



**NHS Golden Jubilee
Duty of Candour Annual Report**

2018/2019

1. Introduction

All health and social care services in Scotland have a Duty of Candour (DoC). 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 DoC is implemented within the NHS Golden Jubilee services. This report describes how we have operated the DoC during the time between 1 April 2018 and 31 March 2019.

2. About NHS Golden Jubilee

NHS Golden Jubilee has always aimed to ensure that we support the delivery of NHS Scotland's national health priorities. Our focus since our establishment has been to meet NHS Board demands and deliver equity of access to high quality healthcare for as many patients as possible so that they benefit from our clinical expertise and excellent facilities.

3. How we prepared for Duty of Candour

In preparing for the DoC legislation going live we held a number of drop in sessions to ensure staff were aware of the legislation and requirements ahead of the implementation date. There was also presentation and discussion at Clinical Governance Forums and local meetings. Approximately 150 staff attended some form of awareness sessions.

The national DoC e-learning module has been made available to all staff. There has been ongoing discussions with Medical and Clinical Education regarding education and support for staff in relation to having discussions with patients/ relatives affected by these events. As a result, a series of workshops were organised entitled 'Breaking Bad News'. These have been targeted at all staff involved in these difficult conversations and are being facilitated by Dorothy Armstrong, DA Professional.

4. Our policies and procedures

Each Adverse Event is reported and reviewed via the Datix system. The procedure for reviewing each level of incident is set out in the Adverse Events Management policy. The Adverse Events Management policy and supporting tools/ guidance have been updated to reflect the introduction of DoC. The decision on DoC is built into the Significant Adverse Event (SAE) review process. Legislation requires that a clinical person must make the final decision; this process is led by the appropriate Division Clinical Governance lead and approved by the Division Divisional Management Team.

Each event is reviewed with a focus on learning from what has happened, regardless of the level of harm. If there is potential to learn from an error this should be harnessed and taken forward. On completion of an adverse event, review actions are identified and these are monitored to completion via the Clinical Governance reporting framework.

All staff receive training on adverse event reporting and the implementation of the Duty at corporate induction. More in depth training is delivered to those responsible for reviewing incidents on Datix and a programme of Root Cause Analysis(RCA) training has been launched for staff who could potentially take part in a Significant Adverse Event investigation.

We know that being involved in a significant adverse event can be distressing for staff as well as those affected by the event. We have support available to staff in the form of the formal line management structure. In addition to this we have the Spiritual Care and Diversity Lead and the Occupational Health team who are available to provide staff support in different forms following significant adverse events, where required.

5. Significant Adverse Event (SAE) Activity 2018/2019

Between 1 April 2018 and 31 March 2019, there were 35 SAE's reported. The table below shows the breakdown of these in relation to type of investigation. As outlined in our policy events may be investigated as Significant Adverse Event Reviews (SAE), or if more complex, escalated for further review via Root Cause Analysis (RCA). As shown we have had five DoC events in this 12 month period:

Type of Review	No of events
RCA	2
RCA - DoC	4
SAE	28
SAE – DoC	1

There were two events that were reviewed as an RCA event that did not trigger the Duty of Candour (DoC). Regardless of DoC status, contact with patients and families to advise of an event and investigation is undertaken.

All SAE's have been reviewed via the Clinical Governance Committee structure as means of a further scrutiny regarding the DoC status. Sharing of these is also a useful learning resource for clinicians.

6. Duty of Candour Events

Of the five events that triggered the DoC, four followed the DoC process including meeting the 90 day timescale for completion of the review process. Each party was spoken to either face to face or via telephone and this was also confirmed in writing. The patient/families were kept updated throughout the process and received a copy of the final report along with an invitation to meet with staff involved to discuss the report. To date, none of these offers have been accepted.

All of the patients/families involved in these DoC events were advised of the process from the initial stages and were given the opportunity to contribute to the Terms of Reference for the investigation.

The event that did not follow the DoC process was a complex and sensitive case, it also involved an event which automatically triggered an RCA and it was only during the review

process that the DoC trigger was realised. Due to the sensitivity of the case, additional meetings to ensure the report was accurate and appropriately investigated took place which meant the timeline was not achieved. The report has been finalised and arrangements are being made to share the findings with the patient's family.

The DoC event that did not progress to RCA review was subject to a robust Significant Adverse Event review. Learning was identified and actioned via the appropriate multidisciplinary forums. On review it was felt that the investigation that had been undertaken was sufficient and no further learning would be identified by conducting another multidisciplinary review via RCA. The DoC process was followed; the review was discussed with the patient and the consultant involved at a follow up appointment and a hard copy of the investigation report was sent to the patient for information.

7. Learning

Further to the review of the events that triggered the DoC, various learning points were identified. Some of this learning currently being implemented includes:

- Revised process for issuing death certificates to ensure this is properly explained to relatives.
- Development of a protocol for a debrief process for all deaths that occur in theatre.
- Development of a protocol for nasogastric tubes used where there is a suspicion of ileus or abdominal deterioration.
- Development of scenario based refresher training in emergency procedures for theatre staff.
- Review of Pharmacy provision over the weekend
- Development of standardised process/guidance regarding the use of anti-platelet therapy and anticoagulation

8. Conclusion

This is the first year of the Duty of Candour being in operation and, so far, it has been a time of learning and refining our existing adverse event management processes to include the DoC outcomes. We have demonstrated the ability to fully achieve the timescale with the exception of one very sensitive case.

This report will be disseminated via the Clinical Governance reporting structure for internal information and will also be published on our public website in line with legislation. It will also be shared with the Scottish Government to ensure our compliance with the DoC provision.

Incident which activates the duty:

The DoC procedure must be carried out by the responsible person as soon as practicable after becoming aware that an individual who has received a health, social care or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- an increase in the person's treatment
- changes to the structure of the person's body
- the shortening of the life expectancy of the person
- 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
- 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
- the person requiring treatment by a registered health professional in order to prevent –
 - the death of the person, or
 - any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.