Glasgow City Health and Social Care Partnership
Report on Duty of Candour
2018 to 2023

Report Contents

Introduction

The statutory 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). The Duty of Candour (Duty of Candour) legislation became active from 01 April 2018.

Organisations are required to apologise and to meaningfully involve patients and families in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen. An important part of this duty is that Glasgow City Health and Social Care Partnership provide an annual report about how the Duty of Candour is implemented in our services.

This report describes how Glasgow City Health and Social Care Partnership has operated the Duty of Candour during the time between 1 April 2018 and 31 December 2023. The statutory organisational duty of candour has been developed to be in close alignment with the requirements of the professional duties of candour.

Duty of Candour means that every health and social care professional must be open and honest with patients and people using their services when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- 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.

The organisation records and reviews whenever the patient or family was not informed to ensure Glasgow City Health and Social Care Partnership fully meet the policy principles. Professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns. The legislation requires that Glasgow City Health and Social Care Partnership must also publish a Duty of Candour annual report.

About Glasgow City HSCP

Glasgow City Health and Social Care Partnership is the integrated planning and delivery of all community health and social care services on behalf of Glasgow City Council and Greater Glasgow and Clyde NHS. The Partnership is directed by the

Glasgow City Integration Joint Board (IJB). Glasgow City Health and Social Care Partnership provide services for Children, Adults and Older People, along with Homelessness and Criminal Justice services.

The Partnership comprises of around 12,000 Social Work (Glasgow City Council) and Health (NHS Greater Glasgow and Clyde) staff. It is led by an integrated Executive Leadership and Senior Management Team, and it provides services through the three localities of North East, North West and South and directly provided day, home and residential care. Services are also delivered through Health and Social Care contractors and providers. Some services cover the wider NHS Greater Glasgow and Clyde Health Board area (for example, sexual health services).

Incidents to Which Duty of Candour Applies

Table 1 – cases which Duty of Candour applies

	Number of Times an incident has happened					
Type of Unexpected or Unintended Incident	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Someone has died	12	11	12	11	7	
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions			1		1	
Someone's treatment has increased because of harm	1			3	3	
The structure of someone's body changes because of harm						
Someone's life expectancy becomes shorter because of harm						
Someone's sensory, motor or intellectual functions is impaired for 28 days or more						
Someone experienced pain or psychological harm for 28 days or more	1			1		
A person needed health treatment in order to prevent them dying						
A person needing health treatment in order to prevent other injuries						
Total	14	11	13	15	11	Nul
Was Duty of Candour followed	Yes	Yes	Yes	Yes	Yes	

*Apologies were not given in 7 cases where a person died due to being unable to contact family - those cases were 2018 - 2 cases, 2019 -1 case 2020 - 2 cases 2021 - 1 case and 2022 - 1 case

There were a total of 64 cases across the years 2018 to 2023.

Compliance with Duty of Candour Procedures

Year	Cases	Was Duty of Candour followed	Exceptions
2018	14	Yes	2 cases where apology wasn't given as family could not be contacted
2019	11	Yes	1 case where apology wasn't given as family could not be contacted
2020	13	Yes	2 cases where apology wasn't given as family could not be contacted
2021	15	Yes	1 case where apology wasn't given as family could not be contacted
2022	11	Yes	1 case where apology wasn't given as family could not be contacted
2023	Nul	n/a	

All Duty of Candour cases were subject to a Serious Adverse Event Review (SAER) where actions are identified for improvements, actions are then monitored for implementation. SAERs and Duty of Candour remain open until all actions have been completed satisfactorily.

Policies and Procedures

Duty of Candour is informed by the requirements set out in The Duty of Candour procedure, and regulations in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) implemented in April 2018.

Guidance and procedures on organisational duty of candour are available by following the link.

GCHSCP staff access training via NHS Education Scotland (NES), training platform, Turas and the NHS training platform LearnPro.

GCHSCP will also host the training on the Glasgow City Council learning platform GOLD and will develop more comprehensive practice guidance for staff, particularly within the social care side of the HSCP.

Improvements Implemented as a Result of Duty of Candour

The following are a few examples of where learning has occurred via a Duty of Candour event and practice has been changed as a result or more learning has been implemented.

Various improvements were implemented as a result of Duty of Candour such as:

- Local improvements have been implemented within the Public Dental Service after an event. Contributory factors identified included poor clinical handover, a lack of confidence in challenging the treatment plan provided by a senior

member of staff, and limited access to clinical notes. The first improvement is an update to the induction for Core Trainee (CT) dentists. The induction process now includes difficult discussions with senior staff, as well as guidance on the Duty of Candour process. The second improvement relates to dentists' preparation and communication prior to treating a patient. This includes allocating adequate time to review clinical records prior to treatment and providing a full handover if another dentist is asked to provide care to a patient they have not seen previously.

- GG&C Board Wide actions been implemented relating to the care of children with complex needs. These improvements include:
    - Lead Health Professional (LHP) introduced to co-ordinate healthcare plans and contribute to multi-agency process (e.g. Child Protection), where required.
    - Children's Health Services Complex Care Management Protocol introduced which includes the use of TAC (Team around the Child) meetings across all areas of Health.
    - Assessment of Care toolkit implemented for all agencies to help assess and support families where neglect is a concern.
    - Child protection discussion and the use of significant events within a child's chronology now a standard practice within supervision and caseload management for Allied Health Professionals (AHPs).
    - The 'Was Not Brought' Policy developed and implemented which replaced the 'Unseen Child/Young Person' Policy
- Ordering and Set up of bedrails and mattresses in service user/ patient homes
    - Training for ordering and set up of pressure relieving mattresses
    - Adapt acute bedrail guidance for use in community – raise awareness of guidance within the community staff group
    - District Nurses must remain in the service user/patient's home until replacement mattress is fully inflated, adjust settings and assesses the ability of the patient to get in and out of their bed independently or with assistance.
    - Update service user/patients notes with transfer information
    - HSCP bedrail and mattress assessment training was updated
    - All DNs attended refresher training
    - Develop specific SOP and Risk Assessment
- Community Mental Health Teams
    - Review of screening allocations SOP
    - Change in the language and process for screening allocations to allow for prioritisation and downgrading if required
    - Include communication with NOK in any changes to prioritisation
- Homelessness Addictions Teams
    - Process implemented to review care plans and risk assessments 4 weekly
    - An audit of risk assessment training was completed and updates for staff training provided
    - Update staff group on the cover provided to the team and service users from psychiatry services
- Community Nursing Teams

- All staff must complete annual pressure ulcer training
- All staff must complete competency framework following training/refresher training