NHS Grampian

Duty of Candour Annual Report

2021- 2022

File Name: NHSG DoC Annual Report 2021-2022 Final	**Version:** 1.0
Produced By: NHS Grampian	**Date:** 09.12.2022
Author: Associate Director, Quality Improvement and Assurance	**Review Date:** Annual

Table of Contents

This document is also available in other formats or languages on request. Please call Equality and Diversity on 01224 551116 or 552245 or email gram.communications@nhs.scot

1. Introduction

As a provider of health and social care services in Scotland, NHS Grampian has a legal duty of candour (DoC). This means that if an unintended or unexpected event happens that results in harm or death as defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and the Duty of Candour (Scotland) Regulations 2018, we must:

- Make sure that those involved and affected understand what has happened and receive an apology from our organisation.
- Learn as an organisation how to improve for the future.

There are always some risks in providing health and social care services and where unintended or unexpected events that result in harm occur, people want know what happened, what we will do in response and what we will do to stop these happening to anyone else.

NHS Grampian produces this annual report about how DoC works within our services. It covers the period from 1 April 2021 to 31 March 2022. Its layout is based on a template issued by the Healthcare Quality and Improvement Directorate of the Scottish Government.

This report only covers the DoC for services that NHS Grampian employs directly. These include:

- Acute Services, Services in Moray, Aberdeenshire and Aberdeen City
- NHS Grampian Public Dental Services
- GMED (who cover GP services in evenings and weekends)
- General Ophthalmic Services

It does not cover independent and contracted services not employed by us but who provide services for people who live in our area. This includes most general practices (GPs), Dentists, Optometrists and Pharmacies. They produce their own reports, which you can find either at their practices or on their websites.

2. About NHS Grampian

NHS Grampian provides healthcare services to the population of the North East of Scotland. We cover the areas administered by Aberdeen, Aberdeenshire and Moray Councils. We employ around 14,000 staff who deliver our services to 500,000 people, spread across 3,000 square miles of city, town, village and rural communities.

Most of our larger hospitals are in Aberdeen. Elgin is the site of Dr Gray's, the main general hospital in the Moray region of Grampian. There are 14 community hospitals, one in each of the main towns.

Our aim is to provide the highest quality care for everyone who uses our services. Where possible we aim to help people receive care at home or in a homely setting. We work at national level with Scottish Government and colleagues in other regional boards and special National Boards such as Scottish Ambulance Service, NHS 24, NHS National Services Scotland, Health Improvement Scotland and NHS Education for Scotland. At a regional planning level, we have a well-established North East Partnership Group which comprises the Chief Executives of NHS Grampian, Tayside, Highland, Shetland, Orkney and Western Isles and the Chief Executives of the respective Local Authority areas.

3. Number and Nature of Duty of Candour (DoC) Incidents

There were a total of 39 DoC confirmed incidents which occurred between 1st April 2021 and 31st March 2022. 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. The outcome which caused DoC to be triggered are categorised below.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	5
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	<5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	25
Changes to the structure of the person's body	<5
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	<5
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	<5

Please note that we have replaced small numbers with 'less than five'. This allows us to provide meaningful reporting by indicating that there were a small number of cases in particular categories, but reduces the risk of the inadvertent identification of patients from their circumstances and the loss of their confidentiality.

Of the confirmed incidents identified we have carried out and completed a review. In each case, we reviewed what happened, what we could have done better and offered to feedback the outcome and learning from the events to the people affected. Individual, team and organisational learning was identified.

At the time of completing this report a further 11 incidents are under investigation and remain open. If those incidents are deemed to be DoC they will be reported in the NHS Grampian 2022-2023 report

4. Information on Policies and Procedures

We record adverse events through our local reporting system in line with our policy for the management of and learning from adverse events and feedback. We record these on a database called Datix and all our staff (except independent contractors and GPs who have their own systems) can access our intranet where they can report incidents on Datix.

Using Datix, complaints or audits we can identify incidents that trigger the DoC process. We review each adverse event to understand what happened and how we might learn and improve what we do. The level of review depends on how serious the event was as well as the potential for learning.

We make recommendations as part of these reviews and local teams develop improvement plans to meet these. We also have a group of senior staff members who meet regularly to discuss how the DoC process is going in their areas. Before and after the DoC Act came into force, we educated our staff about the legislation and its importance. We developed ways to identify adverse events that triggered the act and regularly review these to make sure that they are fit for purpose. DoC can be triggered by the reasonable opinion of any registered health or social care practitioner. This means that different professionals may interpret the definitions produced in the DoC Act differently. In the advent of support being needed help is provided from the sectors various governance groups.

For example, in our acute services, all DoC decisions are reviewed and confirmed at a weekly clinical risk meeting. This can slightly delay the start of the process but ensures that the correct decision is reached.

In Aberdeenshire Health and Social Care Partnership further decision and support comes from professional and clinical leads within Aberdeenshire. Here the decision on whether an incident is or isn't DoC is taken to local teams and local managers with the appropriate support from profession and clinical leads.

In Aberdeen City Health and Social Care Partnership the DoC process is now embedded as part of the local management of clinical and care risk management processes. Here staff can choose the unsure option when reporting incidents that may be DoC Weekly Health and Social Care Partnership Clinical and Care Risk management (CCRM) meetings consider these and provide advice.

In Moray 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 to the Clinical and Care Governance Group. This forum also provides a platform for sharing learning and identifying challenges.

We emphasise that the process of analysing an adverse event and instigating a review supports DoC, so duty of candour being agreed after the event should not hold up the process of engaging with family and commencing an Adverse Event Review.

Across Grampian we follow the national guidelines to assess whether the duty of candour procedure should be activated.

5. Support for Persons/Families and Staff

There are various ways in which we support those persons/families affected and there is regular communication with an identified contact from the team reviewing the case to ensure they are kept fully informed. Support is also available, as appropriate, from primary care and community colleagues with signposting to appropriate external agencies.

Support is also available to staff who are involved in unintended or unexpected incidents. Interdepartmental and partnership support, access to debrief facilitators alongside the wider psychological support and access to our occupation health service.

6. Changes, Learning and/or Improvements to Services

We have attempted to learn from every adverse event. Examples of changes made are:

Patient Identification/Involvement

- Reviewed our process and now show and confirm blood tube with patient for correct identification.
- Our checking process has been updated to confirmation with next of kin or carer as to how to correctly address patients.
- Patient checks at handover between portering/nursing/radiography staff have been revised.
- We have made changes to communication with patients concerning risk and shared decision making.

Process Improvement

- Developing a new discharge criteria for community hospitals in conjunction with the Discharge Hub.
- Deploying Standard Operating Procedures in vaccine centres regarding expiry dates.

- Multiagency review and subsequent work to improve processes, education, documentation, support for decision making and recognition of unwell and/or deteriorating patients.
- Various improvements including staff training have been put in place to help promote patient safety in Community Hospitals to reduce the risk of falls.
- Tasklist set up to support the review of tests results to reduce the risk of delays in treatment.
- Increase the use of electronic patient records to promote consistent recordkeeping.
- Development of a Standard Operating Procedure to formalise the process of supplying discharge medication.
- Falls care plans to be completed on admission alongside falls risk assessment to reduce risk.
- New pathways for how results are followed up post-surgery.
- Provided additional support to ensure compliance with the screening, diagnosis and management of Gestational Diabetes.
- Implemented a pro forma developed for multi-disciplinary meetings to reduce the possibility of missing information.
- Learning from Medication errors has been shared by the Medication Safety Advisor through MedWatch Newsletters, including DoC.
- Reviewed guidance concerning the identification of high risk status and the implementation of management plans.

Education

- Learning was shared widely in primary and secondary care where appropriate, including in quality and safety meetings.
- New training and systems were deployed concerning the management of pressure ulcers.
- Local meetings held in teams to ensure staff wellbeing and identify training needs in areas such as the National Early Warning Score (NEWS), falls prevention and management, and the management pressure ulcers.
- New induction information in Radiology concerning the interpretation of common x-rays.

Equipment

- Instigated a process for equipment checks and the reporting of faulty equipment.
- Increased scanning to improve communication between teams.
- Purchase of equipment for a triage area with a developed Standard Operating Procedure to ensure timely review by the appropriate professional.
- Review of skin integrity including nutrition and special mattress following avoidable pressure ulcers.

Experiential Learning

- A Positive Safety Culture newsletter went out to all staff, it included the contributory factors around record keeping, assessment of clinical presentation and an alert for

clinical staff to be aware of possible significant changes that might influence the treatment plan should there be delay between appointments, as well as other learning from a review of adverse events in the DATIX system.

- It was observed that when cases are more complex staff can lack the confidence or feel they lack the authority in triggering DoC. It highlights the importance of having multi-disciplinary input to the review process to ensure a comprehensive review of the event and increased support of more senior and specialist staff. To support this Moray are planning a sequence of specialist Risk Management and Incident Investigation workshops with an emphasis on Root cause analysis throughout the first quarter or 2023.
- Aberdeen City's experience has shown the benefits of ongoing communication with the individual and/or family members and this has been reinforced through the weekly Clinical Care and Risk Management (CCRM) meetings out to service areas.
- Aberdeenshire identified the learning from incidents highlighted gaps in processes and this resulted in a review of Standard Operating Procedures.

7. COVID-19 Pandemic

The continuing pandemic put unprecedented pressure on our staff and many routine services had to be halted or were delayed. Adverse Event Reviews still occurred and opportunities for learning were shared within services. We continued to use the national guidance as to when the Duty should be activated also seeking legal opinion as to which situations because of the pandemic may or may not trigger the Duty.

There were periods when operational pressures took precedence over starting an investigation but at all times we made a priority of keeping those affected informed. Issues encountered were due to a number of factors including some of the key staff who have expertise around reviews being unavailable due to deployment elsewhere or capacity to take on this activity. We have recognised the need for further training across the organisation and online educational modules are assisting to provide training across the organisation and strengthen our capacity in this regard.

Involving the relevant person or families continued to be altered as face to face meetings were discouraged or prohibited during waves of the pandemic. This impacted on our usual processes around communication, however use of either telephone calls or the option of video conferencing was used to ensure good communication was maintained.

As we continue to remobilise services, we may see instances of harm linked to delays in care. Some of these may trigger the DoC and there has been a lot of learning during the pandemic. For example we have tried to maintain communication with existing service users who had their treatment paused and with the wider public to support them to self-manage and also to come forward should there be a deterioration in their symptoms. There is continued whole system learning regarding how we might strengthen this and ensure ongoing public messaging regarding how they can access services and support.

8. Learning for the Future

Our processes have withstood a severe test and this gives us reassurance but we continue to monitor them and acknowledge that there are always improvements that can be made. It is the sustainability of the changes that is the main challenge along with sharing and embedding learning across wider system and we are committed to achieving such. We will therefore continue to learn both locally and nationally to improve implementation of processes to discharge the statuary organisational Duty of Candour.

Scottish Ministers have been notified that we have published this report on our website.

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

NHS Grampian Clinical Directorate
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE