DUTY OF CANDOUR ANNUAL REPORT (2022/2023) ADDENDUM

Please see below updated information to show the detail of the SAERs where duty of candour legislation was triggered that have now been completed and closed.

There were 42 adverse events reviews still ongoing at the time of publication of the Duty of Candour Annual Report, these have all now concluded, with 20 of these events triggering the legislation, resulting in a total of 53 incidents where duty of candour applied for NHS Lanarkshire during time period April 2022 to March 2023.

There were two incidents recorded that involved multiple patients, 75 patients were affected for one of these and 26 patients affected for another.

Details of these incidents are described below –
There was a pathology laboratory incident that resulted in multiple biopsies being unable to provide a diagnosis due to being destroyed in the processing. All patients involved were reviewed and 75 required repeat biopsies and therefore met the criteria of increased treatment under Duty of Candour. The investigation revealed that there had been an error in how the equipment for the specimen processor had been prepared. Actions have now been put in place to eliminate the chance of this incident happening again.

The ophthalmologist recognised an increase in intraocular pressure with a number of patients following cataract surgery. The stopped using the lens and contacted the manufacturer to find they had issued a warning in Europe but not in the UK. All patients were recalled and examined and 26 required further surgery to replace the lens or correct a defect in the eye and therefore met the criteria of increased treatment under Duty of Candour. In this instance the incident was no fault of the board and the department reacted quickly to resolve the matter. However, the principles of Duty of Candour were followed with a full apology to the patients that this happened to them and explanation of what had happened.

The events noted on the table below 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.

The table below shows the total number of duty of candour events recorded during time period April 2022 to March 2023 for NHS Lanarkshire grouped by Operational Unit and specialty:

DUTY OF CANDOUR ANNUAL REPORT (2022/2023)
ADDENDUM

	University Hospital Hairmyres	University Hospital Monklands	University Hospital Wishaw	North Health & Social Care Partnership
Accident and Emergency	1	1		
Acute Medical Receiving Unit	3			
Ambulatory Emergency Care Unit			2	
Anaesthetics		1		
Breast Surgery	1			
Cardiology		1		
Clinical Laboratories		1		
Colorectal	1	1		
Endoscopy		1	2	
Gastroenterology		1	2	
General Medicine	1			
General Surgery	2	3	1	
Gynaecology			3	
Mental Health	1			3
Obstetrics			8	
Older People's Services		2	1	
Oncology			1	
Ophthalmology	3			
Paediatrics				1
Radiology		1		
Renal Service		1		
Urology		1		
Vascular	1			

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.

DUTY OF CANDOUR ANNUAL REPORT (2022/2023) ADDENDUM

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	24
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	12
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	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.	0
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.	15

The final SAER reports provided detail to demonstrate how staff participated in the reviews as well as the support offered and provided to them during and after the review. Some examples are listed below.

- Staff information leaflets supplied
- Feedback provided to staff and information on the SAER process
- The review team considered all staff recollection of events
- Final reports circulated to the participants to ensure learning
- Team debriefs carried out on conclusion of the review
- Staff involved in the incidents offered support from their team management
- Support provided on an individual basis to staff
- Adverse Events Toolkit shared with all staff participating in review
- Learning from the reviews is shared within the NHS Lanarkshire Learning Bulletin which is produced and circulated quarterly within the organisation to all staff

Staff involved in significant adverse events reviews are all offered support from the Staff Care and Wellbeing team. As in healthcare we are challenged by situations and stressors on an everyday basis, some of these challenges and stressors may energise us but for some, stressors may have a profound impact and how that may affect some people. This service looks at how to build resilience and enhance wellbeing through various routes, i.e.: one to one active listening, peer support and a variety of training courses. They also offer safe and confidential spaces for staff to tell their stories and to reflect on their experiences helping them to identify sources of strength and to build resilience.

Staff can experience further reactions following a stressful event and may cause emotional reaction which can impact on their normal coping mechanisms. Some people prefer to cope with situations by themselves but others may benefit from additional support.

These details are included on the "Significant Adverse Event Information Leaflet for Staff" which is provided to each staff member who participate in a review –

- 24hr helpline on 01698 752000
- Email: **staffcare@lanarkshire.scot.nhs.uk**
- FirstPort page: **http://firstport2/staff-support/staff-care-wellbeing/default.aspx**

Another form of signposting for staff is included on the acknowledgement email within the Datix system with the information as detailed above.

This addendum to the Duty of Candour Annual Report 2022-2023 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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