NHS Borders

Meeting:	**Clinical Governance Committee**
Meeting date:	**Wednesday 28 August 2024**
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 Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 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

2.2.1 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

2.3.1 The attached NHS Borders Duty of Candour Annual Report provides a detailed review of the application of DoC in 2032/2024.

2.3.2 Quality/ Patient Care

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

2.3.3 Workforce

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

2.3.4 Financial

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

2.3.5 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.

2.3.6 Equality and Diversity, including health inequalities

In Compliance

2.3.7 Climate Change

None noted.

2.3.8 Other impacts

None noted.

2.3.9 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.

2.3.10 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** – For Members' information only.
- **Discussion** – Examine and consider the implications of a matter.

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

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

Appendix No 1 – NHS Borders Duty of Candour Annual Report 2023/24

Appendix 1

Duty of Candour Annual Report

1 April 2023 – 31 March 2024

Report Prepared by:	
Joanne Forrest	Clinical Risk Coordinator
Report Approved by:	
Julie Campbell	Lead Nurse for Patient Safety and Care Assurance
Laura Jones	Director of Quality and Improvement
Report Date:	
10 July 2024	

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 3,150 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. Safe Patient Care is paramount within NHS Borders.

How many incidents happened to which the duty of candour applies?

During the reporting period of 01 April 2023 to 31 March 2024 there were 37 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. On final evaluation 30 of these adverse events identified that if a different plan or delivery of care / service was in place this may have resulted in a different outcome for the patient. The outstanding 7 significant adverse events remain under investigation and until finalised we are unable to confirm if these events were avoidable, however, the organisational DoC was activated for these adverse events.

Table 1 shows the number and rationale of the 37 adverse events that met the criteria to activate the statutory DoC procedure:

Table 1:

Nature of unexpected or unintended incident where Duty of Candour applies	**Number**
The death of a person	3
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	26
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	1
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.	2
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 22 adverse events which were directly in relation to Pressure Damage graded 3, 4, suspected deep tissue injury and any 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 standards of care were delivered in a way that we would expect. However, it is difficult to confirm in all instances if this would have mitigated the pressure damage. In 14 out of the 22 identified cases the requirements of the DoC procedure were met. In the remaining 8 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, a full explanation and apology was provided.

Table 2 demonstrates the grading of the adverse events together with the reviews carried out:

Table 2:

Review carried out:	**Extreme**	**Major**	**Moderate**	**Total**
Duty of Candour Report	0	0	4	4
Management Review	0	4	0	4
Pressure Ulcer Investigation Tool	0	22	0	22
Significant Adverse Event Review (SAER)	4	3	0	7
Total	**4**	**29**	**4**	**37**

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 DoC 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.

InPhase, the newly procured Integrated Risk Management and Patient Safety System is replacing Datix with the plan for NHS Borders to go live on the 25 November 2024. The Patient Safety Team have reviewed the DoC function to ensure there is a smooth transition.

There is a weekly Adverse Event process that includes the Patient Safety Team, Risk Team and Health and Safety Team. The process ensures that adverse events are validated and steps are followed in relation to the Adverse Event Management Policy.

The Adverse Event Management Policy incorporates the DoC legislation and was reviewed in September 2023. In addition, the Significant Adverse Event Guidance (including DoC) which was produced to support Lead Reviewers with a specific section detailing 'Involving patient, relative and representatives and applying the Duty of Candour (DoC)' was also reviewed in-line with the Adverse Event Management Policy.

Staff support is offered throughout the review process through our line management structure as well as our Wellbeing Service. The Traumatic Events Staff Support Pathway is also available to support staff through our Psychological Services. 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.

The Patient Safety Team facilitates Significant Adverse Event Lead Reviewer training covering the DoC, this is delivered through group sessions as well as offering 1:1 training if required. The NHS Education Scotland DoC eLearning module link is also promoted within the training. As part of the newly qualified medical and nursing staff induction the Patient Safety Team facilitates DoC 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.

Learning for the future

Through the Adverse Event Network meeting the Clinical Risk Coordinator and Lead Nurse for Patient Safety and Care Assurance engaged with representatives from Scottish Government as stakeholders to support the revision of the national Organisational Duty of Candour non-statutory guidance prior to the publication which was scheduled for Spring 2024.