DUTY OF CANDOUR

ANNUAL REPORT

1st April 2019 - 31st March 2020

NHS Lanarkshire	
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DUTY OF CANDOUR REPORT

The Duty of Candour (DoC) legislation became active from the 1st April 2018. This placed a statutory obligation on health organisations to follow the subsequent regulations which stipulate a number of actions to take place if certain circumstances occur. These are as follows:

If a patient suffers **death** or **serious*** harm as a result of an **adverse event** that the **organisation is responsible** for, the following should occur:

- An apology is offered to the patient or their relative.
- The patient / relative is informed that there will be an investigation.
- The patient / relative is given the opportunity to ask questions to be answered as part of the investigation.
- The result of the investigation is shared with the patient / relative and a meeting is offered.
- The organisation learns from the investigation by implementing the recommendations/ actions.

During this second year of Duty of Candour legislation, NHS Lanarkshire has reported 20 events. These were all unintended or unexpected incidents that resulted in death or harm as defined in the Act and did not relate directly to the natural course of illness or an underlying condition.

There are another 19 Significant Adverse Events reported during this time which may be Duty of Candour, but due to these investigations still being open, it is not possible to declare this at this time. Therefore this report will only cover the known Duty of Candour events recognizing it is likely more will be added to this annual count when the investigations have been completed. Due to a pause in the ability to form review groups during the Covid 19 pandemic, a number of reviews started much later than would be routine processes causing delays. Systems are in place to monitor the delayed investigations to ensure progress is made.

The table below shows the number of duty of candour events recorded for NHS Lanarkshire grouped by Operational Unit and specialty:

	UHH	UHM	UHW	Maternity	North HSCP
Mental Health					1
Paediatrics					1
Critical care	1				
Surgical	2	2			
Medical	2	1	1		
A&E	1	3			
Obstetrics				5	

The table in Appendix 1 provides details of date of incident, specialty, type and status for all the incidents recorded as meeting duty of candour legislation.

The events noted above were assessed for compliance with the following elements of the regulations recognising if the patient died and there were no relatives to contact or following an attempt, relatives would not engage, this would still count as compliance.

- Apology given
- Patient or Relative informed of the adverse event
- Significant Adverse Event Review commissioned
- Patient or Relative invited to participate in review
- Patient or Relative informed of the results of the review

Full compliance was achieved for all concluded incidents.

From the 20 incidents, 6 remain open as the investigations are still on-going but in these cases, it is already known that duty of candour applies.

When carrying out the adverse event review process, the factors listed below are considered to support the decision making on whether any of these have caused or contributed to the adverse event, which can then identify if these are duty of candour incidents or not.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2019 and 31 March 2020)**
A person died	9
A person's treatment increased	5
The structure of a person's body changed	1
A person's 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	5

NHS LANARKSHIRE POLICIES, PROCEDURES AND GUIDANCE

The Board continues to be fully supportive of the principles of Duty of Candour with data collation to evidence compliance against the legislation.

All adverse events are reviewed to help us understand the context and cause of the event, allowing for changes to be implemented to improve the systems involved in healthcare for all patients.

All adverse events that meet the criteria for duty of candour are investigated as a significant adverse event review (SAER) which have a particular process and report template to follow. This includes development of recommendations and an improvement action plan for every review. These actions are taken forward by the operational units who nominate the most suitable staff to be responsible for taking the actions forward and making the changes for improvement.

A report for monitoring Duty of Candour cases was introduced in October 2019 and presented to the Quality Planning & Professional Governance Group; this was well received and has been produced regularly every 2

months since. This tracks the SAERs to establish which events are Duty of Candour and monitors compliance with the Datix fields to ensure all aspects of the legislation have been followed.

SAER investigation and Duty of Candour training sessions were delivered in October, November and December last year in various venues within NHS Lanarkshire; including a specific Duty of Candour Think Tank event which focused on outcome codes, types of harm, scenarios, preparing for meetings and communication with patients/relatives. All staff are also encouraged to complete the NHS Education Scotland Duty of Candour e-learning module, which is available on the organisation's intranet.

There have been several updates made to the Datix System to support improvement of recording the process followed for SAERs including Duty of Candour; these changes act as a prompt to the service for action required and aid decision making. The system is more user friendly and has improved the quality of information recorded which improves monitoring of duty of candour events.

The format of the dataset on the Datix system was reviewed and updated to ensure more accurate recording of the duty of candour information.

The Duty of Candour Guidance document was updated in September 2019 to reflect the updated SAER pathway and is available on the Duty of Candour First Port page:

http://firstport2/staff-support/duty-of-candour/default.aspx

Other resources available on this web page include:

- Duty of Candour presentation slides
- Examples/Scenarios for Primary Care and Mental Health
- Answers to DoC Questions from GPs
- Duty of Candour explanatory leaflets

WHAT HAVE WE LEARNED / CHANGED AS A RESULT OF REVIEWING THESE EVENTS?

NHS Lanarkshire has made changes following review of the duty of candour events. Some examples of these are detailed below.

Duty of Candour Event	Recommendations/Actions
Unexpected findings from imaging not communicated or followed up due to requests being made by admission teams however not reviewed by discharge team. Resulting in delayed diagnosis of lung cancer and treatment.	Proposals are currently being developed to ensure that consultants are viewing and signing off all results regularly. A monitoring system is also being developed to highlight issues and support proposed new way of working.
Post natal readmission due to severe anaemia highlighted that pregnancy guidelines were out of date.	Comprehensive guideline review undertaken, Neonatal Abstinence Syndrome - New West of Scotland Guidance adopted in University Hospital Wishaw. New guidelines being developed for management of anaemia in pregnancy, management of third stage and risk factors for which low dose aspirin is indicated. A new laboratory/maternity interface is being investigated to improve abnormal blood test result communication.

Senior Review was not initiated when NEWS increased to 6 or more, and a diagnosis of acute heart failure was therefore delayed.	NHS Lanarkshire is currently testing PatientTrack, a system which records NEWS and alerts for mandated reviews by senior medical staff. The trial is taking place within a number of wards at one of NHS Lanarkshire's acute hospital sites; and a business case is being developed for PatientTrack to be used within all acute settings.
Following repeated attendances at A&E there was a delay in referring a patient to neurosurgeons. Patient was later diagnosed with Cauda Equine Syndrome.	Completion of education and training for all Emergency Department doctors and Advance Clinical Practitioners for Cauda Equine syndrome, including use of a reviewed MRI pro-forma tool and MRI timescale. An investigation is underway to implement a more appropriate and effective neurosurgical referral pathway and system.
Patient, who suffers from thrombocytopenia, had a fall and there was a delay in CT scan despite known history and medical condition.	Following this incident the Emergency department head injury pro-forma has been updated to include thrombocytopenia as a risk factor, and the requirement for platelet transfusions to take place within the emergency department has been reinforced. A standard operating procedure is being developed with regard to the urgency of CT head scan in relation to platelet level results. Discussions are also taking place with Haematology colleagues with regard to how to encourage and support patients suffering from this condition to understand the urgency of seeking early medical attention following a head or facial injury.

OTHER INFORMATION

This second year of duty of candour legislation has highlighted there is a much better understanding of the legislation and NHS Lanarkshire have agreed to continue with regular monitoring to identify the adverse events that trigger the legislation as well as continued training and regular reporting on the duty of candour incidents.

This report is submitted to Health Improvement Scotland (HIS) and shared within NHS Lanarkshire structures and with all stakeholders.

For any further information regarding this report, please contact:

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APPENDIX 1

Table below provides detail of the incidents recorded as Duty of Candour Legislation from April 2019 and March 2020.

	Month Recorded	Open / Closed	Specialty	Location	Description
1	Apr-19	C	Obstetrics	UH Wishaw	Maternal/Delivery
2	Apr-19	C	Accident and Emergency	UH Monklands	Transfer Problem
3	May-19	C	Accident and Emergency	UH Monklands	Treatment Problems
4	May-19	C	Surgical and Colorectal	UH Monklands	Wrong, Delayed or Misdiagnosis
5	Jun-19	C	Medical Receiving	UH Monklands	Wrong, Delayed or Misdiagnosis
6	Jun-19	C	Accident and Emergency	UH Monklands	Treatment Problems
7	Jun-19	C	Theatres	UH Monklands	Retained Swab or Instrument
8	Jun-19	O	General Medicine	UH Hairmyres	Treatment Problems
9	Jul-19	C	Obstetrics	UH Wishaw	Maternal/Delivery
10	Jul-19	C	Medical Receiving	UH Wishaw	Wrong, Delayed or Misdiagnosis
11	Jul-19	C	Paediatrics	UH Wishaw	Treatment Problems
12	Aug-19	C	Obstetrics	UH Wishaw	Maternal/Delivery
13	Sep-19	C	Obstetrics	UH Wishaw	Fetal/Neonatal Incident
14	Sep-19	O	Older People's Services	Stonehouse Hospital	Ambulance
15	Sep-19	O	Accident and Emergency	UH Hairmyres	Wrong, Delayed or Misdiagnosis
16	Oct-19	O	Theatres	UH Hairmyres	Treatment Problems
17	Oct-19	O	Orthopaedic	UH Hairmyres	Wrong, Delayed or Misdiagnosis
18	Dec-19	O	Intensive Care/High Dependency	UH Hairmyres	Treatment Problems
19	Dec-19	C	Mental Health	UH Wishaw	Suicide
20	Jan-20	C	Obstetrics	UH Wishaw	Maternal/Delivery