department Guidelines (based on the NICE Guidelines) have been reviewed and aligned with paediatric guidance.
- There has been a review of several other procedures and protocols where adverse event and significant adverse event reviews identified the need to do so.

6. Other information

The Duty of Candour section on the electronic reporting system (Safeguard) does not discriminate between Professional Duty of Candour and Organisational Duty of Candour and so each case was reviewed to discern which legislation to apply.

One SAER report is awaiting acceptance and a further two are still in progress.

If you would like further information regarding this report please contact: Arlene Stewart, PA to NHS Forth Valley's Medical Director, on 01324 567558 ore email arlene.stewart@nhs.scot

Appendix 2

Falkirk HSCP (Social Work Adult Services)
Duty of Candour Annual Report: 2019/2020

Every Health and Social Care professional must be open and honest with individuals accessing services when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered duty of candour within our service.

Name and Address of Service	Falkirk HSCP Denny Town House
Date of Report	1st November 2020
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? **How have you done this?**	Falkirk Council has developed a seven minute briefing for staff which brings together key information, fact sheets and guidance available locally and nationally. This includes hyperlinks that take staff directly to relevant information. This also includes a hyperlink to the Duty of Candour E-learning resource produced by NHS Education for Scotland, The Scottish Social Services Council, The Care Inspectorate and Healthcare Improvement Scotland. Seven minute briefings have been designed to assist busy managers to share and discuss key and essential information during team meetings. Staff are thereafter expected to ring-fence time to access the hyperlinked resources as part of their continuous professional development and to ensure they understand their responsibilities relating to and duties. There is often a follow up discussion in team meetings providing staff with opportunities to discuss learning and consider practice implications. And any further training /learning needs. The Duty of Candour E-learning resource is included in the induction of new staff, where appropriate. Managers and Social Work Workforce Development service jointly produced an induction checklist (which complements the Council and Health and Social Care Partnership induction) to ensure that all relevant introductory learning and development was captured. This was also shared with wider Council services. The E-learning resource can be accessed via the Council's online learning platform. The seven minute briefing and organisational guidance is located on the Practitioner's Pages. Whenever an opportunity arises, steps are taken to direct staff to the Practitioner Pages to access key information, guidance and resources. Our Learning Review process and guidance and our

	complaints procedure reference Organisational Duty of Candour. Duty of Candour training and education is also available through existing networks and communication channels. We target existing resources as an important element of implementation. Where relevant, our training programmes and development sessions reference Organisational Duty of Candour, responsibilities and support available to meet those responsibilities. The Scottish Government guide for staff and providers of health, Social care and social work services, Annex A Checklist is specifically highlighted as a helpful resource. Scottish Government guidance leaflets have been sourced and distributed across services. This is available in Council reception areas.
Do you have a Duty of Candour Policy or written duty of candour procedure?	Organisational Duty of Candour is referenced in complaints procedures. A reporting template has been created to ensure the consistency of reporting across services.

How many times have you/your service implemented the duty of candour procedure this financial year?	
A person died	Nil
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions.	Nil
A person's treatment increased	Nil
The structure of a person's body changed	Nil
A person's life expectancy shortened	Nil
A person's sensory, motor or intellectual functions was impaired for 28 days or more	Nil
A person experienced pain or psychological harm for 28 days or more	Nil
A person needed health treatment in order to prevent them dying	Nil
A person needing health treatment in order to prevent other injuries as listed above	Nil
Total	Zero

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	N/A
What lessons did you learn?	N/A
What learning & improvements have been put in place as a result?	N/A
Did this result is a change / update to your duty of candour policy / procedure?	N/A
How did you share lessons learned and who with?	N/A
Could any further improvements be made?	N/A
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	Duty of candour is part of our overall approach to managing incidents and complaints and is integral to our approach regarding transparent and open practice. Staff would be supported by a senior manager and all apologies would be offered verbally and in-person. Support would also be offered to provide a written apology if the service team required it.

What support do you have available for people involved in invoking the procedure and those who might be affected?	We know that adverse events can be distressing for staff as well as people who receive a service from the Council. Support is available for all staff through line management structures as well as through Occupational Health and Workforce and Organisational Development.
Other Information	