Duty of Candour

Annual Report 2023/24

Safety Quality and Risk Team

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NHS Orkney

Duty of Candour Report 2023/24

1. Introduction

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 report describes how NHS Orkney has implemented and operated the duty of candour during the time between 1 April 2023 and 31 March 2024. We hope you find this report useful.

2. Background

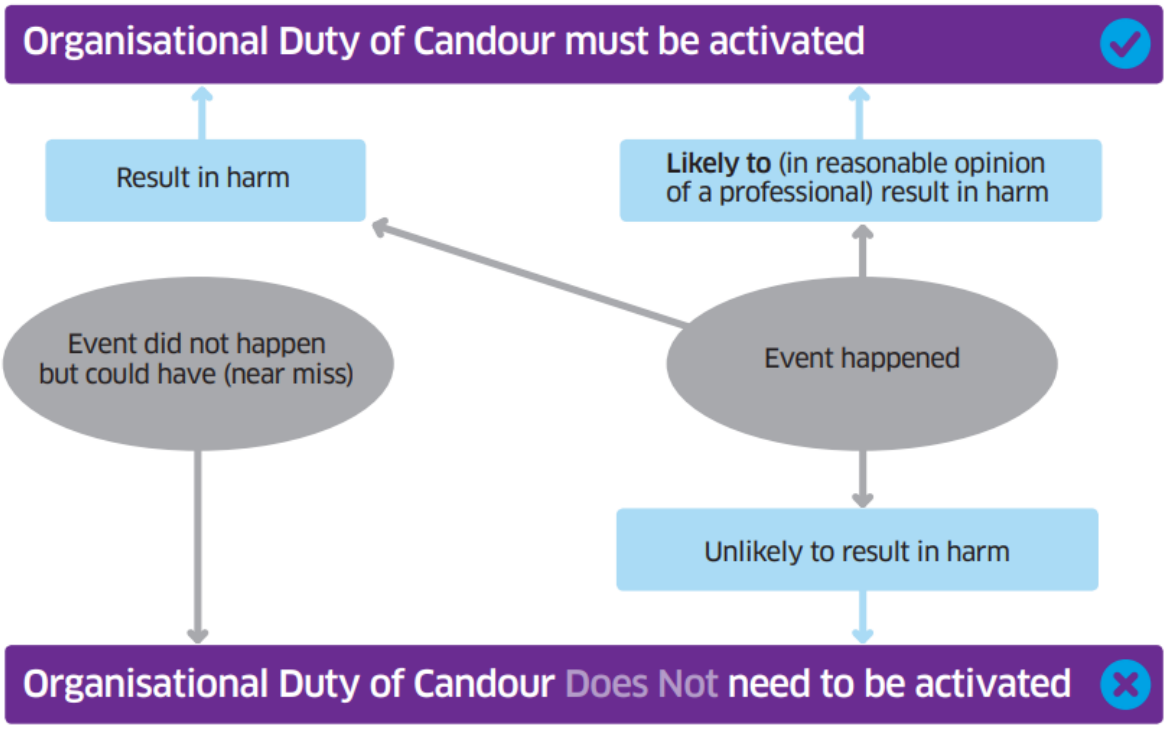
The Duty of Candour (DoC) legislation[1] became active from the 1st of April 2018. This placed a statutory obligation on health organisations to follow the subsequent regulations which stipulate several actions to take place if certain circumstances occur. These are:

If a patient suffers **death or serious[2]** harm because of an adverse event that the organisation is responsible for, the following should occur:

- An apology is offered to the patient or their relative
- The patient / relative is informed that there will be an investigation
- The patient / relative is given the opportunity to ask questions to be answered as part of the investigation
- The result of the investigation is shared with the patient / relative and a meeting is offered
- The organisation learns from the investigation by implementing the recommendations/ actions

Below is a decision flow chart that demonstrates how Duty of Candour is applied

[1] Duty of Candour Legislation
[2] Guidance on serious harm and death



3. NHS Orkney

NHS Orkney is the smallest health board in Scotland and serves an archipelago of islands with a population of approx. 22,000 people. NHS Orkney employs 732 staff (600.14 WTE) who provide a range of primary, community-based and hospital services.

In accordance with NHS Orkney's Learning from Incidents Policy, all clinical incidents are reported to the line manager and recorded on the incident reporting system, NHS Orkney currently uses Datix. DoC is considered as part of this process and reporters have an opportunity to consider potential DoC, both professional and organisational, in relation to the Act.

The clinical risk, and the level of review required of each incident, is assessed by the Weekly Incident Review Group (WIRG) which includes the following individuals:

- Medical Director (or nominated deputy)
- Director of Nursing, Midwifery and AHPs (or nominated deputy) / Acute Services (or nominated deputy)
- Chief Officer of the Integrated Joint Board (or nominated Integrated Head of Service deputy)
- Head of Patient Safety, Quality and Risk
- Clinical Governance & Risk Facilitator
- Patient Experience Officer (or nominated deputy)
- Health and Safety Manager (or nominated deputy)

- Information Governance Manager (or nominated deputy)

Furthermore, all new complaints and potential litigation cases are discussed at WIRG for clinical risk.

Currently NHS Orkney's local Duty of Candour Procedure sits within the NHS Orkney's Learning from Incidents: and management of Significant Adverse Events policy. The policy and procedural documents undergo regular review to ensure that they are in line with latest legislation. This coming year these are being reviewed and revised to ensure they are in line with latest guidance and to include more around working with patients and families and gaining feedback about the process and how we can improve this for patients and families and for staff involved in SAER.

4. Incidents where Duty of Candour applied

During the reporting period, there has been **three** incidents where the duty of candour applied. These are unintended or unexpected incidents that result in harm or death as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

DoC incidents are identified through NHSO Significant Adverse Event management process. Over the reporting period, there have been **seven** Significant Adverse Event Reviews (SAER) launched. These events include a wider range of outcomes than those defined in the DoC legislation as this has included adverse events that did not result in significant harm but had the potential to cause significant harm.

Through the SAER process, it is identified if there were factors that may have caused or contributed to the event, which helps to identify if DoC should be applied.

There are **three** SAER in progress that were reported during this time which may meet the DoC requirements, but due to these investigations still being open, it is not possible to declare this at this time; therefore, these will be reported on in the next DoC annual report.

There were **three** SAER that were outstanding at the time of the last annual report, these have now been completed and of these, **two** met the criteria for DoC.

This report will cover the known DoC events from this reporting period and the two not included in last year's annual report; acknowledging there may be more once the investigations have been completed and these will be included in the next annual report.

Type of unexpected or unintended incident *(not related to the natural course of someone's illness or underlying condition)*	**Number of times this happened**

	(between 1 April 2023 and 31 March 2024, including the two outstanding from the 22/23 report)
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A person's treatment increased	3
The structure of a person's body changed	1
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions were impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them from dying	
A person needing health treatment in order to prevent other injuries as listed above	
Total events Duty of Candour was applied	**5**

5. To what extent did NHS Orkney follow the duty of candour procedure?

When we identified the adverse events listed above had happened, we followed the correct procedure in all cases (100% of the time). This means we informed the people affected, apologised to them, and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future. In some of these cases the patient involved chose not to meet with us and did not want to be involved in the review.

6. Learning from Duty of Candour

For all SAER, not just the reviews where DoC is suspected / confirmed, an apology is given, patients and families are invited to be involved in the review and a comprehensive explanation of the incident is provided.

Below we have set out a number of the recommendations from SAER that meet the DoC criterion. The current position of the actions is highlighted in bold. Where there is no current position highlighted, this is because the SAER was closed at the end of the year and therefore the action plans have not been signed off by the governance committees, so there is no update at this time.

The recommendations and actions from the DoC include:

- The surgical team should focus on improving communication and collaborative working to ensure continuity of care and decision-making for acute surgical admissions, including confirmation of arrangements for ongoing care and follow-up before they are discharged – **This is an ongoing piece of work looking at the flow of patients through the acute services.**
- The WHO Safe Surgery checklist should be reviewed, including confirmation of the Crossmatch/ 'Group & Screen' status of the patient. A regular debrief at the end of the operating list should be promoted. - **This is now complete, the WHO checklist has been revised and is completed per the expected process for every surgery undertaken.**
- Review and implement clinical pathways for the management of several different conditions presenting to The Balfour ED – **The review of clinical pathways is being undertaken by the Clinical Nurse Managers to ensure that they meet the needs of the service user and best practice guidance.**
- a consistent approach to the review of all MSK x-rays requested by ED clinical staff, underpinned by a standard operating procedure (SOP) - **This has been completed and a process is in place.**
- Review the process for coordinating access to previous ED record card(s) for returning patients, including administrative support – **This has been completed and a process is in place.**
- Regular incident / near miss and Duty of Candour refresher / update training for clinical staff – **Currently there is training available for all staff, but we are working to improve this, to support all staff as they move into different areas and different roles within the organisation. This piece of work will be completed by the end of the year.**
- Review of current Tissue Viability documentation – **This is complete and new documentation is in place to support staff in prevention, recognition and treating pressure ulcers.**
- Training for staff in tissue viability and pressure ulcer prevention – **This is on track for completion and staff are supported in accessing specialist nurses when required.**
- Quality Measures board(s) in clinical areas to look at pressure ulcer prevalence and using data to drive improvement / raise awareness. 5 minute learn boards to be adopted in clinical areas – **Boards are in place to raise awareness of current areas of concern and to provide up to date best practice advice. This is within the acute inpatient areas of the Balfour.**
- Access to tissue viability resources for clinical staff to promote best practice – consideration to use of NHS Grampian resources – **This is complete and sharing of resources and knowledge is in place for all staff as they need it.**

- Review handovers and handover documentation to ensure pressure area concerns are captured – **This is underway and is part of a larger piece of work on handover information / documentation.**
- Review current pressure relieving aids and equipment to identify any gaps / needs going forward – **This is underway as part of the pressure area reviews that have been taking place.**
- Review of the current documentation and regular audits to monitor standards of record keeping / compliance – **This is ongoing. The audits have been commenced and learning is being shared but will continue to be a regular audit moving forward.**
- Review of current dressings being stocked and alignment to NHS Grampian Joint Wound Care Formulary – **This is completed, and ward stock is now in line with the formulary.**
- Morbidity and Mortality meetings to recommence – **This is an area that requires strengthening. The meetings happen, but not on a regular basis, so plans to increase the visibility of these and activities are being put in place.**
- Medical Staff Involvement in Patient Placement: Revise the admission process for IP2 with effective medical input to match treatment intentions with the care setting.
- Communication with Families: Improve communication methods to address family concerns, especially during care transitions and supporting management of uncertainty.
- Inter-Site Communication: Review communication channels internally and externally,
- Clinical Ownership and Treatment Planning: Clarify care planning and ownership roles in complex cases, particularly where external support is involved.
- Multidisciplinary Team (MDT) Function and Effectiveness: Review and strengthen the MDT function, including consistent documentation and identification of gaps.
- Proactive Escalation Processes: Develop escalation processes with clear triggers for timely management responses and good communication
- Learning from Events and Incident Management: Improve learning from incidents at the ward level, including timely review and management of incident reports in keeping with the local quality framework – **This is part of the work already underway to review the processes and will be completed before the end of the year.**

7. NHS Orkney Policies, Procedures and Guidance

All adverse events are reviewed to help to understand the context and cause of the event, allowing for changes to be implemented to improve the services for all

patients, as set out in the Learning from Adverse Events Policy. All adverse events are treated as if they meet the criteria for DoC until investigated and found not to. This means that for all adverse events a SAER is undertaken, and the requirements set out within the DoC guidance is undertaken. This includes an apology and an invitation to patients' and if the patient requests, their families, to be involved in the SAER process. From all SAER there are recommendations and an action plan to meet the recommendations. These actions are led by the most suitable staff to be responsible for taking the actions forward and ensuring changes are made, embedded into business as usual, and learning shared. At the end of this year the action plans have been revised to ensure that all actions are SMART (specific, measurable, achievable, relevant, time-focused). The monitoring process for DoC is carried out by the Safety, Quality and Risk Team. This includes tracking the SAERs to establish which events have met the DoC criteria (in conjunction with Medical Professionals), monitoring compliance to ensure all aspects of the legislation have been followed and correlation with the causation codes recorded for each incident. This is currently reported at the WIRG and at the Quality Forum, which are led and attended by a range of senior leaders and mangers. The Quality Forum has undergone a change of structure in the last couple of months and moving forward will consist of monthly Clinical Quality Group and a quarterly Clinical Governance Committee. The reports and learning summaries will continue to be reviewed at these groups with the collated action plans being reviewed until completion to ensure a 'closing of the loop' process. This year the training which was highlighted in last year's report has continued with the aim to increase the number of staff able to undertake SAER and to support staff in understanding the process. This work will continue to support resilience and knowledge within the organisation. For all adverse events staff are offered the opportunity to discuss the incident, whether this is through a debrief session or a one to one with their line manager. If the staff member feels that they need further support, then this can be sought through occupational health and the wellbeing processes within the organisation.

We constantly strive to provide the best standards of care, and this includes when we review adverse events. To ensure that we do this, this year we are reviewing the policy and procedures that underpin the management of adverse events which includes Duty of Candour. This review will include looking at the internal processes to try and complete the reviews in a timelier manner and to look at how we engage service users in the reviews and gain their feedback of the process. We also want to seek more feedback from our teams that are involved in SAER, and how we can make the process better for them and share learning in a meaningful way.

8. Conclusion

It is recognised that there are a small number of SAER annually and that due to this being able to look at themes and trends from these is difficult. We do however aim to look at these in conjunction with incidents and complaints in the coming year, so

that we can look for themes and trends and be able to provide greater understanding of where we need to focus in more detail. Over the coming year this work will continue and be evidenced in the way we report on DoC next year.

We always contact patients' and if appropriate and with the patient's consent, their families, to be involved in SAER from the start of the process. This ensures that their voices are heard and that we review areas that are important to them and answer any questions that they may have. As part of this we offer the opportunity to meet with the people carrying out the review once the report is completed as well, so that the patient and family can go through with the team and if there are any questions or comments, this can be looked at. This is irrespective of whether a SAER meets the criteria of DoC or not.

This year has highlighted to us the need to look more closely at service user experience, not just within the clinical services of NHS Orkney, but also when they are involved in SAER. We are looking at ways to gain feedback from people involved in SAER and feed this back into the policy and processes.

We have continued to engage with the Health Improvement Scotland (HIS) Adverse Event Network and continue to do this, being part of any work that looks to standardise incident reporting and learning across Scotland. These networks provide invaluable support in sharing ideas, resources and learning and we look forward to continuing this in the coming year.