Duty of Candour Annual Report 2021/2022

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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 2021 and 31 March 2022.

2. Number & Nature of Duty of Candour Incidents

In the last year, there were **42 incidents** where the Duty of Candour procedure was judged to apply. **32** of the cases have been investigated and are now closed, 10 remain under investigation.

The table below refers only to closed incidents and 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 *	3
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	23
The shortening of the life expectancy of the person	5
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:	2
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.	
TOTAL	34

It should be noted that 10 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 conclusively whether duty of candour applied.

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.

Elements Completed			
Patient/Family Informed	Apology Offered	Recorded in Patient's Notes	Relevant Manager Notified
32 (100%)	26 (81.25%)	30(93.75%)	32(100%)

Our clinicians offer an apology when an incident occurs as per their professional duty but are not always recording this at the conclusion of the investigation, we are working to address this.

It should be noted that there is an automatic function whereby relevant managers are notified and at the conclusion of Significant Adverse Event Reviews it is recorded on the report.

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. Adverse events may be 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.

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.

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.

4. Covid 19

Revised guidance from Scottish Government indicates that all hospital acquired (nosocomial) cases of Covid 19 should be treated as a Healthcare Acquired Infection and be subject to the same reporting, investigation and Duty of Candour legislation.

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

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:

- Within our mental health directorate a Learning Summary is produced and disseminated following all Significant Adverse Event Reviews where learning has been identified.
- We are testing a debrief meeting for all staff who have been involved in an adverse event.
- Our adverse event recording system has been updated and our duty of candour section now has a forcing function to ensure mandatory fields are completed.
- The dashboard reporting module is established and used by all directorates to view and track DOC cases to support them in ensuring all required actions are completed.
- Recording and communication of severe anaphylactic reactions has been improved as a result of a specific incident regarding a medication error.
- Medication stock control issues were highlighted in another case with action taken to improve communication between prescribers and those responsible for ensuring adequacy of stock levels.

6. Conclusion & Next Steps

This is the fourth year where Duty of Candour has applied in Scotland and we are beginning to see improvements in the recording of all elements of the procedure.

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 will ensure that when Significant Adverse Events are concluded and closed that the information is recorded in patients notes and on our adverse event 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