NHS Dumfries & Galloway

DUTY OF CANDOUR ANNUAL REPORT 2020/2021

Prepared by Patient Safety and Improvement Team

Approved by Healthcare Governance Committee on behalf of NHS Dumfries and Galloway Health Board on 13th September 2021

Duty of Candour – NHS Dumfries and Galloway

1. Introduction

NHS Dumfries and Galloway (NHS D&G) serves a population of just over 150 000. We cover a diverse geographical area, including small towns as well as rural areas. Our aim is to provide high quality care for every person who uses our services and where possible help people to receive care at home or in a homely setting.

All health and social care services in Scotland have a statutory duty of candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

Within NHS D&G potential incidents which trigger the duty of candour are identified through the Adverse Event Management process.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This report describes how NHS D&G has operated the duty of candour during the time between 1 April 2020 and 31 March 2021. We hope you find this report useful.

2. Number & Nature of Duty of Candour Incidents

In the last year, there were **50 incidents** where the Duty of Candour procedure was judged to apply. The table below sets out the number of incidents in each of the categories within Duty of Candour legislation guidance.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died *	14
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	21
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	3
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.	8
TOTAL	50

* This figure includes 2 nosocomial Covid-19 HAI deaths – advice on whether these should be included is currently being sought from Scottish Government)

It should be noted that some incidents reported in the period covered by this report are still open i.e. under investigation, and as such it may not be possible to say yet whether duty of candour applied.

29 of the cases listed have had the investigation completed and are now closed. 21 remain under investigation.

There are four elements to the procedure which are required to be considered and documented in Datix, our risk management system. The table below outlines the number and % of cases where we have this recorded. In 68% of cases all aspects of the procedure were enacted and recorded as such. It should be noted that there is an automatic function whereby relevant managers are notified but that this does not automatically populate the field on the duty of candour form.

Elements Completed			
Patient/Family Informed	Apology Offered	Recorded in Patient's Notes	Relevant Manager Notified
42 (84%)	40 (80%)	43 (86%)	39 (78%)

All incidents and complaints are reviewed during the investigation process to consider whether they trigger any of the duty of candour conditions. It may not be clear at the beginning of an investigation whether the incident was preventable or part of the natural disease progression which can result in a delay in confirming duty of candour and thus in informing patients and their families.

3. Policies and Procedures

Unintended or unexpected incidents that may require activation of the duty of candour procedure are indentified through our adverse event management system. Adverse events are reported through our local reporting system (Datix) as set out in our adverse event management policy. Through our adverse event management process we identify incidents that trigger the duty of candour procedure. Adverse events are sometimes picked up through our complaints process. Our adverse event management policy contains a section on implementing the duty of candour.

Each adverse event is reviewed to understand what happened, why it happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. All significant adverse events are reviewed by the Executive chaired Patient Safety Group (PSG) to determine level of review. Level 1 Significant Adverse Event Reviews are commissioned by and report back to the PSG.

Recommendations are made as part of the adverse event review, and Directorate management teams develop improvement plans to meet these recommendations. They share their wider improvements plan with the PSG.

Training on adverse event management and implementation of the duty of candour is available for staff to access, to ensure they understand when it applies and how to trigger the duty. Additional online training and guidance is also available and for those who are our key risk contacts in the Directorates we provide development

sessions. The uptake of training for the period covered by this report was much reduced but staff could and did access professional advice from the Patient Safety & Patient Services teams.

All regulated healthcare professionals have a personal duty of care which includes:

- A duty to be open and honest with patients in your care, or those close to them, if something goes wrong. This includes offering an apology
- A duty to be open and honest with your organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure, through the practice of 'hot debriefs' as well as through occupational health. A focus on staff wellbeing has extended the offer of pastoral support and psychological therapy to all staff.

People who are affected by unintended or unexpected incidents are supported primarily by clinical and care staff, and where appropriate by senior managers with support from Patient Safety & Patient Services Team.

4. Impact of Covid 19

The overall number of adverse events reported dropped dramatically during April, May and June of 2020 as admissions and outpatient activity was curtailed. Normal reporting levels resumed from July 2020 onwards.

The capacity of clinical teams to undertake adverse event reviews within specified timeframes was significantly affected and has lead to a backlog of reviews.

Convening incident review meetings and meeting directly with people affected by adverse events has been challenging with virtual meetings taking the place of face to face meetings. Staff have tried to maintain contact with patients and their families but this has been more challenging this year.

All nosocomial Covid19 cases were subject to Incident Management Team (IMT) and/or significant adverse event review. Low numbers of confirmed cases prevents formal reporting of learning outcomes as the cases may be identified locally.

Reduced staffing within directorate and the corporate patient safety & improvement team due to redeployment and unfilled vacancies further disrupted and delayed full implementation of the procedure during the first half of this reporting period.

5. What has changed as a result?

Last year we reported a number of changes to our procedure and systems for recording adverse events as well as changes to clinical processes following review of duty of candour events. These are now in place and include:

- A Learning Summary is produced and disseminated following all Significant Adverse Event Reviews where learning has been identified.
- Family feedback has enabled us to produce an information leaflet and standard letter templates to keep families informed throughout the investigation process. This is now incorporated into our framework but further work is required to ensure these are being used routinely.
- Our adverse event recording system has been updated and a prompt added for reporters and investigators to record whether Duty of Candour applies and if so what the trigger was. In addition confirmation is now sought when an incident is being closed that all required actions have taken place. We have recently purchased a dashboard module for our risk management system that will enable Directorate and the corporate team to view and track to ensure all required actions are completed.

6. Conclusion & Next Steps

This is the third year of the duty of candour being in operation and we had hoped to see significant improvement in our adherence and enactment of the procedure. It has been a very challenging year with much disruption to service provision, staff working in other roles and under significant pressure.

Ensuring that staff understand the requirements of the duty of candour legislation and the requirement to document that the actions have been taken are key areas that we will continue to address in the year ahead. We plan to add a forcing function to our adverse event management system.

Understanding that, in some cases it is not immediately apparent that an incident triggers duty of candour, had been learning for us and meant that patients and their families waited longer than we would have anticipated to be informed, to be offered an apology and to be invited to participate in the review process. This year we have noted an increase in the number of incidents where duty of candour has been identified but later at the conclusion of the investigation found not to apply.

Much of what we have learned has been case or team specific but we have where it was appropriate to do so shared the themes and learning beyond the teams immediately involved via Learning Summaries and educational events.

There is much for us to build on in the year ahead to ensure that patients, their families and our staff are supported when things go wrong and that we continue to strive to keep people safe, well and free from harm when they are in our care.

If you would like more information about this report, please contact us using these details: maureen.stevenson3@nhs.scot