APPENDIX 1

Duty of Candour Annual Report

1st April 2021 – 31st March 2022

Approved: Clinical and Care Governance Group
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Background

All health and social care services in Scotland have a 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.

An important part of this Duty is that an annual report is produced about how the duty of candour is implemented in services. This short report shows how Health and Social Care Moray has operated the Duty of Candour (DoC) during the time between 1st April 2021 and 31st March 2022.

About Health and Social Care Moray

Health and Social Care Moray (HSCM) is an integrated health and social care partnership working under the direction of the Moray Integration Joint Board (MIJB). Moray has a population of approximately 95,000 (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Moray Integration Joint Board (MIJB) was established in February 2016 and became operational as of 1 April 2016. It has responsibility for the planning and delivery of all community based adult health, and social care services within Moray. In addition MIJB has strategic planning responsibilities in respect of emergency care and it also hosts those pan Grampian services relating to the out of hours, Grampian Medical Emergency Services (GMED) and Primary Care Contracts who are responsible for all contractual arrangements for the 4 Contracted Services (General Practice, Community Pharmacy, Optometrists and Dentists).

Most people live in the natural communities/main towns of Elgin, Lossiemouth, Buckie, Forres and Keith. Other smaller communities are also scattered throughout Moray e.g. Hopeman, Burghead, Cullen and Aberlour, Dufftown, Fochabers, and Tomintoul in remote and rural locations.

Three community hospitals exist in Moray in the towns of Buckie, Dufftown and Keith providing 51 inpatient beds in total delivering a range of acute and intermediate care services for local areas. Community health and social care services are built around the community hospitals with community based teams co-located where possible.

Adverse Events Reporting and Duty of Candour Process

HSCM identify DoC incidents through Datix – NHS Grampian's adverse event management process. Through the significant adverse event review process any factors that may have caused or contributed to the event are established, which helps to identify DoC incidents.

At present, consideration as to whether the Duty should be triggered is requested for all adverse events where a patient is the person affected, the event resulted in harm and the event was reported on or after 1st April 2019. In all instances where the

criteria are met it is mandatory to record whether the event triggers the Duty, the person who made the decision and the rationale for the decision. If it is decided that the Duty is not triggered, there are no further changes to the information required to be recorded on Datix. Where it is decided that the Duty has been triggered, additional sections and questions will appear on the form.

Once the Duty has been triggered, the next step is to identify the 'relevant person' i.e. the person that NHS Grampian will be communicating with regarding the event and the application of the Duty.

If it has not been possible to identify a relevant person, make initial contact with them or provide an account of the event and subsequent actions to expect, it will be recorded why that has not been possible.

Following the notification, a meeting should be arranged with the relevant person. There is no set timescale for when this meeting should occur by but, given that the relevant person's views and questions should inform the terms of reference for the review, it is expected that it will be as soon as is reasonably possible.

It is recommended that where the Duty has been triggered a minimum of a Level 2 review is carried out by the local management team, including a service manager with multidisciplinary team input. A Level 1 review where a significant adverse event analysis and review is required can also be initiated.

Following the review, a copy of the report should be offered to the relevant person and provided if requested. The relevant person should also be offered the opportunity for follow-up discussions after that time. Recommendations are made as part of the adverse event review, and local management teams develop improvement plans to meet these recommendations.

From 1 December 2020, all services are required to identify on Datix which of the relevant outcomes from legislation has occurred and caused the Duty to be triggered. This will be in addition to the information already collected. This assists in clarifying and confirming the decision to trigger the duty of candour and will help NHS Grampian fulfil its reporting requirements to the Scottish Government.

It is recognised that adverse events can be distressing for staff as well as people who receive care. Support is available for all staff through the line management structure as well as through the occupational health service.

Number and Nature of Duty of Candour Incidents in Health and Social Care Moray

To help to support the correct allocation of the Duty, all incidents that have caused harm have been reviewed for accuracy.

Between 1 April 2021 and 31 March 2022, **8** incidents were considered as DoC. At the time of writing, DoC has been confirmed and applied to **4** incidents. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or

underlying condition. In each case, a review of what happened takes place and what went wrong to try and learn for the future.

All of these incidents which were definitively classified as having Duty of Candour applied have been closed effectively. All incidents which were identified were Minor incidents with the data showing that the Pathway followed in relation to tissue viability being the most successful in effectively identifying Duty of Candour at an early stage and allowing effective preventative action and closing of the incident to be put in place. This indicates good practice which should be taken forward as a learning.

Of those incidents which have been ranked as "Query – requiring advice" in relation to Duty of Candour, they tend to be those which are more serious and complex in nature, with another common theme being that all 4 related to episodes of patient treatment which span multiple departments or disciplines.

This trend mirrors the general "silo working" between disciplines which may at times impact patient care.

Of these queried incidents 2 are still in the investigation phase, with one being a Level 1 Review, recently commenced. All Level 1 and Level 2 reviews are considered at the fortnightly Clinical Risk Management (CRM) Group to monitor progress and provide challenge. Going forward this group will review all "Query" DOC's as a defined agenda item and will seek to provide guidance to investigation teams at an earlier juncture to ensure DOC status is defined early in the investigation process.

It is clear from the data that in the case of minor incidents within their own department staff feel empowered and confident to assign DOC status and deal with the incident effectively.

In relation to more complex cases it takes longer to categorise incidents and this can lead to a delay in engaging patients and family members. Improved support for teams via the CRM meeting on a fortnightly basis and additional training workshops to improve overall Incident Investigation skills are anticipated to significantly improve staff confidence and competency in being able to identify Duty of Candour incidents more rapidly and deal with them more effectively.

Overview of 4 DoC from reviews completed:

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	1
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	
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	

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.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	1

Learning

All staff receive training on adverse event management and implementation of Duty of Candour as part of the NHS Grampian induction, this to ensure staff understand when it applies and how to trigger the Duty. Additional training and support is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

Adverse events, whether they trigger the Duty or not, are reviewed fortnightly at the local Clinical Risk Management (CRM) group, and exceptions are escalated through the HSCM Clinical and Care Governance Group. This forum also provides a platform for sharing learning and identifying challenges.

The fortnightly CRM will apply a more robust process going forward ensuring all 'unsure' DoC are discussed with the appropriate service manager and subsequently recorded appropriately on Datix. A contact will be provided for staff to discuss DoC legislation to assist in decision making. DoC training will be refreshed for all staff as matter of priority.

A sequence of specialist Risk Management and Incident Investigation workshops with an emphasis on Root cause analysis will be rolled out for staff, throughout the first quarter or 2023. The objective of this face to face training series is to significantly up-skill staff in terms of undertaking rapid and effective incident and complaint handling.

It is observed that when cases are more complex staff lack the confidence or feel they lack the authority in triggering Duty of Candour. The more rigorous support of more senior and specialist staff through the CRM process, should address this in conjunction with face to face training rather than on-line modules alone is expected to address this.

Summary

This is the fourth year of the DoC being in operation. Moving out of the challenges of the pandemic allows us freed time and resource to strengthen processes and competency to continually improve our approach to Duty of Candour events. A continuous programme of learning is required to ensure that new staff and post holders are confident of processes.

Going forward we anticipate continuing to move towards more proactive Risk Management to reduce the number of adverse events and complaints, overall.