REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **DUTY OF CANDOUR ANNUAL REPORT (2021/2022)**

BY: **CHIEF NURSE - MORAY**

1. REASON FOR REPORT

1.1 To submit for information the contents of Duty of Candour Report for Health and Social Care Moray for the year 2021/2022

2. RECOMMENDATION

2.1. It is recommended that the Committee consider and note the contents of this report and the attached Duty of Candour Annual Report (Appendix 1).

3. BACKGROUND

3.1 There is a statutory legal duty placed upon Health & Social Care Moray (HSCM) as a Health Care Provider to implement robust Duty of Candour processes. This is in order that patients who may be affected by unintended or unexpected incidents which may cause them harm may be involved in a meaningful way in a review of those incidents and to provide a framework whereby they may receive an apology.

3.2 The report provided for consideration here relates to an annual review of Duty of Candour processes and incidents which have taken place in the preceding year with a view to monitoring and continually improving these processes.

3.3 This report covers the period 1 April 2021 to 31 March 2022. The delay in submission is due to vacancies and secondments of key personnel following on from the Covid-19 pandemic. Details of Duty of Candour activity in HSCM was submitted to NHS Grampian in time for inclusion in the NHS Grampian Duty of Candour Annual Report.

3.4 The 2022/23 HSCM Duty of Candour Annual Report is currently being compiled and is on track for being finalised by 30 June 2023 and will be presented to the August Clinical and Care Governance Committee.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 During the Period 1 April 2021 to 31 March 2022 a total of 8 incidents were considered under Duty of Candour.

4.2 Of those 8 incidents Duty of Candour was applied in relation to 4, all of which were effectively closed. All 4 incidents were classified as Minor and were uncomplicated.

4.3 Of those 4 incidents remaining "queried", all were found to be more complex in nature and spanning multiple departments. This trend has been well noted and actions are underway to address this trend.

4.4 In order to improve the handling of more serious and complex potential Duty of Candour incidents a series of improvements are scheduled to take place over the first 6 months of 2023.

4.5 The following improvements are scheduled:

- The Clinical Risk Management (CRM) structure is under review, with a proposed improvement being that there will be a heightened focus on flagging and allocating Duty of Candour status to all queried incidents as they arise within the meeting. This allows the combined expertise of the team to be effectively utilised.

- There is a review of incident investigation processes underway within the HSCM with face to face training and workshops being made available. Key to these will be the further training and understanding of Duty of Candour and where it applies.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022-2032"

Governance arrangements are integral for the assurance of the delivery of safe and effective services that underpins the implementation of the strategic plan.

(b) Policy and Legal

Duty of Candour (Scotland) Regulations, 2018, clearly state the requirements to engage with patients in a meaningful way should it be identified that unintended or unexpected incident's 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.

(c) Financial implications

There are no financial implications arising as a direct result of this report.

(d) Risk Implications and Mitigation

The process is to ensure continued compliance with the relevant statutory requirements and continue to reduce risk by rapidly integrating learnings taken from effective and meaningful interactions with patients who may have been impacted whilst under the care of HSCM. Of significance is the reduction of reputational risk which can be achieved effectively in applying the Duty of Candour (Scotland) Regulations, 2018.

(e) Staffing Implications
There are no staff implications arising as a direct result of this report.

(f) Property
There are no property implications arising as a direct result of this report.

(g) Equalities/Socio Economic Impact
An Equality Impact Assessment is not required because there are no changes to policy as a result of this report.

(h) Climate Change and Biodiversity Impacts
No climate change or biodiversity implications have been determined for this report.

(i) Directions
There are no directions required as a result of this report.

(j) Consultations
Consultations have taken place with Head of Clinical Governance and members of the Clinical and Care Governance Group and their comments have been incorporated in the content of this report.

6. CONCLUSION

6.1 The committee are recommended to acknowledge the implementation and ongoing improvements put in place in order that the HSCM comply with its Statutory Duty under Duty of Candour (Scotland) Regulations, 2018 and that following the Covid-19 pandemic period learnings and improvements are being implemented rapidly and effectively in this regard.

Author of Report: Jacqui Shand, Interim Clinical Governance Co-ordinator (HSCM)
Background Papers: DOC annual Report April 2021 – March 2022
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