NHS Highland

NHS Highland Duty of Candour Annual Report 2022/23

1. Introduction

The requirements of the legislation relating to organisational duty of candour apply to all health and social care services in Scotland and 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 of what has been learned and how improvements for the future will be made.

An important part of this duty is that we publish an annual report which describes how NHS Highland has implemented and operated the duty of candour procedures over the previous year.

2. About NHS Highland

NHS Highland serves a population of 320,000 people across 32,500 square kilometres in the north and west of Scotland, making it one of the largest and most sparsely populated Health Boards in the UK. Our operational front line services are provided through two distinct operational units – Highland Lead Agency 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. Number and Nature of Duty of Candour incidents

For duty of candour to apply, the patient/service user needs to have suffered a harm as defined below (not related to the natural course of someone's illness or underlying condition) AND for care or service issues to have contributed to this event i.e.

• A different plan and/or delivery of care may have resulted in a different outcome though uncertainty regarding impact on patient outcome/event.

• A different plan and/or delivery of care, on the balance of probability, would have been expected to result in a more favourable outcome, i.e. how the case was managed had a direct impact on the level of harm

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	<5
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	<5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	19
Changes to the structure of the person's body	<5
The shortening of the life expectancy of the person	0
An 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	<5
The person experiencing 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.	<5
The person required treatment by a registered health professional in order to prevent:	
The person dying	<5
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
TOTAL	29

Between 1st April 2022 and 31st March 2023, 29 incidents were investigated and confirmed as meeting the criteria for organisational duty of candour. The figures declared over the last 5 years can be seen below.

2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
15	22	53	36	29

Robust scrutiny of cases with a wide range of senior clinicians and managers in attendance has continued at weekly and monthly meetings in all operational units.

Some of the adverse events included in this report occurred prior to 1st April 2022 and were confirmed as duty of candour within 2022/2023. Adverse events which occurred within 2022/2023, where the investigation is ongoing and status of duty of candour has not yet been confirmed are not included in this years figures. These cases will be included in the 2023/2024 annual report.

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

Of the 29 identified cases, each one was reviewed to assess for compliance for the following elements recognising if there was no response from the patient or relative following attempts to contact them this would still count as compliance.

- Patient and or relative were notified and informed of the adverse event
- Providing an apology
- A review was undertaken
- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting

In the 29 identified cases the requirements of the duty of candour procedure were met in 22 of the cases. Of the remaining 7 cases - in 4 cases it was not possible to determine to what

extent the requirements of the act had been met. In 3 of the cases it was not considered appropriate to contact the patient/family.

Improvement since last year has been made in:

• Recording of the written apology sent to patients/family

Areas for improvement

• Recording and documenting follow up meetings and output from these on the Datix system

5. Information on policies and procedures

Adverse events are identified through the incident reporting system (Datix) and also through complaints received by the Feedback Team. Through our adverse event management procedures we can identify incidents that trigger duty of candour and the adverse event policy has the requirements for duty of candour embedded within it. The policy and procedures were updated in line with the re issue of the National Adverse Events Framework in December 2019. Complaints triaged as high level are considered for duty of candour and if activated this will be stated in the complaint response with the offer of a follow up meeting.

Each of the operational units have a weekly check-in meeting to identify cases which may trigger duty of candour and to establish what further investigation is required. The level of review depends on the severity of the event as well as the potential for learning. Monthly validation meetings also consider the output from investigations, ratify recommendations and confirm if Duty of Candour applies.

Staff have access to information on the intranet via our dedicated duty of candour page and training is available via the NES Education Scotland Duty of Candour e-learning module. For those staff frequently involved in the review process bespoke training can be provided by the CGST.

We recognise that adverse events can be distressing for patients, families and staff. Our chaplaincy service are also sighted on this work and are happy to help patients, families and staff if they need assistance in dealing with a distressing event. Additional support is available for all staff through our line management structure as well as through Occupational Health.

6. What has changed as a result?

Falls :

NHS Highland have recently introduced a daily care plan (DCP) (Appendix 1) to prescribe person centred nursing care for each patient. The DCP was rolled out across Raigmore Hospital over May and June 2023 supported by Clinical Educators

and Quality Improvement practitioners. It has now been rolled out across Acute Services Division, including the Rural General Hospitals. The DCP is currently being audited across all areas with local improvement plans being implemented.

- Falls improvement practitioner and clinical educators supporting ward areas with falls improvement work

Pressure Ulcers:

As above regarding the daily care plan work

- Identification of new tissue viability link nurses and additional support and input from the clinical educator.
- Recruitment to Lead Nurse for Tissue Viability post.
- Change in process regarding escalation of unavailability of pressure relieving equipment
- Review of process of reporting and referral of pressure ulcers

Other cases

- Teaching and Information surrounding Bakri balloon has been published on for all health care professionals on departmental 'risky business' newsletter for learning

- Review of current state of Risk Assessment and Management documentation in use in in patient mental health services

- Ensure that care plans are consistent with Mental Wefare Commission best practice, are person centred and describe the specific interventions for the patient and are regularly evaluated**.** Monitoring of this recommendation should be assured monthly using the NHS Highland 'Mental Health Nursing Record Keeping and Care Planning Audit' tool.

- Development of SOP for safe Walking Aid Provision

7. **Covid-19 Pandemic**

No cases of organisational duty of candour have yet been confirmed relating to patients adversely affected either directly or indirectly as a result of a delay in treatment or not receiving treatment as a consequence of COVID 19.

8. **Additional Information**

Continue to develop and refine our existing adverse event management processes and procedures to embed the principles of organisational duty of candour requirements.

Ensuring that a plan for communication with patient and family is clear and included as part of commissioning reviews

Further amendments to the datix system are planned to better record evidence of the key steps in the procedure particularly follow up meetings.

Ensure appropriate early communication with patient and families where it is unclear whether the statutory duty of candour applies at the outset

Continued discussion and collaboration with other Duty of Candour Leads through the Adverse Event Networking Group to achieve greater consistency in application of the Duty between health boards

Continued involvement with Scottish Government update to guidance and communication /implementation of this when complete

Continued training and updates to those involved in the Duty of Candour process

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: nhshighland.feedback@nhs.scot