Dumfries and Galloway
IJB Clinical and Care Governance Committee

21st April 2022

This Report relates to
Item 5 on the Agenda

Duty of Candour Annual Report 2020/21

Paper presented by Lillian Cringles/Ken Donaldson

For Approval/Discussion/Noting etc

Author:	Person who drafted the Report – Lillian Cringles, CSWO / Ken Donaldson
List of Background Papers:	n/a
Appendices:	**None**

1. Introduction

1.1 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).

2. Recommendations

2.1 **The IJB Clinical and Care Governance Committee is asked to**:

- note the outcome of the Annual reporting requirements in respect of the provisions for Duty of Candour as set out in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act).

3. Background and Main Report

3.1 Dumfries and Galloway Health and Social Care Partnership (HSCP) serves a population of just over 150 000. We cover a diverse geographical area, including small towns as well as rural areas. 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.

3.2 Dumfries & Galloway Council and NHS Dumfries and Galloway report separately via their respective governance arrangements on the statutory duty of candour. It is important that the Clinical & Care Governance Committee of the HSCP also receives assurance.

3.3 Within NHS D&G potential incidents which trigger the duty of candour are identified through the Adverse Event Management process.

3.4 Within Dumfries & Galloway Council Social Work Services potential incidents which trigger the duty of candour are identified through the Significant Occurrence process

3.5 An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. NHS Dumfries and Galloway report this to the NHS Board whilst Dumfries & Galloway Council report via the Social Work Services Committee.

D&G Council

3.6 Dumfries & Galloway Council Social Work Services advised that there has been no reported incidents during this reporting year 2020/2021 and the Annual Report was presented at Social Work Services Committee on 23 March 2022.

NHS D&G

3.7 In the last year, there were **50 incidents** where the Duty of Candour procedure was judged to apply. The table below sets out the number of incidents in each of the categories within Duty of Candour legislation guidance.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died *	14
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	21
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	3
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.	2
The person required treatment by a registered health professional in order to prevent:	
i.) The person dying or ii.) an injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	8
TOTAL	50

* *This figure includes 2 nosocomial Covid-19 HAI deaths – advice on whether these should be included is currently being sought from Scottish Government)*

3.8 It should be noted that some incidents reported in the period covered by this report are still open i.e. under investigation, and as such it may not be possible to say yet whether duty of candour applied.

3.9 29 of the cases listed have had the investigation completed and are now closed. 21 remain under investigation.

3.10 There are four elements to the procedure which are required to be considered and documented in Datix, our risk management system. The table below outlines the number and % of cases where we have this recorded. In 68% of cases all aspects of the procedure were enacted and recorded as such. It should be noted that there is an automatic function whereby relevant managers are notified but that this does not automatically populate the field on the duty of candour form.

Elements Completed			
Patient/Family Informed	Apology Offered	Recorded in Patient's Notes	Relevant Manager Notified
42 (84%)	40 (80%)	43 (86%)	39 (78%)

3.11 All incidents and complaints are reviewed during the investigation process to consider whether they trigger any of the duty of candour conditions. It may not be clear at the beginning of an investigation whether the incident was preventable or part of the natural disease progression which can result in a delay in confirming duty of candour and thus in informing patients and their families.

Impact of Covid 19

3.12 The overall number of adverse events reported dropped dramatically during April, May and June of 2020 as admissions and outpatient activity was curtailed. Normal reporting levels resumed from July 2020 onwards.

3.13 The capacity of clinical teams to undertake adverse event reviews within specified timeframes was significantly affected and has lead to a backlog of reviews.

3.14 Convening incident review meetings and meeting directly with people affected by adverse events has been challenging with virtual meetings taking the place of face to face meetings. Staff have tried to maintain contact with patients and their families but this has been more challenging this year.

3.15 All nosocomial Covid19 cases were subject to Incident Management Team (IMT) and/or significant adverse event review. Low numbers of confirmed cases prevents formal reporting of learning outcomes as the cases may be identified locally.

3.16 Reduced staffing within directorate and the corporate patient safety & improvement team due to redeployment and unfilled vacancies further disrupted and delayed full implementation of the procedure during the first half of this reporting period.

3.17 Last year we reported a number of changes to our procedure and systems for recording adverse events as well as changes to clinical processes following review of duty of candour events. These are now in place and include:

- A Learning Summary is produced and disseminated following all Significant Adverse Event Reviews where learning has been identified.
- Family feedback has enabled us to produce an information leaflet and standard letter templates to keep families informed throughout the investigation process. This is now incorporated into our framework but further work is required to ensure these are being used routinely.
- Our adverse event recording system has been updated and a prompt added for reporters and investigators to record whether Duty of Candour applies and if so what the trigger was. In addition confirmation is now sought when an incident is being closed that all required actions have taken place. We have recently purchased a dashboard module for our risk management system that will enable Directorate and the corporate team to view and track to ensure all required actions are completed.

Initial Case Review (ICR) & Significant Case Review (SCR)

3.18 Protecting children, young people and vulnerable adults is an inter-agency and inter-disciplinary responsibility. In Dumfries and Galloway, this responsibility sits with the Public Protection Committee (PPC). The Chief Officers' Group (COG) is responsible for deciding whether a Significant Case Review (SCR) is merited.
An SCR is a multi-agency process for establishing the facts of, and learning lessons from, a situation where a person has died or been significantly harmed or where opportunities to prevent harm were missed. SCRs should be seen in the context of a culture of continuous improvement and should focus on learning and reflecting on day-to-day practices, and the systems within which those practices operate.
Wherever possible, staff are involved in reviews and receive feedback when the review is finished.

3.19 In 2020/21, DG Social Work as part of the Public Protection Partnership (PPP) developed and agreed the Dumfries and Galloway "Conducting an Initial and Significant Case Review Guidance (Children and Adults)" bringing together separate national Guidance for children and adults into a local document.

3.20 For children during 2020/21 *"The National Guidance for Child Protection Committees for Conducting a Significant Case Review (2015)* (*The National Guidance)"* set out the criteria for establishing whether a case is significant. For

adults this was the *"Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (The Interim Framework)"*

3.21 In the reporting period, there were no ICR cases that were escalated for a decision to Chief Officers Group on whether an SCR was merited, and no SCRs were undertaken or concluded in Dumfries and Galloway.

4. Conclusions

4.1 We are confident that the partnership has the correct police and procedures in place to ensure we meet our statutory obligations

5. Resource Implications

5.1 Not applicable.

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

6.1 The Duty of Candour report contributes to all of the Nine National Health and Wellbeing Outcomes and reflects the priorities within the Strategic Plan.

7. Legal and Risk Implications

7.1 There are no legal or risk implications relating to this update paper

8. Consultation

8.1 This paper provides an update on current position. It does not require consultation

9. Equality and Human Rights Impact Assessment

9.1 An impact assessment is not required as this report does not propose a change to a policy, strategy, plan or project.

10. Glossary

HSCP	**Health & Social Care Partnership**
IMT	**Incident Management Team**
ICR	**Initial Case Review**
SCR	**Significant Case Review**
PPC	**Public Protection Committee**
COG	**Chief Officers Group**
PPP	**Public Protection Partnership**