NHS FORTH VALLEY

Duty of Candour Annual Report

1st April 2018 to 31st March 2019

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 and 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 report describes how NHS Forth Valley has operated the Duty of Candour during the time between 1st April 2018 and 31st March 2019. We hope that you find this report useful.

1. About NHS Forth Valley

NHS Forth Valley is one of the fourteen regions of NHS Scotland and serves a population of around 306,000. It provides healthcare services in the Clackmannanshire, Falkirk and Stirling areas. NHS Forth Valley is headquartered in Castle Business Park, Stirling.

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

2. How many incidents happened to which the Duty of Candour applies?

Between 1st April 2018 and 31st March 2019, there were 12 incidents where the Duty of Candour applied. These were unintended or unexpected incidents that resulted in harm or death as defined by the Act and they did not relate directly to the natural course of someone's illness or underlying condition(s) although, in two cases, it was difficult to confirm. In one case, the timescales were challenging due to the requirement for an external review.

NHS Forth Valley identified these incidents through our adverse event management process. Over the time period for this report, we carried out 8 significant adverse event reviews, one of which was a Multi-Board review. These events include a wider range of outcomes than those defined in the Duty of Candour legislation but there were also 4 adverse events which we applied the legislation to.

We identified, through the adverse and significant adverse events process, if there were factors that may have caused or contributed to the event, which helps to identify Duty of Candour incidents (see Table 1 below).

Table1: Number of Times Unexpected or Unintended Incidents occurred between 1st April 2018 and 31st March 2019

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition(s))	Number of times this happened (between 1st April 2018 and 31st March 2019)
A person died	8
A person incurred permanent lessening of bodily, sensory, motor, psychological or intellectual functions	1
A person's treatment increased	1
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them dying	1
A person needed health treatment in order to prevent other injuries as above	0
TOTAL	**12**

3. To what extent did NHS Forth Valley follow the Duty of Candour procedure?

NHS Forth Valley followed the correct procedure in 11 out of 12 cases. This means that we informed the people affected, apologised to them and offered to meet with them (in one case, although a full review was carried out and the patient received an apology, there were a number of communication issues after the patient was transferred to another hospital). We always offer to share the final report with the patient and/or family in Duty of Candour cases. In each case, we reviewed what happened, what went wrong and what we could have done better. Individual and organisational learning has been undertaken and subsequent action and improvement plans have been developed and completed.

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4. Information about our policies and procedures

Every adverse event is reported through the NHS Forth Valley clinical governance reporting structures as set out in our adverse event management process and, through this, we can identify incidents that trigger the Duty of Candour procedure. Our Management of Adverse and Significant Adverse Events policy contains a section on Duty of Candour and there are guidance documents available on the NHS Forth Valley intranet.

All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module. Over 700 staff have completed this to date.

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 local management teams develop action and improvement plans to meet these recommendations.

Staff receive training on adverse event management as part of their induction. Additional support is available for those members of staff who review adverse and significant adverse events and for those who are key points of contact with people who have been affected by such events.

NHS Forth Valley understands that adverse events can be distressing for staff as well as those affected by the event. Support is available for all staff through the line management structure as well as through Occupational Health.

5. What has changed as a result?

NHS Forth Valley has made a number of changes following review of the Duty of Candour events. There include:

- The search policy for patients reported missing after time out of the ward has been reinforced and re-launched. A red, amber, green' ('RAG') status for patients during the head count to ensure that the patients are well at the time of the observation was introduced. This adheres to Healthcare Improvement Scotland's guidance on improving observational practice.

- Storage of liquid detergent in the ward areas has been secured to reduce the risk of possible ingestion.

- Emergency Department Guidelines (based on the NICE Guidelines) following the death of a child are being reviewed and aligned with Paediatric guidance.

- Microbiology Standard Operating Procedures have been reviewed including introduction of a controlled, formatted template for recording all work on the blood cultures when dealing with positive results. This followed a failure to flag a Gentamicin resistance to medical staff which resulted in a patient requiring transfer to another hospital for treatment.

- There has been a review of several other procedures and protocols where adverse event and significant adverse event reviews identified the need to do so.

6. Other information

This is the first year of the Duty of Candour being in operation and it has been a year of learning and refining our adverse event management processes to include the Duty of Candour outcomes.

The Duty of Candour section on the electronic reporting system (Safeguard) does not discriminate between Professional Duty of Candour and Organisational Duty of Candour and so each case was reviewed to discern which legislation to apply.

As required, NHS Forth Valley has submitted this report to the Scottish Ministers and has also placed it on our website.

If you would like further information regarding this report, please contact: Irene Graham, PA to the Medical Director, 01786 457293, Irene.graham@nhs.net