THE STATE HOSPITALS BOARD FOR SCOTLAND

DUTY OF CANDOUR

ANNUAL REPORT

1 April 2020 – 31 March 2021

Lead Author	Stewart Dick – Risk Management Facilitator
Approval Group	Clinical Governance Committee
Responsible Officer	Dr Duncan Alcock – Associate Medical Director

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1 INTRODUCTION

The Health (Tobacco, Nicotine etc. and Care) Scotland Act 2016 ("The Act") introduced an organisational Duty of Candour on health, care and social work services. The Act is supplemented by the Duty of Candour Procedure (Scotland) Regulations 2018, which highlight the procedure to be followed whenever a Duty of Candour incident has been identified.

The State Hospitals Board for Scotland ("The Board") is fully committed to the provision of high quality health care in all aspects of its service provision to patients. As part of this objective, we have a duty to limit the potential impact of a wide variety of clinical and non-clinical risks. We do this by developing and implementing robust and transparent systems to ensure that all incidents, which may cause potential or actual harm, are identified, investigated and where appropriate action taken to prevent a recurrence.

Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients and the quality of our healthcare systems and provision.

However, when things go wrong (i.e. where there has been an unexpected 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) the focus of the Duty of Candour involves notifying the person (and/or relevant person) affected, apologising and offering a meeting to provide an account of what happened, reviewing the incident and offering support to those affected (e.g. those delivering and receiving care).

An important aspect of the Duty of Candour process is the provision of an Annual Report describing how the State Hospital has operated the "Duty of Candour" during the period 1 April 2019 to 31 March 2020.

2 STATE HOSPITAL

The State Hospital is one of four high secure hospitals in the UK. Located in South Lanarkshire in central Scotland, it is a national service for Scotland and Northern Ireland and one part of the pathway of care available for those with secure care needs. The principal aim is to rehabilitate patients, ensuring safe transfer to appropriate lower levels of security.

There are 140 high-secure beds (plus four beds for emergency use) for male patients requiring maximum secure care: 12 beds specifically for patients with an intellectual disability. A range of therapeutic, educational, diversional and recreational services including a Health Centre is provided.

3 POLICIES & PROCEDURES

All adverse events and near misses are reported through the State Hospital's risk management system (Datix), as set out within the Incident Reporting & Review Policy - RMO1. This system includes a section whereby staff can record if an adverse event has the potential to trigger a Duty of Candour incident. Consequently, through the Incident Reporting and Review process, together with the Duty of Candour Policy incidents that would trigger the Duty of Candour procedure will be identified.

Furthermore, all adverse events and near misses reported within the incident reporting system (Datix) are reviewed in accordance with the Incident Reporting & Review Policy - RMO1 to understand what happened and to establish if there is action that can be taken to prevent/ minimise a recurrence and/or improve patient care.

Within the State Hospital there are two levels of review:

- Local (standard) Review - undertaken for all incidents reported on Datix by the line manager, person responsible for the area where the incident occurred or by a nominated expert relevant to the issue in question; and

- Enhanced Review – following local review and grading of an incident further review may be necessary to establish the root cause of the incident.

4 TRAINING

Members of staff responsible for inputting incidents onto Datix and for reviewing incidents receive training on the use of the Datix reporting system. During the previous year registered clinicians have been targeted with regard to undertaking Duty of Candour Learnpro e-learning training.

Duty of Candour Learnpro e-Learning Training						
Group	**Total Within Target Group**		**Number Completed Module**		**% Uptake**	
Year	**2019/20**	**2020/21**	**2019/20**	**2020/21**	**2019/20**	**2020/21**
Registered Practitioners	286	290	278	280	97%	97%
Non-Registered Practitioners	156	140	152	139	97%	99%
Total	442	430	430	419	97%	97%

The proposed Training Plan for 2020-21 targeted all front-line clinical staff with regard to completion of the Duty of Candour e-learning module. The table shows 97% of staff required to complete this module have completed it, matching the previous year target which has been consistently high.

5 DUTY OF CANDOUR – GOVERNANCE & MONITORING

The Duty of Candour Group, which reports to the Senior Management Team monitors activity relevant to the Duty of Candour process and comprises of the following members:

- Associate Medical Director **(Chair)**
- Clinical Operations Manager
- Lead Consultant Forensic Clinical Psychology
- Lead AHP
- Head of Social Work
- Head of Corporate Planning and Business Support
- Risk Management Team Leader/Facilitator

The Risk Management Department, on behalf of the Group monitor the incident reporting system on a weekly basis and report all potential incidents to the Group for consideration and action, where required. Furthermore, the following information sources are also utilised in order to identify potential Duty of Candour incidents:

- Enhanced (Level 1 & 2) Incident Reviews;
- Complaints;
- Patient incidents reported to the Health & Safety Executive as RIDDOR;
- 24-hour Security Report;
- Whistleblowing;
- Adult Support & Protection Referrals; and
- Child Protection/Contact Issues

The Duty of Candour Group ensure all incidents meeting the Duty of Candour criteria are investigated in line with Scottish Government guidance and timescales and action taken, where required to prevent/minimise a recurrence. The Group meet on a monthly basis (or more frequently, if required) to discuss potential Duty of Candour incidents. During the period 1 April 2019 to 31 March 2020 the Duty of Candour Group met on 12 occasions.

6 DUTY OF CANDOUR - INCIDENTS

Between 1 April 2020 and 31 March 2021 the Risk Management Department forwarded 63 incidents for consideration by the Duty of Candour Group, up from 43 in the previous year. None of the incidents fulfilled the criteria for Duty of Candour, i.e. an unintended or unexpected act incident that resulted in death or harm, as defined within the Act, and did not relate directly to the natural course of a person's illness or underlying condition.

The outcomes are:

(a) the death of the person,

(b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm"),

(c) harm which is not severe harm but which results in—

(i)an increase in the person's treatment,

(ii)changes to the structure of the person's body,

(iii)the shortening of the life expectancy of the person,

(iv)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,

(v)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.

Duty of Candour Incidents	2018/2019	2019/2020
Considered	43	63
Confirmed	1	0

In the last year, how many incidents did the duty of candour procedure apply?

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

6.1 Duty of Candour Procedure

No incidents required the procedure to be followed.

6.2 What has changed as a result?

No incidents required any changes to take place.

7 Duty of Candour – Provision of Support

In line with the expectations of all staff regardless of the cause or outcome of any Incident, patients and/or relevant persons will be provided with all reasonably practical support necessary to help overcome the physical, psychological and emotional impact of such an incident. This includes:

- Treating the patient and/or relevant person with respect, consideration and empathy;
- Offering the patient the option of direct emotional support during any notification of an "Incident (e.g. from a family member, a friend, a care professional or a trained advocate;

- Offering access to assistance with understanding what is being said, e.g. through interpreting services, non-verbal communication aids, written information, etc;
- Providing access to any necessary treatment or care to recover from or minimise the harm caused by the adverse event, where appropriate; and
- Providing information about available impartial advocacy and support Services

When an Incident occurs, members of staff involved in the patient's clinical care may also require emotional support and advice. Any members of staff who have been directly involved in the incident and those with the responsibility for undertaking the Review process and communicating with the patient and/or relevant person should be given access to assistance, support and necessary information, where required.

To support staff involved in Incidents, the following arrangements are in place within the State Hospital:

- A 'fair blame and open' culture that discourages the apportion of blame and, following adverse incidents, focuses on "what went wrong" and what can be done to prevent a recurrence;
- De-briefing arrangements are in place for members of staff involved in patient safety incidents; and
- Counselling and support services are available via the Occupational Health Service

8 COVID-19

As a result of the COVID-19 pandemic the duty of candour procedure involved switching face to face meetings to meetings occuring remotely.

There was no impact as a result of COVID-19 on reviewing any potential duty of candour cases.

There were no times when the duty of candour procedure was activated whether due to COVID-19 or otherwise during this review period.

As there were no duty of candour procedures activated during this review period there was no impact from COVID-19 in involving the relevant persons.

Should a duty of candour procedure be activated in relation to COVID-19 then a person centred approach would be adopted to ensure that individuals are actively involved in the process.

In terms of learning switching to remote meetings has been more efficient than relying on face-to-face meetings previously. We have not encountered any specific issues unintended or otherwise in relation to the process and COVID-19.

9 FURTHER INFORMATION

The Duty of Candour Policy highlights the responsibilities of staff and the procedure to be followed when undertaking the Duty of Candour process can be found on the intranet.

As required, this is report is available on The State Hospital website.

If you would like further information about this report please contact us using the following contact details:

Associate Medical Director
The State Hospitals Board for Scotland
Carstairs
ML11 8RP

tsh.info@nhs.net