Item No. 19

Meeting Date **Wednesday 11th September 2024**

Glasgow City Integration Joint Board Finance, Audit and Scrutiny Committee

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Duty of Candour

Purpose of Report:	The purpose of this report is to inform the IJB Finance, Audit and Scrutiny Committee about Duty of Candour cases identified within Glasgow City Health and Social Care Partnership and of the requirements for annual reporting to the Scottish Government.

Background/Engagement:	In February 2018 The Duty of Candour Procedure (Scotland) Regulations 2018 was introduced. In July 2018 a paper was submitted to the Integration Joint Board(IJB) to provide the IJB Performance Scrutiny Committee (at that time) with an overview of the legal duty applying to health and social care services. This was effective from 1st April 2018 with recommendations made to future development and administrations of the process. This process was delayed due to the HSCP response to the COVID-19 pandemic and a report went to the Senior Management Team meeting on 7th August 2024 to agree actions and next steps.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐

	Not Applicable ☐

Recommendations:	The IJB Finance, Audit and Scrutiny Committee is asked to: a) note the content of the report; b) note the draft report to the Scottish Government (Appendix 1); and c) note the next steps to ensure robust reporting and monitoring.

Relevance to Integration Joint Board Strategic Plan:
This is a legislative requirement of the HSCP and is required to enable the HSCP to fulfil its duties outlined within the strategic plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Outcomes 3, 7 and 8 – improve service user experience, protect from harm, support continuous improvement.
Personnel:	None
Carers:	None
Provider Organisations:	Provider organisations have their own responsibility to report and follow duty of candour legislation.
Equalities:	None
Fairer Scotland Compliance:	None
Financial:	None
Legal:	The Duty of Candour Procedure (Scotland) Regulations 2018 is part of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Risk Implications:	Failure to comply with duty of candour would be a failure of GCHSCP to fulfil its legislative duties.
Implications for Glasgow City Council:	Duty of Candour applies to Glasgow City Council delegated services provided by Glasgow City Health and Social Care Partnership. There are implications for risk and claims management.

Implications for NHS Greater Glasgow & Clyde:	Duty of Candour applies to NHS Greater Glasgow &Clyde delegated services provided by Glasgow City Health and Social Care Partnership. There are implications for risk and claims management.

1. Purpose

1.1. The purpose of this report is to inform the IJB Finance, Audit and Scrutiny Committee about Duty of Candour cases identified within Glasgow City Health and Social Care Partnership and the requirements for annual reporting to the Scottish Government.

2. Background

2.1 In February 2018 The Duty of Candour Procedure (Scotland) Regulations 2018 was introduced and relates to unintended / unexpected events that have, in the opinion of a registered health professional, resulted in death, serious harm lasting 28 days or more, or intervention required to prevent either of these outcomes. It should be the opinion of a registered health professional that the incident itself, rather than an underlying condition, has caused the outcome.

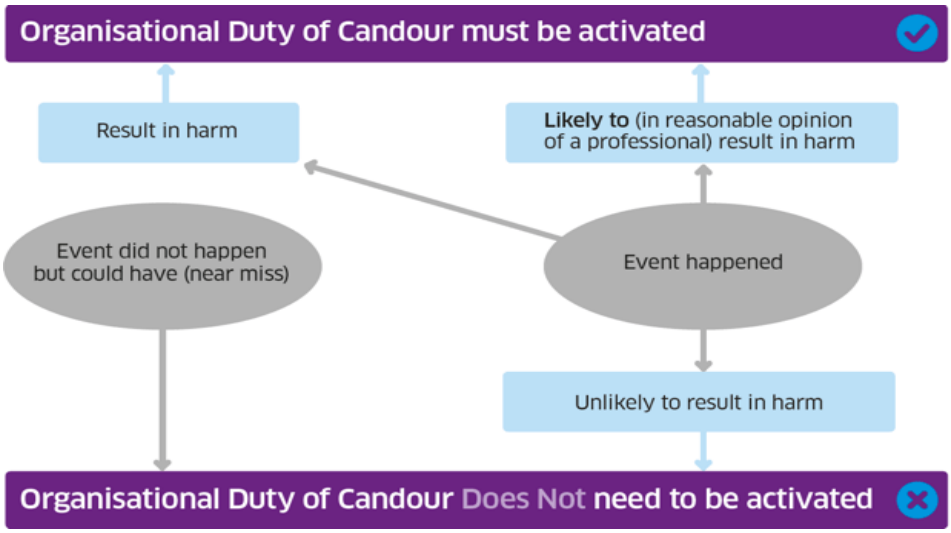
2.2 When an incident that meets the Duty of Candour definition occurs, health and care providers are required to:

- Notify the person affected or their family.
- Apologise.
- Report the incident.
- Review related processes.
- Involve the person affected or their family in the process, with meetings and opportunity to ask questions and provide views.
- Provide a written account of the review outcome to the person or their family.

2.3 Each organisation providing health and social care should also compile a monitoring process to enable annual reporting of:

- Number of incidents.
- Degree to which duties were discharged.
- Changes in policy and procedures resulting from incident.
- Support to staff and individuals affected.

2.4 Comprehensive guidance is available from the Scottish Government relating to fulfilling organisational Duty of Candour. A chart below demonstrates in what circumstances organisational Duty of Candour should be followed.



2.5 In July 2018 a paper was submitted to the Integration Joint Board (IJB) to provide the IJB Performance Scrutiny Committee (at that time) with an overview of the legal duty applying to health and social care services with effect from 1st April 2018, and to make recommendations as to future development and administrations of the process.

2.6 Due to business continuity arrangements during the pandemic, further actions were not implemented, and the item was tabled again in July 2022 at the Social Work Professional Governance Board to agree next steps and actions.

3. Requirements

3.1 In 2018 the Scottish Government established a reporting and monitoring subgroup to define how annual Duty of Candour reports should be structured, presented, and monitored.

3.2 The group comprised of representatives from the Care Inspectorate, Healthcare Improvement Scotland, Scottish Care, Coalition of Care and Support Providers Scotland, NHS National Services Scotland, and a number of health boards.

3.3 The guiding principles from this group state:

- The system of monitoring should be proportionate.
- There should be no unnecessary duplication with existing approaches.
- There should be interoperability across the health and social sectors – especially around language – so that sector-wide conclusions can be easily drawn by monitoring bodies.
- The system of monitoring should itself be capable of being evaluated.
- There should be a person-centred approach across the pathway of care to ensure that reports focus on the experiences of people, not just processes.

3.4 Reporting should occur annually and include nil reports and in the suggested report format shown below:

Type of Unexpected or Unintended Incident	Number of Times Incident has Happened
Someone has died	
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	
Someone's treatment has increased because of harm	
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	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries	

3.5 Officers in Business Development were tasked by the Chief Social Work Officer with reviewing Duty of Candour cases within the Partnership and making recommendations for the recording and monitoring of future cases.

3.6 Each organisation must produce an annual report outlining the Duty of Candour cases for the previous year and this report must be publicly available.

3.7 A report through the IJB Finance, Audit and Scrutiny Committee would meet this criterion for Glasgow City Health and Social Care Partnership.

3.8 When reports have been published, a notification must be made to the Scottish Ministers.

3.9 The Scottish Government report should cover:

- Background information about the reporting body.
- How many incidents happened to which Duty of Candour applies?
- To what extent the Duty of Candour process was followed for each of the incidents.
- Information about our policies and procedures surrounding Duty of Candour.
- What changes were put in place following the incident(s)?
- Any other information.

4. Legal

4.1 Legal advice was sought from the Glasgow City Council legal team who advised that the apology provided in Duty of Candour processes is excluded from the Apologies (Scotland) Act 2016, therefore is admissible in civil proceedings as the actual duty is to offer an apology. The Legal advice to offer

an apology, and only provide one if that offer is accepted seeking advice from Legal as to content of the apology.

4.2 As the guidance and policy is a national legislative requirement, there is no need for us to draft our own policy however some guidance and procedure for internal processes should be provided.

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5 Review of Retrospective Cases

5.1 Cases were reviewed across the Health and Safety system (HandS). This is the system that social work use to record, monitor and track all health and safety incidents for staff and users of the services and facilities. From this review some cases were identified, and Heads of Service asked to review against the Duty of Candour thresholds. None of the cases were found to be eligible.

5.2 Further cases were identified by reviewing Stage 2 complaints. These are complaints that have been escalated due to their severity, or where a resolution has not been found with initial complaint handling procedures. Several cases were identified, and these cases should they have met Duty of Candour then should have been identified prior to starting a complaint procedure.

5.3 Learning Reviews (LR) are managed by a Multi-Agency Learning Review Panel who decide which cases should be subject to the learning review procedures. The panel is made up of a range of public protection agencies, and cases reviewed are from a range of providers and services. The LR Panel screen cases and make recommendations as to whether a review should be completed. Timescales for the review and recommendations are then monitored by the panel and what outcomes have been delivered. The panel can provide support to resolve issues with completing the review. As such Duty of Candour should be considered well before this stage and it is difficult to extract cases that would be the responsibility of the Partnership to report and follow Duty of Candour process due to the multi agency nature of the Panel and its referrals.

5.4 However as part of the review process, many of the processes for a Duty of Candour case are carried out, such as liaising with the patient / their family, learning from outcomes, and potentially improving service's approach to care provision.

5.6 Claims against Glasgow City Council were also included in the review however, when investigated it transpired that all claims are linked to a HandS report or complaint procedure so there would be no additional cases identified via this route.

5.7 NHS Greater Glasgow and Clyde cases are identified from Datix (the NHS GGC incident recording system) and are logged as the result of being identified as a complaint or Serious Adverse Event Reviews (SAERs). There is an NHS Greater Glasgow & Clyde policy where all incidents are rated with a 1-5 severity rating. The Chief Nurse reviews all cases that warrant a level 4 and 5 rating. Cases potentially identified as a SAER go through various incident review, governance, and quality assurance groups before being classed and reported as a SAER. Duty of Candour is captured as part of this process. SAERS are all shared with patients / and or their families and learning is

shared and promotes service improvements. A summary of the cases identified can be found in the table below:

	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						
Was Duty of Candour followed	Yes	Yes	Yes	Yes	Yes	n/a

Table 1 Duty of Candour Reportable Cases from SAERs

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

5.8 All NHS Greater Glasgow & Clyde complaints are logged on Datix with a function to tick Duty of Candour, so there would be no additional cases identified that aren't in the reporting above.

6 Commissioning

6.1 It is the responsibility of the provider to report on Duty of Candour. However good practice would be ensuring that there is a mechanism in place for Commissioning to be alerted of any cases identified as Duty of Candour by the Partnership's providers for quality assurance.

7 Next Steps

7.1 The retrospective scoping work suggests that there is a potential risk of underreporting of cases within Social Work services, particularly for the cases not resulting in a fatality. This could be due to a lack of understanding of the full application of the Duty of Candour legislation or no robust process to examine events and learn from them. These cases can be identified via a myriad of routes and there isn't a governance route to examine incidents at an early stage to determine if Duty of Candour applies. Also, not all Duty of Candour cases could result in a HandS report, a Stage 2 investigation, or a learning review. The governance process within NHS services should be considered for replication to ensure consistency and accurate reporting.

7.2 The Partnership is obliged to report and publish where cases have been identified and inform Scottish Government that the report is available. The report is available in Appendix 1.

7.3 Good practice would be to ensure that refresher training is put in place for frontline services. Officers are considering an option to adapt existing training, including a certificated tutorial created by NES, Scottish Social Services Council, the Care Inspectorate and Healthcare Improvement Scotland, to add to the Council's online learning platform.

7.4 Officers are developing a robust process to monitor and log cases as they occur throughout the year, and it would be the duty of the Chief Social Work Officer to keep such a log.

8 Recommendations

8.1 The IJB Finance, Audit and Scrutiny is asked to:

a) note the content of the report;
b) note the draft report to the Scottish Government (Appendix 1); and
c) note the next steps to ensure robust reporting and monitoring.

Appendix 1 – Duty of Candour Report from Glasgow City Health and Social Care Partnership to Scottish Government for 2018 to 2023.

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

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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 1st 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 1st April 2018 and 31st 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	Nil
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 was a total of 64 case 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 cases were subject to a Serious Adverse Event Review (SAER) where actions are identified for improvements, actions are then monitored for implementation. SAERS 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

Various improvements were implemented as a result of SAERs such as:

- Local improvements have been implemented within the Public Dental Service after an event. Contributory factors identified include 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 have 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