NHS FORTH VALLEY

Duty of Candour Annual Report

1st April 2022 to 31st March 2023

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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.

The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm)

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 2022 and 31st March 2023.

About NHS Forth Valley

NHS Forth Valley is one of the fourteen regions of NHS Scotland and serves a population of around 306,000. NHS Forth Valley has one acute hospital and Community Hospitals in the Clackmannanshire, Falkirk and Stirling area. NHS Forth Valley is headquartered in Castle Business Park, Stirling.

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

The Duty of Candour annual report provides detail of all incidents triggering Organisational Duty of Candour across NHS Forth Valley.

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

During the reporting period 1st April 2022 and 31st March 2023, there were 13 completed significant adverse event reviews (SAER), which had been commissioned in the previous reporting period (1st April 2021-31st March 2022) 10 of which the Organisational Duty of Candour applied. In addition, 14 SAERs were commissioned during this reporting period. One of these reviews is complete and the Organisational Duty of Candour applied. This gives a total of 11 incidents to which the Organisation Duty of Candour applied. Confirmation of Organisational Duty of Candour of the further 13 reviews commissioned and in progress cannot be determined until the reviews are completed. If however any of these reviews are identified as an organisational Duty of Candour, because we have followed our SAER process, the appropriate communication and engagement has taken place. These reviews were undertaken when 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).

NHS Forth Valley identified these incidents through our adverse event management process.

NHS Forth Valley Board approved funding for additional resources to support the reviews, reports and family engagement. SAER Lead Reviewers and Clinical Governance Managers were recruited and we hope that this investment will improve the speed and efficiency of the review process. Although there were initial delays, all reviews were undertaken robustly in accordance with the Scottish Government framework, ensuring communication and engagement with the patient and or relatives.

Although we are continuing to progress our service mobilisation plans to try to resume services to pre- pandemic levels there are still capacity pressures, restrictions and risk mitigations in place across our clinical areas and services. Discussions concerning Duty of Candour in relation to the impact of the Covid-19 pandemic are also taking place at a national level.

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 2022 and 31st March 2023

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition(s))	Number of times this has happened between 1st April 2022 and 31st March 2023
A person died	9
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 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 needed health treatment in order to prevent other injuries as above	0
TOTAL	11

It should be noted that, for the families of those who died, there is significant associated pain and psychological harm which is not captured in the table above. Our process in NHS Forth Valley ensures families are offered appropriate support if required.

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

NHS Forth Valley followed the Duty of Candour procedure, this means that we informed the people affected, apologised to them and offered to meet with them.

We always offer to share the final report with the patient and/or family. 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.

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.

We have developed a Clinical Governance webpage which includes a section on Duty of Candour. This supports our education and offers access to the NHS Education Scotland, TURAS, Duty of Candour module as well as Scottish Government guidance.

All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module as well as training on adverse event management as part of their induction. Additional education and training sessions in the management of adverse events and identification of Duty of Candour are being offered to support our updated processes. Education and training sessions to support clinical staff will also be undertaken as part of our Clinical Governance process.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. Recommendations are made as part of the adverse event review and local management teams develop action and improvement plans to meet these recommendations.

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.

What has changed as a result?

NHS Forth Valley has made a number of changes following review of the Duty of Candour events. There are significant changes that we wish to highlight:

- There has been a review of several procedures and protocols where adverse event and significant adverse event reviews identified the need to do so.
- Development of referral pathways to the appropriate clinical teams
- Review of medical consultant rotas
- New process developed to ensure patients waiting over 4 hours in the emergency department have appropriate observations and care.

Other information

The Duty of Candour section on the electronic reporting system (Safeguard) does not discriminate between Professional Duty of Candour and Organisational Duty of Candour but with our enhanced process and the introduction of the briefing note and briefing arrangements, we are confident of which legislation to apply.

If you would like further information regarding this report, please contact: the Clinical Governance Team at fv.clinicalgovernance@nhs.scot