APPENDIX 1

Duty of Candour Update Report May 2019

Author: **Pauline Merchant,**
Clinical Governance Coordinator
HSCM

Lead : **Liz Tait**
Head of Clinical and Care Governance
Moray Alliance

Duty of Candour Report
Health and Social Care Moray (HSCM)

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 we provide an annual report about how the duty of candour is implemented in our services. This short report shows how Health and Social Care Moray has operated the duty of candour during the time between 1April 2018 and 31 March 2019.

About 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 93, 000 (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Health & Social Care Moray is responsible for adult social care, adult primary health care and unscheduled adult hospital care, along with some hosted services including GMED, Primary Care Contracts and Children and Families.

Four community hospitals exist in Moray in the towns of Buckie, Aberlour, Dufftown and Keith providing 71 (= 10 MH) 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.14 GP services are arranged in practice clusters around the natural communities.

This report comprises events from Community Hospitals, hosted services and community nursing services. Independent contractors complete and report on their own investigations.

1. Duty of Candour Process

HSCM identify Duty of Candour incidents through DATIX - our adverse event management process. We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour 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 2018. 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 it has been decided that 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 information the terms of reference for the review, it is expected that it will be as soon as is reasonably possible.

It is, however, recommended that where the Duty has been triggered a **minimum** of a Level 2 review is carried out by local management team review, including a service manager with multidisciplinary team input. A level 1 review where a significant adverse event analysis and review is required. This can be viewed in our local policy -Policy for the Management of and Learning from Adverse Events and Feedback.

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.

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 as well as through our occupational health service.

Over the time period for this report we carried out, or are in the process of, 4 significance adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

2. Learning

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction, so that they understand when it applies and how trigger the duty. Additional training 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 are reviewed weekly at our local Clinical Risk Management group, and exceptions are escalated through the HSCM Clinical Governance Group. This also provides a platform for sharing learning and identifying challenges

As the process is relatively new, all incidents that have caused harm are reviewed to see if the Duty has been or should be triggered. There have been a limited number of incidents which have been up or down graded following review. Reporting staff are always informed if there has been a change to the allocation of the duty of candour.

Overall, it would appear that the processes in place are being followed appropriately, with staff being open to appropriate discussion and decisions. Learning from these

events is being shared through governance structures. Ensuring learning is shared across all staff groups in a meaningful way is to be developed.

3. Improvements

Following review of duty of candour events, improvements to services has included;

- Adoption of NICE guidance NG12
- Recording of lesions –position, size, shape, colour and digital photograph.
- Introduction of regular record keeping audits.
- Identification and delivery of specific training for targeted/ specialist groups of staff

Overall there is more conversation and discussion taking place between staff, with greater awareness evident regarding duty of candour.

4. Challenges

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

The main challenge around duty of candour has been ensuring that all relevant incidents/events trigger the duty. Having mandatory fields within the reporting system has assisted in raising awareness of the need to consider duty of candour. To help us to support the correct allocation of the duty, all incidents that have caused harm have been reviewed for accuracy. As awareness and confidence grows, it is envisaged that the need to review all incidents will decrease.

Sharing learning between sectors and services is not yet established. We need to continue to engage with independent contractors to build relationships and systems to facilitate sharing of learning from adverse and duty of candour events.

5. Numbers

Between 1 April 2018 and 31 March 2019, there were 4 incidents where the duty of candour applied. These are unintended or unexpected incident's 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.

HSCM identified these incidents through DATIX - our adverse event management process. Over the time period for this report we carried out, or are in the process of, 4 significance adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

In each case, we reviewed what happened and what went wrong to try and learn for the future. Currently, one of the reviews have been completed, with the remaining 3 ongoing.

The appropriate level of review has been applied, with two Level 2 reviews and two Level 1 reviews allocated. The correct procedure was followed in 2 out of the 4 occasions (50%). This means we informed the people affected, apologised to them, and offered to meet with them. The remaining 2 occasions are still under investigation and it is currently unclear if we followed the duty of candour procedure.

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

If you would like more information about this report, please contact us:

pauline.merchant@nhs.net
Pauline Merchant
Clinical Governance Coordinator
Health and Social Care Moray.

liz.tait@nhs.net
Liz Tait
Head of Clinical and Care Governance
Moray Alliance

Intentionally left blank