Duty of Candour – NHS Dumfries and Galloway

1. Introduction

NHS Dumfries and Galloway (NHS D&G) serves a population of 151,324. We cover a diverse geographical area, including small towns as well as rural areas. Our aim is to provide high quality care for every person who uses our services and where possible help people to receive care at home or in a homely setting.

All health and social care services in Scotland have a statutory 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.

Within NHS D&G potential incidents which trigger the duty of candour are identified through the Adverse Event Management process.

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 describes how NHS D&G has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

2. Policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy. Through our adverse event management process we identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on implementing the duty of candour.
Each adverse event is reviewed to understand what happened, why it happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. All significant adverse events are reviewed by the Executive chaired Patient Safety Group (PSG) to determine level of review. Level 1 Significant Adverse Event Reviews are commissioned by and report back to the PSG.

Recommendations are made as part of the adverse event review, and Directorate management teams develop improvement plans to meet these recommendations. They share their wider improvements plan with the PSG.

Training on adverse event management and implementation of the duty of candour is available for staff to access, to ensure they understand when it applies and how to trigger the duty. Additional online training and guidance is also available and for those who are our key risk contacts in the Directorates we provide regular development sessions.

All regulated healthcare professionals have a personal duty of care which includes:

- A duty to be open and honest with patients in your care, or those close to them, if something goes wrong. This includes offering an apology

- A duty to be open and honest with your organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.

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 occupational health.

3. How many incidents happened to which the duty of candour applied

Between 1 April 2018 and 31 March 2019, there were 25 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directory to the natural course of someone's illness or underlying condition. NHS D&G identified these incidents through our adverse event management process.

It should be noted that some incidents reported in the period covered by this report may still be open i.e. under investigation, and as such it may not be possible to say yet whether duty of candour applied.

All incidents and complaints are reviewed during the investigation process to consider whether they trigger any of the duty of candour conditions. It may not be clear at the beginning of an investigation whether the incident was preventable or part of the natural disease progression which can result in a delay in confirming duty of candour and thus in informing patients and their families.

Table 1 below summarises the number of incidents identified in each category between 1 April 2018 and 31 March 2019.

Table 1

Type of unexpected or unintended incident	**Number of times this happened**
A person died	5
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	13
The structure of a person's body changed	0
A person's life expectancy shortened	2
A person's sensory, motor or intellectual functions was impaired for 28 days or more	1
A person experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them dying	3
A person needing health treatment in order to prevent other injuries listed above	0
TOTAL	**25**

4. To what extent did NHS D&G follow the duty of candour procedure?

NHS D&G followed the correct procedure in 20 out of the 25 occasions (80% of the time).

This means:

- we informed the people affected and offered to meet with them
- we apologised to them
- we reviewed what happened and what went wrong to try and learn for the future.

Table 2 below summarises the steps staff are required to document and the compliance for each of the triggers.

In 5 out of the 25 cases, no apology was documented in the notes. We are working with staff to understand why, to offer training on giving an apology and to modify the system to ensure the reasons for this are documented in future.

Table 2

Trigger	Total	Patient/ Family Informed	Apology Offered	Recorded In Patient's Notes	Relevant Manager Notified
Increase in treatment	**13**	11	10	12	12
Death of the person	**5**	4	3	5	5
Shortening of the life expectancy	**2**	2	2	2	2
Person experienced 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	**1**	1	1	1	1
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	**1**	1	1	1	1
Required treatment by a Registered Health Professional to prevent (i) the death of the person or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	**3**	3	3	3	3
TOTAL	**25**	**22**	**20**	**24**	**24**

5. What has changed as a result?

We have made a number of changes to our procedure and systems for recording adverse events as well as changes to clinical processes following review of duty of candour events.

- A Learning Summary is produced and disseminated following all Significant Adverse Event Reviews.
- Family feedback has enabled us to produce an information leaflet and standard letter templates to keep families informed throughout the investigation process. This is now incorporated into our framework.
- A review of Mental Health ward pass (time out of the hospital) arrangements has commenced with some immediate recording issues strengthened.
- Maternity, neonatal and paediatric teams have agreed that a multidisciplinary meeting should be arranged with parents ahead of planned pre term births to discuss possible complications, management plans and any anxieties.
- Following an incident where people were harmed as a result of scalds, we rapidly disseminated a risk awareness notice to make all staff aware of the hazard and importance of risk assessment.

6. Conclusion & Next Steps

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

Ensuring that staff understand the requirements of the duty of candour legislation and the requirement to document that the actions have been taken are key areas that we will address in the year ahead.

Understanding that, in some cases it is not immediately apparent that an incident triggers duty of candour, has been learning for us and has meant that patients and their families have waited longer than we would have anticipated to be informed, to be offered an apology and to be invited to participate in the review process.

Much of what we have learned has been case specific but we have where it was appropriate to do so shared the themes and learning beyond the teams immediately involved.

There is much for us to build on in the year ahead to ensure that patients, their families and our staff are supported when things go wrong and that we continue to strive to keep people safe, well and free from harm when they are in our care.

If you would like more information about this report, please contact us using these details: mstevenson@nhs.net