DUTY OF CANDOUR

ANNUAL REPORT

1st April 2022 - 31st March 2023

NHS Lanarkshire	
Duty of Candour Lead:	Karon Cormack
Review Interval:	1 Year
Issue Date:	May 2023

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, 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 short report describes how NHS Lanarkshire has operated the duty of candour during the time between 1 April 2022 and 31 March 2023.

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.

About NHS Lanarkshire

NHS Lanarkshire is the third largest health board in Scotland. We serve a population of 655,000 across rural and urban communities in Lanarkshire. We employ around 12,000 staff working in communities, health centres, clinics and offices and at our three district general hospitals – University Hospital Hairmyres , University Hospital Monklands and University Hospital Wishaw.

We are committed to delivering high quality, innovative health and social care that is person-centered. Our aim is that everyone is able to live longer, healthier lives at home, or in a homely setting.

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

Between 1 April 2022 and 31 March 2023, there were 33 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone’s illness or underlying condition.

There are another 42 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 recognising it is likely more will be added to this annual count in an addendum to this report when the investigations have been completed.

NHS Lanarkshire identified these incidents through the adverse event management process. Over the time period for this report we carried out 112 significant adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

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.

Nature of unexpected or unintended incident where Duty of Candour applies	**Number**
A person died	14
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	7
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.	10

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

	University Hospital Hairmyres	**University Hospital Monklands**	**University Hospital Wishaw**	**North Health & Social Care Partnership**
Accident and Emergency	1	1		
Acute Medical Receiving Unit	1			
Anaesthetics		1		
Breast Surgery	1			
Cardiology				
Colorectal	1	1		
Coronary Care				
Emergency Care Unit				
Endocrinology				
Endoscopy		1		
Gastroenterology		1	1	
General Medicine	1			
General Surgery	2	3		
Gynaecology			2	
Infectious Diseases				
Mental Health	1			1
Obstetrics			4	
Older People's Services		2	1	
Oncology			1	
Ophthalmology	2			
Orthopaedic				
Radiology		1		
Renal Service		1		
Respiratory				
Theatres				
Urology		1		

The table in Appendix 1 provides details of date of incident, specialty, type and location for all 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.

Post Covid-19 Pandemic

Following on from the circumstances surrounding COVID-19 situation, which had limitations on the amount of time clinical staff were able to provide and participate in significant adverse event reviews, resulting in delayed completion times; this has continued to have an impact, whereby the timelines for reviews took longer to conclude.

At the time of publication of this report and comparing the number of significant adverse event reviews that were delayed from last year's report, the figures have shown it is taking longer to conclude the reviews, the majority are being completed between 91 and 150 days; and less reviews managing to conclude within the 90 days' timeline. However the same issue has been recognized in other boards and comparatively, NHS Lanarkshire's timescale for completion is reasonable.

Quality Assurance

A Quality Assurance (QA) Checklist was developed which included points to cover all aspects of the significant adverse event reviews (SAERs). This was used to carry out the quality assurance checks on a selection of SAERs from each hospital area/site to capture the relevant information on completeness of data entry onto the Datix system, documentation, detail of the review, content of the SAER reports and duty of candour information.

The areas of focus for duty of candour included details of apology, patient/family informed, invited to participate in review, received a copy of the report, causation codes and whether or not the incident triggered the legislation.

The findings from this QA demonstrated there was a very high level of completeness from all hospitals/areas providing details on all elements for duty of candour, which resulted in a 95% compliance, providing evidence to show there is a robust process and understanding from staff within the organisation for all aspects of reporting and reviewing of SAERs.

NHS Lanarkshire Policies, Procedures and Guidance

As a Board, NHS Lanarkshire 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. For all adverse events that meet the criteria for duty of candour, these 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.

The process to monitor duty of candour is well established and includes tracking all SAERs to identify the duty of candour events, monitoring compliance to ensure legislation is followed, correlation with the causation codes and monitoring of the action plans. Reports are produced on a regular basis and shared within the organisation, with a detailed report on all duty of candour incidents to demonstrate status and compliance which is submitted to the Quality Planning & Professional Governance Group, bi-monthly.

SAER Investigation and Duty of Candour training sessions were carried out with 345 staff having attended these sessions, along with training videos which were produced and shared with various staff groups throughout the organization. To continue with the delivery of these training sessions, a training programme was developed for 2023, with 7 sessions planned for February through to December 2023. These sessions aim to help provide staff with the knowledge, tools and techniques to feel confident when involved or participating in investigating significant adverse events. 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, with an overall total of 6739 staff completing the module and during time period April 2022 to March 2023, 1010 staff completed the module.

The Significant Adverse Event Information Leaflet for Staff includes information on support services available from the Staff Care & Wellbeing Team, this is in addition to support being available from relevant professional bodies and partnership representation.

The Staff Care and Wellbeing team delivered sessions to staff as part of Quality Week within NHS Lanarkshire, these sessions highlight the fundamentals of staff care, how to access their services and the types of support available to all staff throughout NHS Lanarkshire with topics covering resilience, burnout, sleep and anxiety, the sessions also give staff an opportunity to ask questions.

The leaflet includes details of how to make contact with the NHS Lanarkshire Staff Care and Wellbeing team with a 24-hour helpline telephone number, email address and details of links to access this information via the First port page on NHS Lanarkshire's intranet.

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

A continuous improvement programme is in place for adverse events including updates and improvements to the incident reporting system with enhancements to the functionality, standardisation of categories and sub categories, for ease of recording and to allow more effective reporting.

The Duty of Candour Guidance document is available on the Duty of Candour First Port page, as well as other resources which include Duty of Candour presentation slides, some examples and scenarios for Primary Care and Mental Health, Answers to DoC Questions from GPs and Duty of Candour explanatory leaflets.

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

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**
A frail patient developed multiple areas of skin pressure ulceration whilst they were an inpatient, they were discharged to their care home with no communication regarding the number and severity of wounds and there was no treatment or management plan in place. The patient was readmitted 2 days. This patient was at high risk of pressure ulceration, and whilst the development of these may not have been entirely avoidable, there was evidence that many aspects of this person's care could have been improved such as: skin assessment and documentation; pressure relieving equipment *(eg: airflow mattress)*; positional changes and a lack of involvement of tissue viability (TV) and podiatry teams. There was inadequate handover to the care home and within the ward environment there were significant staffing issues as well as the patient being boarded out with the relevant specialty.	From this incident an evaluation of the availability of appropriate equipment has been carried out, a review of the discharge planning from acute setting to care homes was completed with a checklist for discharges developed and TV team have provided education learning sessions to improve staff knowledge of skin care, topics incorporated pressure ulcer assessment including grading and mattress selection, prevention and management of pressure ulcers, sskins intervention, TV/podiatry referral pathway as well as wound assessment/management. The SAER report was shared at relevant governance groups and safety briefs to raise awareness of these learning points.

A referral for an antenatal diagnosed renal issue and a referral for hip ultrasound on a baby was missed. Several issues were identified at the initial examination of the new-born which were escalated for review, however, review and request for renal ultrasound was missed. The neonatal doctor was asked to review multiple tasks for this baby, unfortunately due to a breakdown in communication these were not all reviewed and referrals not made. Distractions and time pressures are inherent in the environment of the postnatal wards and currently there is no quiet space with both IT systems and a phone in which to complete checks and referrals.	Resulting from this incident a quiet, dedicated space on the postnatal ward with all necessary equipment to complete a detailed check in full and without interruption, including IT and phone access has been created and being utilised by staff. There was also agreement to change practice to ensure all babies with high risk alerts and complexities *(beyond hip referrals)* will have their detailed check carried out by neonatal staff to avoid a fragmented approach with outstanding tasks such as referrals being missed; and alerts to be generated from the Badger system for risk factors triggering hip referral *e.g. breech at 36 weeks,* to prompt the checker to refer to Orthopaedics.
Over several years, this patient had been attending hospital for chronic outpatient haemodialysis treatment, they also have other significant medical problems as well as a large number of infection-related hospital attendances/admissions; and they were aware of the ongoing infection risks associated with using a tunneled central venous catheter (TCVC) as vascular access for haemodialysis. A swab from the patient's TCVC exit site grew Staphylococcus aureus, this was reported but the result was not seen until six days later when the patient became acutely unwell and required hospital admission where their condition deteriorated while receiving inpatient haemodialysis treatment, leading to deterioration. The review has highlighted the inadequate system for tracking pending test results sent from the outpatient haemodialysis unit.	Following on from this review and the recommendation from the review team, the introduction of a robust system to track pending results for tests sent from the outpatient haemodialysis unit has been established, this was carried out on a trial basis for a 3-month period initially in one of the areas of out-patient dialysis. The results from the trial are being reviewed and if no further changes required and the process is working, arrangements will be made for additional documentation to be printed and ordered for ongoing use.
A patient with no significant past medical history and independently mobile was admitted to hospital with pyelonephritis *(kidney infection)* but did not receive venous thromboembolism *(VTE)* prophylactic treatment *(preventative medication, usually an injection under the skin, to reduce the risk of blood clot formation in the legs or lungs).* They were then admitted with bilateral pulmonary emboli *(PE- blood clots in both lungs)* which they were treated for and required a minimum of 6 months treatment with apixaban *(an oral anticoagulant).* The lack of VTE thromboprophylaxis assessment highlighted contributing factors of misperception of risk; local working conditions i.e.: workload, boarding status of patient; failure of written communication from pharmacy to act as prompt; and non-robust current paper-based assessment of risk.	The review of this case concluded that the current paper based assessment of VTE risk for medical in-patients was not robust and easily omitted. The recommendation of a mandatory electronic prompt through the hospital electronic prescribing and medicines administration (HEPMA) system was introduced to ensure that all admitted patients have their VTE risk assessed, the risk assessment is documented and medication prescribed as appropriate. Compulsory VTE assessments was introduced and is available on the HEPMA system within NHS Lanarkshire.

OTHER INFORMATION

This is the fifth annual report produced on duty of candour legislation, which demonstrates NHS Lanarkshire have a good understanding of the legislation and will continue with the monitoring process to identify all 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:

Karon Cormack
Director of Quality
Duty of Candour Lead
NHS Lanarkshire
Kirklands Hospital Headquarters
Fallside Road
Bothwell G71 8BB
karon.cormack@lanarkshire.scot.nhs.uk

APPENDIX 1

Table below provides detail of the incidents recorded as Duty of Candour Legislation from April 2022 and March 2023.

	Month	Specialty	Location	Description
1	Apr-22	Mental Health	UH Hairmyres	Admission/Appointment/Discharge Issue
2	May-22	Surgical	UH Hairmyres	Breach of legislation policies and procedures
3	May-22	Gastroenterology	UH Monklands	Falls
4	May-22	General Surgery	UH Monklands	Treatment Problems
5	May-22	Obstetrics	UH Wishaw	Fetal/Neonatal Incident
6	May-22	General Medicine	UH Hairmyres	Pressure Ulcer
7	May-22	Older People's Services	UH Monklands	Medication Administration Incident
8	May-22	Renal Service	UH Monklands	Infection, Prevention and Control (IPC)
9	Jun-22	Older People's Services	UH Wishaw	Treatment Problems
10	Jun-22	Endoscopy	UH Monklands	Treatment Problems
11	Jul-22	Gynaecology	UH Wishaw	Wrong, Delayed or Misdiagnosis
12	Jul-22	Colorectal	UH Monklands	Wrong, Delayed or Misdiagnosis
13	Jul-22	Surgical	UH Hairmyres	Medication Prescribing Incident
14	Jul-22	Urology	UH Monklands	Falls
15	Jul-22	Obstetrics	UH Wishaw	Fetal/Neonatal Incident
16	Aug-22	Anaesthetics	UH Monklands	Ill Health
17	Aug-22	Mental Health	UH Hairmyres	Ill Health
18	Aug-22	General Surgery	UH Monklands	Cardiopulmonary/Respiratory Arrest
19	Aug-22	Ophthalmology	UH Hairmyres	Wrong, Delayed or Misdiagnosis
20	Aug-22	Ophthalmology	UH Hairmyres	Wrong, Delayed or Misdiagnosis
21	Aug-22	Gastroenterology	UH Wishaw	Wrong, Delayed or Misdiagnosis
22	Aug-22	Surgical	UH Monklands	Cardiopulmonary/Respiratory Arrest
23	Sep-22	Gynaecology	UH Wishaw	Wrong, Delayed or Misdiagnosis
24	Sep-22	Obstetrics	UH Wishaw	Fetal/Neonatal Incident
25	Sep-22	Acute Medical Receiving Unit	UH Hairmyres	Wrong, Delayed or Misdiagnosis
26	Sep-22	Obstetrics	UH Wishaw	Wrong, Delayed or Misdiagnosis
27	Oct-22	Accident and Emergency	UH Monklands	Cardiopulmonary/Respiratory Arrest
28	Oct-22	Colorectal	UH Hairmyres	Wrong, Delayed or Misdiagnosis

	Month	Specialty	Location	Description
29	Oct-22	Breast Surgery	UH Hairmyres	Wrong, Delayed or Misdiagnosis
30	Oct-22	Radiology	UH Monklands	Wrong, Delayed or Misdiagnosis
31	Nov-22	Accident and Emergency	UH Hairmyres	Wrong, Delayed or Misdiagnosis
32	Nov-22	Oncology Day Unit	UH Wishaw	Ill Health
33	Dec-22	Older People's Services	UH Monklands	Falls