Draft Duty of Candour Annual Report 2022/2023 June 2023

Approved:
Date:

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Background

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) outline the legal obligations of all Health, Social Care and Social Work providers within Scotland.

These obligations specifically relate to the requirement to be transparent and to communicate with and apologise to those who may be effected by unintended or unexpected events which may result in death or harm to those in their care, resulting from acts and omissions by the organisation.

This report fulfils the requirement under these regulations to produce an annual report to illustrate how Health and Social Care Moray (HSCM) has implemented the requirements of the legislation over the period of 2022/ 2023.

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 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).

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. This system is governed by an adverse review process which prompts investigative panels to identify the factors which have caused and contributed to adverse events. It is through this process that incidents which fulfil the criteria to trigger Duty of Candour may first be recognised.

Secondary to this process, Clinical Risk Management meetings take place fortnightly to review adverse events as they are under investigation. Those events identified as "Query Duty of Candour" may be reviewed and discussed by the wider multi-disciplinary management team. Senior staff may be assured that incidents are correctly identified and that the Duty of Candour process is being correctly implemented. This process provides support to those staff implementing the Duty.

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.

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. A Terms of Reference (TOR) will be commissioned by a member of the management team and an investigation team will be appointed. A Level 1 review where a significant adverse event analysis and review is required can also be initiated following the same process.

Following the review, a copy of the report should be made available to the relevant person. The relevant person should also be offered the opportunity for follow-up discussions. Recommendations are made as part of the adverse event review, and local management teams will consider developing improvement plans to ensure all actions and recommendations are implemented.

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 for the Period 2022/2023

Between 1 April 2022 and 31 March 2023, 17 incidents were considered as DoC. At the time of writing, DoC has been confirmed and applied to **6** of these incidents with **1** still under review and categorised as "Query Duty of Candour".

All of these incidents which were definitively classified as having Duty of Candour applied have been closed effectively.

All Level 1 and Level 2 reviews are considered at the fortnightly Clinical Risk Management (CRM) Group to monitor progress and provide challenge. The one outstanding "query" incident is on the agenda of this meeting.

The wound care pathway remains the most effective process by which incidents are systematically reviewed and closed rapidly and efficiently, with clear learnings and outcomes being recorded.

Where incident investigations are complex and span multiple departments, there continues to be challenges in carrying out the investigation and this may result in a delay in identifying incidents as triggering the Duty of Candour process. This may cause delays in communicating with people who may have been effected.

These issues have been recognised within the organisation and further work is being done at a NHS Grampian wide level to address this.

Overview of 6 Duty of Candour from reviews completed:

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	0
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
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	0
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.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	3

Learning

Adverse events, whether they trigger the Duty or not, are reviewed fortnightly at the local Clinical Risk Management (CRM) group, and a report is presented monthly to the HSCM Clinical and Care Governance Group. This is also included in the quarterly Escalation Report to Clinical and Care Governance Committee. This forum also provides a platform for sharing learning and identifying challenges. The fortnightly CRM is undergoing a process of continuous improvement.

It is observed that when cases are more complex staff may lack the confidence or feel they lack the authority in triggering Duty of Candour. This can result in increased number of 'Unsure Duty of Candour' cases being recorded for discussion at CRM. There continues to be a role for support from senior and specialist staff through the CRM process. Training is provided via on the online Turas platform and consideration will be given to face to face sessions as the need arises.

There is an acknowledgement for continuous improvements to the overall incident investigation process and developing staff confidence in identifying when the Duty is triggered.

There is currently no clear process by which the outcome of Duty of Candour incidents (particularly from the patient's perspective) is shared within the organisation and this is being addressed through the refresh of the Clinical and Care Governance framework.

Summary

The number of events which have triggered Duty of Candour remains low and consistent with the previous year.

Improvements have been proposed to proactively drive down the number of incidents generally, but Duty of Candour incidents specifically. The challenges of managing complex or multi service adverse events, in particular Duty of Candour, are recognised within the organisation. We continue to support staff in their learning and understanding around Duty of Candour. The organisation also continues to refresh the processes, post pandemic, to ensure continuous improvement and shared learning.