1. Introduction

All health and social care services in Scotland have an organisational 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 are informed by the organisation what has been learned and how improvements for the future will be made.

An important part of this duty is that NHS Highland publishes an annual report which describes how the Board has operated the duty of candour procedures during the time between 1 April 2018 and 31 March 2019.

2. About NHS Highland

NHS Highland serves a population of 320,000 people across 32,500 square kilometres in the north of Scotland, making it one of the largest and most sparsely populated Health Boards in the UK. Operational front line services are provided through two distinct operational units – Highland Health and Social Care Partnership and Argyll and Bute Health and Social Care Partnership.

Our aim is to provide high quality care for every person who uses our services, in hospitals, community health and social care settings and in their own homes.

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

Between 1 April 2018 and 31 March 2019, there were 16 incidents which were fully investigated and where it was confirmed that 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 directly to the natural course of someone’s illness or underlying condition.

NHS Highland identified these incidents through the adverse event management procedures. Over the time period for this report further significant adverse event reviews were carried out which include a wider range of outcomes than those defined in the duty of candour legislation. Significant adverse event reviews are also undertaken where there is no harm to patients or service users, but there has been a significant impact to service or care delivery.

Staff identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Please note, some adverse events occurred in the period 1 April 2018 and 31 March 2019 and the investigation is ongoing. Adverse events where the status of duty of candour is not known at the time of this report are not included in the table below. If duty of candour applies, these adverse events will be included in the 2019/2020 annual report.
Table 1.

<table>
<thead>
<tr>
<th>Type of unexpected or unintended incident (not related to the natural course of someone’s illness or underlying condition)</th>
<th>Number of confirmed DoC cases (between 1 April 2018 and 31 March 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person died</td>
<td>3</td>
</tr>
<tr>
<td>A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions</td>
<td>2</td>
</tr>
<tr>
<td>A person’s treatment increased</td>
<td>10</td>
</tr>
<tr>
<td>The structure of a person’s body changed</td>
<td></td>
</tr>
<tr>
<td>A person’s life expectancy shortened</td>
<td></td>
</tr>
<tr>
<td>A person’s sensory, motor or intellectual functions was impaired for 28 days or more</td>
<td>1</td>
</tr>
<tr>
<td>A person experienced pain or psychological harm for 28 days or more</td>
<td></td>
</tr>
<tr>
<td>A person needed health treatment in order to prevent them dying</td>
<td></td>
</tr>
<tr>
<td>A person needing health treatment in order to prevent other injuries as listed above</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
</tr>
</tbody>
</table>

4. To what extent did NHS Highland follow the duty of candour procedure?

When it was identified that the events listed above had happened, staff followed the correct procedure in 13 out of the 16 occasions.

The people affected were informed in all 16 cases; apologies were made to them in all cases via leaflet and / or letter and staff apologising at the time. NHS Highland also invited the people affected to be involved in the investigation with approximately one third confirming they wished to be involved. Just under one fifth of the cases included in the figures resulted from a complaint being received. Some patients were subject to ongoing care with regular involvement with clinical staff so it is more difficult to ascertain the point at which information was shared as this was incorporated into ongoing conversations relating to care.

Of those who confirmed agreement to be involved, they were given the opportunity to meet and discuss their concerns or if they preferred raise them in a letter. They were then given feedback on the report in either written form and/or by meeting as per their wish. The feedback encompassed what happened, what went well, what did not go well, raised learning and subsequent actions.

NHS Highland noted challenges in completing three quarters of investigation processes in the three month timescale. This challenge also applies to cases which are still in the process of investigation and will be included in the 2019/20 report.

5. Information about our policies and procedures

The requirements of duty of candour have been embedded in the NHS Highland Adverse Event Management Policy and Procedures. Every adverse event is reported through our local reporting system (Datix) as set out in the NHS Highland Adverse Event Management Policy and Procedures. Through these procedures we can identify incidents that trigger the duty of candour procedure or are potential duty of candour cases.
Each adverse event is reviewed to understand what 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.

Recommendations are made as part of the adverse event review, and clinical and managerial teams take action to implement these recommendations. These are followed up until conclusion.

Complaints are also screened for potential duty of candour by the Feedback Team.

Staff receive training on adverse event management and incident reporting as part of their induction. Newsletters, communications and training events took place throughout 2018 and 2019 to highlight the procedures for escalating cases which had the potential to meet duty of candour. Committees and groups meet regularly in all operational units in NHS Highland to oversee the investigation of SAERs, with Associate Medical Directors and Lead Nurses having key responsibility in this area of work.

Staff have been encouraged to complete the Learnpro Duty of Candour training and additional training is also available for those members of staff who frequently review adverse events and chair SAERs.

We know that adverse events can be distressing for staff as well as people who receive care. Support is available for all staff through line management structures as well as through Occupational Health. Chaplains are also sighted on this work and happy to help not only patients and their families in times of distress but also staff that may be impacted. The chaplaincy department offers staff time and space to talk about how they feel following such events and helps them to get back to doing their job with confidence.

6. What has changed as a result?

We have made a number of changes following review of adverse events which have been identified as meeting the criteria of duty of candour. Please see the following cases as examples:

| Example 1: | A patient was admitted for an elective total hip replacement. During surgery the cement used to fix the femoral component set more quickly than usual resulting in an inadequate volume of cement in the femoral canal to support the implant. A subsequent x-ray confirmed that the femoral component required revision and the patient returned to theatre. The product was withdrawn until the investigation was completed |

It was identified that variation in the setting time of orthopaedic joint cement can be directly related to the ambient temperature of the storage location. The storage of orthopaedic joint cement must comply with the recommendations from the manufacturers and should be stored in a temperature monitored environment.

Temperature probing was completed of new storage areas in new orthopaedic theatres and daily temperature recording is taking place.

Assurance that the storage temperature for orthopaedic bone cement is within range has been added to the daily orthopaedic theatre safety brief.
Example 2:  A complaint was received in October 2018 from parents raising concerns about the treatment their son had received. The complaint was graded as ‘high’ and investigated as an SAER and potential DoC.

The patient had toothache and was seen by the Public Dental Service. Following filling of a tooth, a dental abscess developed resulting in significant, increased swelling and pain associated with a lower molar tooth. Some days later a further concern was noted by a PDS Dental Practitioner who was providing emergency dental care about the potential for the patient’s airway to become compromised. Following consultation with Oral Maxillofacial Surgery staff, urgent admission to Hospital was arranged.

Despite contact with in-hours/OOH dental services, NHS 24 and Raigmore Hospital A&E Department, urgent admission to Raigmore Hospital and onward transfer to Aberdeen for surgical drainage/management/tooth removal was necessary.

The review highlighted several concerns, and improvements have been made in various department, including:

- Improved adherence to guidelines
- Ensuring patients are directed to the most appropriate service or receive appropriate assessment
- Improved communication between organisations
- Availability of antibiotic/analgesia for dispensing at Out-of-Hours Dental Clinics
- Availability of medicines at community pharmacies
- Awareness raising of the challenges raised by this case and auditing of practice

Throughout the investigation, the Investigating Officer was in regular timely contact with the family. The review has been shared with the parents.

Example 3:  In July 2018, an older patient was discharged from the Community Hospital following an admission via A&E after a fall at home. The patient had a known risk of pressure ulcer development prior to this admission to hospital and received treatment for a pressure ulcer during his stay in the community hospital. Upon discharge the district nurses were advised to visit the patient to assess his situation at home and provide wound care to the pressure ulcer on his heel every second day. However the pressure ulcer on the heel deteriorated in the two days from his discharge to when he was visited at home by the district nursing team.

As part of the discharge planning from the community hospital, a profiling bed and a pressure relieving air mattress were requested from the NHSH Equipment Store via the District Nursing Team. In the absence of any air mattresses, the Equipment Store delivered a foam pressure relieving mattress along with a profiling bed prior to discharge.

As a result of this review the Equipment Store has implemented a process which requires the referrer to be notified of any delay or gap in provision of equipment which enables them to reassess and take any alternative action as required.
7. Other information

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the organisational duty of candour requirements. We have developed a number of new tools and resources to enable us to do this effectively and will continue to refine these. We have also undertaken some process mapping events to consider the end to end process from the adverse event occurring. We also review all formal complaints for potential duty of candour and may initiate a significant adverse event review following receipt of a complaint.

As required, we have advised Scottish Ministers of this report and we have also placed it on our website.

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