NHS Highland

NHS Highland Duty of Candour Annual Report 2020/21

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 between 1st April 2020 and 31st March 2021.

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

Between 1st April 2020 and 31st March 2021, there were 53 incidents which have been investigated and assessed as meeting the criteria for organisational duty of candour.

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 that person's illness or underlying condition.

NHS Highland identified these incidents through our adverse event management procedures.

Please note, some of the adverse events included in this report occurred prior to 1st April 2020 and were investigated and assessed as meeting duty of candour within 2020/2021. Adverse events which occurred within 2020/2021 but where the status of duty of candour was not confirmed within this time period are not included in the table below. These cases will be included in the 2021/2022 annual report.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	8
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	9
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	21
Changes to the structure of the person's body	4
The shortening of the life expectancy of the person	1
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	3
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.	6
The person required treatment by a registered health professional in order to prevent:	
The person dying	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	
TOTAL	53

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

In 42 out of the 53 identified cases contact with the affected person was made and an apology offered. 4 did not respond, 4 did not wish to be involved further, 16 indicated they wished to be involved. In 18 cases there is no information recorded relating to family involvement. In 9 cases it is not recorded whether contact with the relevant person was made.

Of the 16 who wished to be involved 3 wished a face to face meeting, otherwise the preference was for email, letter or telephone communication. Findings were fed back to all who wished this. Of the 16 patients / families who confirmed they wished to be involved, the duty of candour procedure and timescales were fully met for 10, and partially for 6.

On 2 occasions contact was not made – 1 was a deceased patient with no next of kin, the other the reason for not making contact has not been documented.

It is noted that some cases were identified via receipt of complaints. Not all patients / families were offered a meeting which may be related to the restrictions in place due to COVID 19. We are working to improve the reliability of inviting people to follow-up meetings to discuss the event and also improve timescales for investigation and how we record this.

5. Information on policies and procedures

Every adverse event is reported through our local reporting system (Datix) as set out in our adverse event management policy and procedures. They may also be notified through case reviews, mortality reviews, the complaint process or disclosure/reporting by clinicians. Through our adverse event management procedures we can identify incidents that trigger duty of candour and the adverse event management policy has the requirements for duty of candour embedded within it. The policy and procedures have been updated following the re-issue of the National Adverse Events Framework in December 2019 and contains a section on communicating with patients and families.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. Each of the operational units have a weekly check-in meeting to identify cases which may meet the requirements of Duty of Candour and to establish what further investigation is required. The criteria used for assessing whether duty of candour should be activated is when a system or care delivery issue has been identified which has resulted in unexpected/unintended harm as defined by the act and is unrelated to an underlying condition 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.

Staff have access to information on the intranet via our dedicated duty of candour page and are encouraged to complete the NES Education Scotland Duty of Candour e-learning module. Additional training and readily available advice is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

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. Our Chaplains are also sighted on this work and happy to help patients and their families and in addition staff if they need assistance in dealing with a distressing event.

6. What has changed as a result?

- Flat lifting device purchased for a community hospital following a fall with harm
- Enhanced awareness of increased level of care policy and the use of risk assessment and care plans when care rounding identified as required through falls risk assessment
- Revision of the metastatic spinal cord compression policy after a patient was admitted with suspected spinal cord compression out of hours to a wing ward as per policy. Abnormal ECG's were not actioned and there was a delay in recognition of hyperkalaemia resulting in cardiac arrest and death.
- Delay in diagnosis of aortic dissection in a patient with known aortic aneurysm presenting with back pain – all patients such as this are to have CT angio on first presentation. This has been communicated to all acute hospitals in NHS Highland and added to departmental policy pages.
- Missing persons policy reviewed and relaunched following a patient absconding from mental health services
- Gentamicin Patient Safety Alert highlighting the potential for toxicity Updated prescription chart highlights and requires clinicians to monitor for potential toxicity prior to every dose. Patient information leaflet also produced.

7. Covid-19 Pandemic

The procedure for activating duty of candour did not significantly alter in NHS Highland. An additional section was added to datix to indicate if the adverse event was related to COVID 19. Weekly check in meetings and monthly sub group meetings continued via TEAMS. Some of those involved in facilitating reviews were required to return to clinical duties which impacted.

Hospital outbreaks and other issues related to COVID were largely investigated and actioned by the Infection Control Team. Advice and discussion relating to declaring duty of candour in relation to COVID 19 was sought from the Central Legal Office.
Only 1 case was attributed directly to COVID 19 involving a hospital acquired infection where the patient, on the balance of probability, acquired COVID from a member of staff. NHS Highland has not yet declared duty of candour relating to patients who have been 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

This is the third year of the duty of candour procedures being in operation and we continue to develop and refine our existing adverse event management processes to include and embed the principles of the organisational duty of candour requirements.

We continue to review all formal complaints for potential duty of candour.

The number of incidents of duty of candour has almost doubled although this could be attributable to more robust processes and discussion at the weekly check ins and also a more widespread and improving knowledge of the process and required criteria.

It is clear that we need to ensure that a plan for communication with the relevant person is clear and that the roles in relation to this communication is clarified at the commissioning of the review.

From reviewing the data it is clear that we need to make amendments to the manner in which we record the evidence of the key steps in the procedure and disseminate this information to those involved in recording it.

It would be useful to develop local networks to reflect and learn from Duty of Candour decision making particularly around thresholds for increase in treatments.

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.net