

Duty of Candour report for NHS Grampian for year 2018-2019

Background

As a provider of health and social care services in Scotland there is a legal organisational duty of candour. This means that should an unintended or unexpected event happen that results in death or harm, those involved and affected understand what has happened, receive an organisational apology and that we 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.

Providing health and social care services is associated with risk and, from time to time, there are unintended or unexpected events resulting in death or harm. When this happens, people want to be told honestly what happened, what will be done in response, and to know how actions will be taken to stop this happening again to someone else in the future.

Part of this duty is that we provide an annual report about how the duty of candour (DoC) works within our services. This report describes how NHS Grampian has put the duty of candour legislation into practice from the 1st April 2018 to 31st March 2019. Its layout is based on the template issued by the national expert group.

This report covers the DoC process for all areas in NHS Grampian where services are directly employed. That is services in Moray, Aberdeenshire and City as well as dental practices, GMED and ophthalmic services. It does not cover independent and contracted services such as the majority of general practices (GPs). Independent contractors include those GPs, dentists, opticians and pharmacies who are not employed by NHS Grampian but provide services for people who live within the NHS Grampian area. These are required to produce their own report which can be seen either at their practices or on their websites.

About NHS Grampian

NHS Grampian provides healthcare services to the North-East of Scotland, covering the local government areas administered by Aberdeen, Aberdeenshire and Moray Councils. We employ around

17,000 staff who deliver our services to half a million people spread across 3,000 square miles of city, town, village and rural communities. Aberdeen is where most of our hospitals are located. Elgin in Moray is the site of Dr Gray's: the principal general hospital in the west of Grampian. In addition, there are a further 14 community hospitals, situated in each of the main towns. Our aim is to provide the highest quality care for every person who uses our services, and where possible help people to receive care or in a homely setting.

Adverse event reporting and management procedures

Our adverse events are reported through our local reporting system (Datix). Our adverse events are reported through our local adverse event reporting system (Datix). All our staff who work in NHS Grampian (except independent contractors such as GP's who have their own reporting systems) have the ability to access our intranet where they can report incidents on Datix.

Using Datix, complaints or audits we can identify incidents that trigger the Duty of Candour Act principles. Each adverse event is reviewed to understand what happened and how we might learn and improve what we do from it. The level of review that is carried out will depend on how serious the event as well as the potential for learning.

Recommendations are made as part of the adverse event reviews and local management 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 progressing in their areas.

Before and after the act came into force, staff were educated regarding the legislation and its importance. We developed ways to identify adverse events that triggered the act and regularly reviewed these to make sure that they were fit for purpose.

The Duty of Candour regulation can be triggered by the reasonable opinion of any registered health or social care practitioner. This can result in the definitions produced in the Act being interpreted differently by different professionals. When we first set up our process we consciously did not allow staff to select an unsure choice as we felt that this may 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 Duty of Candour

decisions are reviewed and confirmed by their clinical risk meeting which takes place once a week. This can sometimes introduce a small delay in the start of the process but ensures that the correct decision is reached.

Numbers of Duty of Candour Events in Grampian

Between 1st April 2018 and 31st March 2019, there were 65 adverse events where the Duty of Candour trigger took place. It is important to realise that the act is only triggered when there are unintended or unexpected adverse events that result in harm as defined by the act and do not relate directly to the natural course of someone’s illness or underlying condition or its complications. We identified these incidents using our adverse event management database (Datix).

Sector	Number of times DOC was triggered
Aberdeen City HSCP*	11
Aberdeenshire HSCP*	8
Acute	40
Mental health Services	3
Moray HCSP*	3

*Health and social care partnership

The majority of events happened in the Acute Sector (62%) with the remainder spread amongst our other sectors.

To what extent were we able to follow the Duty of Candour Act process?

The Duty of Candour legislation states that we must complete the process within 90 working days and there are certain steps that are time limited in that process. These are 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 duty of candour process. Eighty percent (80%) of the time we were able to perform the appropriate level of review and started 77% of all reviews within the stipulated time scale of one month. Some of these delays were because we were not able to contact the individual concerned or their relatives but sometimes it was because we were not able to organise the start of the review ourselves. In 75% 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 were able to complete the investigation in

56% of cases within the 90 day limit specified by 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 with them. In every case, we reviewed what happened to try and learn for the future.

Learning

We have tried to learn from every adverse event reviewed. The majority of changes and improvements that have taken place have been to our systems and processes that support staff to make a decision about whether an event triggers the act. We have also improved our processes for ensuring the act is complied with as much as possible. Clinical improvements include:

- Reviews of patients who have had falls and have triggered the act has improved especially in the Acute sector.
- We have improved how we record lesions including using digital photography.
- We have introduced regular record keeping audits in Moray.

From analysing our data bases we know that front line staff are taking the decision to trigger the duty of candour process themselves more often in the Acute sector. This reflects better understanding of the process and confidence in the decision making process.

Next Steps

We realise that despite ongoing improvements during the first year we have not managed to comply with time scales set out in the act every time. Each sector is producing an improvement plan based on their own data for next year and we will be looking at our performance in this area very closely. We will also be using an e learning module produced by NES (the education and training body for NHS Scotland) to promote and embed training for staff. We are also conscious of the level of support that staff who have been involved in an incident may need and we are reviewing how we as an organisation might be able to improve that support.

Summary

This is the first year of the duty of candour legislation and it has been a period of learning and refining our existing adverse events management processes so that the duty of candour legislation is included in our everyday business. This development will continue with our improvement plan for the coming year.

S Stott

Associate Medical Director

June 2019