Integration Joint Board
Clinical & Care Governance

7th February 2019

This Report relates to
Item 10 on the Agenda

Duty of Candour

(Paper presented by Maureen Stevenson)

For Discussion

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List of Background Papers	Web link embedded (knowledge.scot.nhs.uk/dutyofcandour)
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SECTION 1: REPORT CONTENT

Title/Subject: Duty of Candour

Meeting: IJB Clinical and Care Governance Committee

Date: 7th February 2019

Submitted By: Dr Ken Donaldson

Action: For Discussion

1. Introduction

1.1 The organisational Duty of Candour (DoC) provision came into effect on the 1st April 2018. This created a legal requirement on health and social care organisations to:

- inform people (or their carers/families) when they have been harmed as a result of the care or treatment they have received
- to offer an apology
- invite them to participate and be informed by a review
- offer an appropriate remedy or support to put matters right (if possible)
- and explain fully to the patient (or, where appropriate, the patient's advocate carer or family) the short and long term effects of what has happened.

Duty of Candour provisions will apply when there's been an unexpected or unintended event or incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care.

2. Recommendations

2.1 The Integration Joint Board is asked to: disuss and note the Duty of Candour Implementation plans for health and social care.

2.2 Consider Governance Arrangements for the Partnership

3. Background

3.1 The Duty of Candour Provisions are set out in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act). Implementation of the new Act is supported by regulations. These regulations identify the procedures that organisations should follow when an unintended or unexpected incident results in the death or harm of an individual (or additional treatment is required to prevent injury that would result in death or harm).

Duty of candour is a legal requirement for Health, Care Services and Social Work to inform people (and their families) of incidents where they have been harmed as a

result of the care or treatment they received. The intention of the legislation is to promote openness and transparency and ensure individuals are made aware of occurrences. The purpose of the new provisions is to support the implementation of consistent responses across health and social care providers. The duty of candour provisions reflects the Scottish Government's commitment to ensure that where harm occurs, the focus should be on personal contact with those affected. The Act outlines the arrangements that need to be in place to ensure individual cases are identified, reviewed and action taken. The principles of learning and continuous improvement are the philosophy underpinning the approach.

The Act outlines the incidents which give rise to duty of candour and sets out the role of a Registered Health Professional in deciding whether the incident meets the criteria attaching to Duty of Candour. In this regard a Registered Health Professional must give their view on the incident and its relationship to the occurrence of death or harm and to any pre-existing illnesses or underlying conditions. The Registered Health Professional should not be involved in the case.

The attached Implementation Plan (Appendix 1) sets out the work undertaken to date which the NHS Performance Committee have reviewed. It is important to note that the organisational duty is in addition to that which applies to registered health and social care professions.

4. Main Body of the Report

4.1 Implementation of the new Act requires health and social work to establish comprehensive arrangements to support implementation of Duty of Candour. This has necessitated the development and /or refinement of systems and processes to ensure staff are aware of responsibilities, incidents are reported, cases are reviewed, and findings examined and acted on.

Whilst health and social work have different reporting systems and mechanisms for incident and complaints reporting, investigation and learning the fundamental principles around how we identify and respond to Duty of Candour cases remain the same.

4.2 Implementation

NHS Dumfries & Galloway's (D&G) implementation plan was drawn together and approved by Performance Committee last year. Appendix 1 provides an update on that plan.

The Social Work Services Committee received a paper setting out the implications for Social Work of the legislative changes arising from Duty of Candour and the resource implications regarding implementation (Appendix 2). They have in addition developed a Duty of Candour Policy and Process to inform and guide staff.

Social Work Procedures ensure staff are aware of responsibilities when Duty of Candour applies. They provide advice and guidance on the steps that need to be followed in these circumstances. There are tight timescales attaching to processes

and these are highlighted in the associated guidance referred to in the linked background papers. Social Work Procedures should include:

- The development of pathways for notification of incidents;
- The establishment of robust systems and processes to guide case reviews;
- Processes ensuring notifications to relevant regulatory bodies take place;
- The links to other relevant processes;
- The delivery of training to ensure staff are aware of responsibilities;
- The development of staff support arrangements;
- The development of improvement plans linked to findings from reviews;
- The establishment of monitoring and oversight arrangements; and
- The completion of annual reports.

On the 27th November 2018 NHS D&G's DoC tracking system went live. This system will allow us to gather quantitative and qualitative data on incidents which trigger Duty of Candour. The Patient Safety and Improvement Manager on behalf of the organisation is required to submit an annual report to Scottish Government and this will include the number of DoC triggered within our organisation and our organisational response.

NHS D&G's Adverse Event System (DATIX) has been updated to ensure that incident investigators consider if DoC should be triggered, logging the reasons for the decision. An alert that a specific incident has triggered DoC will be automatically sent to the Adverse Events Team. An information box has also been added which lists what would trigger DoC should further clarification be needed. HS D&G's Adverse Event System (DATIX) has been updated to ensure that incident investigators consider if DoC should be triggered, logging the reasons for the decision. An alert that a specific incident has triggered DoC will be automatically sent to the Adverse Events Team. An information box has also been added which lists what would trigger DoC should further clarification be needed.

A similar process has been set up within Social Work which works within current complaints and Significant Occurrence procedures.

Within health any incidents triggering DoC are automatically sent to Patient Safety Group (PSG) for review, this group is chaired by the Executive Nurse or Medical Director. Incidents which were felt not to trigger DoC are reviewed by the Adverse Events Team to ensure that this was the correct decision, if it was felt not to be the correct decision this is taken to PSG for further review. PSG includes senior social work membership

NHS Dumfries and Galloway's (NHS D&G) Adverse Event Co-ordinator is currently delivering DoC awareness sessions within her Adverse Events Investigation Training and has delivered Development Sessions, which include discussion on DoC, to the organisations key contacts. At this time attendees are being asked to complete the online module in order to enhance their knowledge.

Link to duty of candour online module: (knowledge.scot.nhs.uk/dutyofcandour)

NHS D&G's Adverse Event Framework has been updated to reflect the new legislation brought in and this is in line with changes made to the national framework in summer 2018. The Adverse Events Framework is currently awaiting approval from the appropriate governance committees – following which it will be promoted and made available on Beacon intranet site.

4.3 Reporting

The Act also sets out clear reporting arrangements and outlines the need for annual reports to be prepared. Health and Social work must prepare and publish an annual report, as soon as reasonably practicable after the end of the financial year. The report must include:

- information about the number and nature of incidents to which the duty of candour procedure has applied;
- an assessment of the extent to which the organisation carried out the duty of candour;
- information about policies and procedures in relation to the duty of candour. This should include information about procedures for identifying and reporting incidents, support available to staff and support available to persons affected by incidents;
- Information about any changes to the responsible person's policies and procedures
- as a result of incidents to which the duty of candour has applied;
- other information identified as relevant;

When an organisation publishes a report, they must also notify:

- Healthcare Improvement Scotland, in the case of a report published by an organisation which provides an independent healthcare service (within the meaning of section 10F(1) of the NHS (Scotland) Act 1978);
- The Scottish Ministers, in the case of a report published by any other organisation
- which provides a health service; and
- The Care Inspectorate, in the case of a report published by an organisation which provides a care service or a social work service.

4.4 Governance Arrangements

Clear governance and reporting arrangements need to be established as part of implementation of this new Act, this will require the development of joint reporting processes with colleagues within the Health and Social Care partnership, NHS and Police Scotland in addition to organisation specific Governance arrangements.

It is proposed that leads from each of the organisations come together to explore how this might happen.

SECTION 2: COMPLIANCE WITH GOVERNANCE STANDARDS

5. Resource Implications

5.1. Time from each of the partners to come together and explore shared Governance arrangements.

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

6.1. Duty of Candour is a National priority backed up by legislation and enshrined in; *Outcome 7. People using health and social care services are safe from harm.*

7. Legal & Risk Implications

7.1. Implementation of Duty of Candour is a legal requirement as set out in the Health (Tobacco, Nicotine etc. And Care) (Scotland) Act 2016.

8. Consultation

8.1. NHS Performance Committee; Social Work Services Committee, Area Clinical Forum; NHS Healthcare Governance Committee.

9. Equality and Human Rights Impact Assessment

9.1. As this report does not propose a change in policy/strategy/plan/project, it is not necessary to complete an Impact Assessment.

10. Glossary

10.1.

DoC:	Duty of Candour
GM:	General Manager
HR:	Human Resources
NHS D&G:	NHS Dumfries and Galloway
PSG:	Patient Safety Group
QI:	Quality Improvement

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