Duty of Candour report – main points

- The Duty of Candour Act is the legislation that describes how NHS Grampian should deal with “adverse events” (when something goes wrong and harm is caused to someone).

- Candour means openness and honesty.

- When things go wrong, we’ll find out why, let the people involved know what happened and try to prevent it from happening again.

- This report tells you more about the process we use, how often we triggered it in the past year and what we’ve learned.

Duty of Candour (DoC) report for NHS Grampian
For year 2019 to 2020

Background

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 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.

These points are defined in the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 and the Duty of Candour (Scotland) Regulations 2018.

There are always some risks in providing health and social care services. From time to time, there are unintended or unexpected events that result in harm. When these happen, people want know what happened, what we'll do in response and what we'll 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 2019 to 31 March 2020. Its layout is based on the template issued by the national expert group.

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

- services in Moray, Aberdeenshire and City
- dental practices
- GMED (who cover GP services in evenings and weekends)
- 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
- opticians
- pharmacies

They produce their own reports, which you can find either at their practices or on their websites.

About NHS Grampian

NHS Grampian provides healthcare services to the north east of Scotland. We cover the areas administered by Aberdeen, Aberdeenshire and Moray Councils.

We employ around 17,000 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 in Moray is the site of Dr Gray's, the main general hospital in the west 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.

Adverse event reporting and management procedures

We record adverse events on a database called Datix. All our staff (except independent contractors such as 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. Different professionals can interpret the definitions produced in the DoC Act differently.

To prevent this, when we first set up our process, we deliberately did not allow staff to select an unsure choice as we felt that this might delay the process. However, as we learnt more, it became clear that frontline staff needed a second line of support for their decision-making.

We have now introduced this across all sectors of the organisation. For example, in our Acute sector, all DoC decisions are reviewed and confirmed at their weekly clinical risk meeting. This can slightly delay the start of the process but ensures that the correct decision is reached.

Numbers of DoC events in Grampian

Between 1 April 2019 and 31 March 2020, there were 87 adverse events where the DoC was triggered.

DoC is only triggered when there are unintended or unexpected adverse events that result in harm as defined by the Act. Adverse events don’t include the natural course of someone’s illness or underlying condition or its complications.

We identified these incidents using our adverse event database (Datix).

Sector	Number of times DOC was triggered
Aberdeen City HSCP*	14
Aberdeenshire HSCP*	2
Acute	63
Mental health Services	6
Moray HCSP*	2

*Health and social care partnership

Most events happened in the Acute Sector (72%) with the remainder spread among our other sectors.

Because some areas have very low numbers of events, we did not break down these events as this could allow identification of those involved. We are working on ways to allow us to provide more information around this.

To what extent were we able to follow the DoC process?

DoC legislation states that we must complete the process within 90 working days, We also have to decide what level of investigation is necessary, to contact the individual concerned and start the investigation within a month of the incident triggering the DoC process.

We performed the appropriate level of review 84% of the time.

We started 67% of all reviews within the stipulated time scale of one month.

Some delays were because we couldn't contact the individual concerned or their relatives but sometimes it was because we couldn't organise the start of the review ourselves.

In 80% of cases, we were able to notify the person concerned or their relatives about the investigation. Sometimes we were not able to contact those affected, or they did not want to proceed after we had contacted them.

We completed the investigation in 40% of cases within the 90 day limit in the act. This means that we informed those who were affected, apologised to them that the event happened when they were in our care and offered to meet them.

In every case, we reviewed what happened to try and learn for the future.

Learning

We have tried to learn not only from every adverse event we reviewed but also from reviewing our processes and our decision-making. Changes we have made because of DoC incidents include:

- Reviewing policies around locked doors in areas where patients maybe unsupervised.
- Reassessing how we assess patients who may need thromboembolic prophylaxis (to help prevent blood clots) in certain clinical areas.
- Introducing a formal process of criteria-led discharge for day case patients.
- Agreeing a standardised approach to the documentation and communication of instructions after surgery.
- Developing a policy for the insertion and management for central venous access devices. This includes a standardised process to record the length of any line inserted.
- Developing a policy for the identification of faulty equipment and returning items to manufacturer for assessment.

From analysing our databases, we know that frontline staff are deciding to trigger the DoC process less often than in the previous year, preferring to refer it to clinical risk meetings. We are looking into why this is and providing further education.

Other information

We realise that despite ongoing improvements we have not managed to meet the timescales in the act every time.

We will continue to provide education as well as highlighting to staff the elearning module produced by NES (the education and training body for NHS Scotland). This will help to promote and embed training for staff.

We are also aware of the level of support that those who have been involved in an incident may need. Staff can get support from our occupational health service, as well as our psychological hub. We also provide a values-based reflective practice service and our organisational development department can provide support for system type issues.

Each DoC case has a nominated member of staff for those involved or affected to liaise with. Levels of support offered depend on the type of incident and will vary. For example, mental health and learning disability services always contact the family involved though an independent consultant. Maternity and neonatal services can organise a debrief meeting outwith the review with a consultant and a midwife

Summary

This is the second year of the DoC legislation and our process has developed. It has been a period of learning and refining our existing processes so that DoC legislation is included in our everyday business. This development will continue with our improvement plan in the coming years.

S Stott
Associate Medical Director
September 2020