Duty of Candour Report 2022/23

Final version approved by NHS Board on 12th February 2024

Final Duty of Candour Annual Report 2022-23

The data in the previous report provided to Healthcare Governance Committee in July 2023 (part of the 2022-23 Adverse Event Annual Report) was incomplete as not all Category 1 Significant Adverse Event Reports had been completed by 31st March 2023.

DUTY OF CANDOUR

The Board is required to produce and publish on our website a Duty of Candour Annual Report.

Duty of Candour is an integral part of our Adverse Event Framework and procedures.

In the reporting year from April 1st 2022 to March 31st 2023, there were 13 incidents reported where Organisational Duty of Candour applied. 11 of these have been closed and 2 remain pending final decision.

Number & Nature of Duty of Candour Incidents

The number & nature of Duty of Candour Incidents confirmed in 2022/23 is displayed in Table 2.

166 adverse event reported and closed in 2022/23 were reviewed to ensure that the guidance had been appropriately applied and the system was updated.

Duty of Candour may commence at the time of the incident but is officially enacted by Patient Safety Group when they commissioning a Significant Adverse Event Review (SAER) and confirmed at closure of SAER process.

Two cases reported in 22/23 remain open and therefore Duty of Candour has yet to be confirmed at case conclusion.

Table 2 - Duty of Candour Triggers

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died *	2
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	3
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	2
Changes to the structure of a person's body	0
The shortening of the life expectancy of the person	1
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.	1
TOTAL	*11*

There are four elements to the procedure which are required to be considered and documented in our Risk Management system. The table below outlines the number and % of cases where we have this recorded. It should be noted that the system (Datix) automatically informs managers but that ticking the correct box is a manual action.

Table 3 - Duty of Candour Elements

	Elements	**Completed**	
Patient/Family Informed	Apology Offered	Recorded in Patient's Notes	Relevant Manager Notified
10/11 (91%)	10/11 (91%)	11/11 (100%)	11/11 (100%)

Of Note:

- All 11 of the above cases were commissioned as Significant Adverse Event Reviews
- All elements of the Duty of Candour procedure were confirmed to have been applied in 10 of the above cases.
- In the one case where Patient/Family was not informed and no apology given this was a senior level management decision, based on the individual circumstances.
- The incidents spanned 10 different categories:
    - Pressure ulcer
    - Falls
    - Discharge/transfer/readmission
    - HAI
    - Obstetrics, incident involving baby
    - Patient observations
    - Self harm
    - Sudden illness/deterioration/collapse
    - Missed injury/diagnosis
    - Medication prescribing

Learning

Investigation of Duty of Candour incidents follows the same mechanism as other Significant Adverse Event Reviews with very similar contributing factors and learning themes identified.

All of the cases reviewed identify a number of factors/issues that contributed to the adverse event. These include factors that may be out with the control of the individual or the team on that day, on that shift or with the person concerned.

Factors relating to the environment, the task and the persons involved all interact to create error inducing conditions which most of the time our teams successfully navigate around. Common themes found in the Duty of Candour cases this year include:

- The cases were complex and involved multiple specialties
- Intra and inter team communication at the interface of care could have been better
- Documentation of care and investigations was not always clear nor easy to find

Involving people and their families and supporting them throughout the process has been strengthened this year with family contacts identified for the majority of cases.

Internal processes to ensure Duty of Candour is appropriately and comprehensively enacted have been strengthened this year which has improved our compliance with the act.

Plans for 2023/24

- Standardise recording and investigation processes across Directorates to ensure Duty of Candour is consistently identified, enacted and applied
- Patient Safety Group to strengthen their scrutiny of Duty of Candour Procedure when commissioning and reviewing Significant Adverse Event Review reports.
- Strengthen Learning System to ensure that we learn from each case and the themes emerging.
- We will review our Clinical Information systems to ensure they support clinical teams to access and record clinical information.