Duty of Candour Annual Report

1st April 2023 - 31st March 2024

Duty of Candour Report

All health and social care services in Scotland have a duty of candour as an organisation. 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 Lothian has operated the duty of candour during the time between 1 April 2023 and 31 March 2024. We hope you find this report useful.

1. About NHS Lothian

NHS Lothian serves a population of more than 850,000 people living in Edinburgh, East, Mid and West Lothian. We cover a diverse geographical area, including large and small towns as well as some rural areas. We also provide some services for patients in the Borders and in Fife and are a national centre of expertise for some specialties provided to people across Scotland.

Our aim is to provide high quality care for every person who uses our services, and where possible, help people to receive care at home or in a homely setting.

2. Number and nature of Duty of Candour incidents

Since the last annual report, there have been 41 incidents identified where the duty of candour applied. These are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

NHS Lothian identified these incidents principally through our adverse event management process although these can be highlighted through other routes such as a complaint but would then be reviewed through the adverse event management process.

We review and consider all adverse events where the patient outcome was either moderate or major harm or death for application of Duty of Candour. The inclusion in our review of events where there was moderate harm is used to capture instances

which did not result in severe harm, but harm which resulted in one or more of the criteria as set out in the legislation.

We identify through the 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.

Nature of unexpected or unintended incident where Duty of Candour applies	Number of events identified between 1 April 2023 and 31 March 2024
A person died	8
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	≤5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	30
Changes to the structure of the person's body	
The shortening of the life expectancy of the person	≤5
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.	≤5
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	41

3. To what extent did NHS Lothian follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure in 34 cases. This means we informed the people affected, apologised to them from the organisation, and invited them to participate in the review.

Reviews have been commissioned for all of these events, 40 of which have been completed. In all cases, we reviewed what happened, what went wrong and what we could have done better and offered to feedback the outcome and learning from the events to the people affected. There have been 24 cases where we have not been able to feed back the outcome and learning to people involved for a variety of reasons. In most cases this has been through patient/family choice, either indicating that they did not wish feedback or did not respond to offer of feedback.

Individual and organisational learning has been considered in each case with improvement plans developed and completed or in progress for each one.

We continue to progress improvement work to improve the reliability of communication processes with patients and families where a significant adverse event has occurred, which will in turn improve our compliance with the Duty of Candour process.

4. Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy and associated procedures. This may be retrospective if an adverse event is identified through a claim, complaint or other means. Through our adverse event management process, we can identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on communicating with patients and families about adverse events, including implementing the duty of candour where relevant.

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 relevant management teams develop improvement plans to meet these recommendations.

Staff have access to information on the intranet via our dedicated duty of candour page and are encouraged to complete the NES Education Scotland Duty of Candour e-learning module, also sign posted through the intranet pages.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction. Additional training and advice are also readily available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through the following various support services available:

- Occupational Health Services
- Staff Support & Confidential Counselling Services
- Staff Peer Support Service
- Here 4 U helpline
- Staff Listening Service offered by the Spiritual Care Team

5. What has changed as a result?

We always consider what actions we will take to try to prevent a repetition of adverse events. Our Quality Strategy has a vision of the systematic application of Quality Management (QM) at its core which uses the four domains of Quality Planning, Quality Improvement, Quality Control and Quality Assurance – improving processes and systems, whilst learning from past events. A key part of the approach is comprehensive quality planning focussed on improving patient safety and reducing avoidable harm, informed by capturing lessons from adverse events, identifying themes, and implementing improvements through planned programmes of work.

In addition, some examples of specific changes following individual DoC events are highlighted below:

- Following administration of an incorrect vaccine due to a failure to follow the standard operating procedure (SOP) for appropriate storage of vaccines in the portable vaccine storage unit, the SOP for use of portable vaccine storage units has been updated to incorporate all vaccine types. Clinical audits are also now in place to monitor compliance with vaccinator competency, documentation and record keeping process

- As a result of a patient who was discharged home with no care package in place and subsequently had to be readmitted to hospital, a discharge planning checklist is now in place and embedded within the nursing team processes

- Due to a delay in anaesthetic review which resulted in a patient requiring additional treatment (an invasive procedure), a SOP has been introduced for surgical listing for all patients following anaesthetic review in that service. It outlines the process for communicating with all relevant services/specialists involved in the patient's care

- Following a patient suffering a serious event due to the administration of an oral medication via the wrong route, the following processes have now been put in place:
    - Improved education for nursing and medical staff on induction to area regarding the use of the purple syringe system for oral with improved sign alert system in medication preparation room and the doctor's room
    - Spot checks on the stock levels of oral medication syringes
    - 2 yearly review of nursing team competencies
    - Update of training on oral and intravenous administration of medication

- Following a misplacement of a Central Venous Catheter (CVC) which resulted in bleeding after it was removed, there is now a link to the critical care

guidance embedded within the relevant section of the 'Guideline for the Insertion, Care and Removal of short–term Non-Tunnelled Central Venous Catheter (CVC) (Adult)'

- Following a medication error caused by poor communication between inpatient sites on transfer and handover, changes have been made to admission/transfer documents and a named admission nurse is allocated to each patient.

- As a result of delay in recognising an abnormal antenatal CTG (Cardiotocography – used to monitor fetal wellbeing), there was a delay in carrying out a caesarean section and the baby was born in poor condition. A fetal wellbeing improvement programme, overseen by the Maternity and Neonatal programme board is now in place which covers actions arising from this case including:
    - Revised guideline to incorporate additional information on fetal physiology to aid decision making about timing of delivery, implemented with support from the education and training team and the fetal wellbeing midwifes
    - A CTG audit introduced to monitor compliance.
    - A CTG competency test will be introduced for all staff working on labour ward as is used in NHS England.

6. Other information

We continue to learn both locally and nationally and to improve implementation of processes to discharge the statutory organisational Duty of Candour. For NHS Lothian, priorities continue to be:

- Development of planned programmes of work informed by identified themes from adverse event review to improve patient safety and reduce avoidable harm
- Improving reliability of communication with patients and families at all stages of the review process, including clarity of roles and responsibilities all those involved

As required, we have notified the Scottish Ministers that we have published this report on our website.

If you would like more information about this report, please contact us.

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