Appendix 1

Duty of Candour Annual Report 2023-24

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

In the reporting year from April 1st 2023 to March 31st 2024, there were 18 incidents reported where Organisational Duty of Candour was thought to apply. 11 of these have been closed with **6 confirmed as duty of candour** and 7 remaining open pending duty of candour confirmation. 5 incidents on review were assigned an outcome code of 1 and 2 (outcome codes described Appendix 2) and therefore did not trigger organisational DOC.

Number & Nature of Duty of Candour Incidents

The number & nature of Duty of Candour Incidents confirmed in 2023/24 is displayed in Table 2.

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

Three cases reported in 22/23 are now closed with an outcome code of 4, Duty of Candour was deemed to apply.

Table 2 - Duty of Candour Triggers

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died *	1
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	1
Changes to the structure of a person's body	0
The shortening of the life expectancy of the person	0
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.	1
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.	2
TOTAL	*6*

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
6/6 (100%)	6/6 (100%)	6/6 (100%)	6/6 (100%)

Of Note:

- All 6 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 all of the above cases.
- The incidents spanned 5 different categories:
  - non compliance with policy/guideline/protocol
  - Gynaecology incident
  - treatment problem
  - sudden illness/deterioration
  - slips, trips and falls

Learning

Investigation of Duty of Candour incidents follows the same mechanism as other Significant Adverse Event Reviews with 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:

- Pathways of care not always clear or accessible
- Intra and inter team communication at the interface of care could have been better
- Documentation of care including risk assessments was not always clear nor easy to find

Involving people and their families and supporting them throughout the process continued this year with family contacts identified for all of the cases.

Internal processes to ensure Duty of Candour is appropriately and comprehensively enacted continues to be effective which is demonstrated through sustaining 100% compliance with all duty of candour elements.

Plans for 2024/25

- Continue to keep up the good practice across Directorates to ensure Duty of Candour is consistently identified, enacted and applied
- Patient Safety Group continues to maintain the high level of scrutiny of Duty of Candour Procedure when commissioning and reviewing Significant Adverse Event Review reports.
- Promote Duty of Candour Turas training and include this in SAER training
- Continue to link and contribute with national programmes
- Strengthen Learning System to ensure that we learn from each case and the themes emerging.
- Develop the duty of candour form on our new risk management system 'In Phase', to ensure they support clinical teams to access and record clinical information.