NHS Highland

NHS Highland Duty of Candour Annual Report 2021/22

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

Between 1st April 2021 and 31st March 2022, 36 incidents were investigated and confirmed as meeting the criteria for organisational duty of candour, 17 fewer than 2020/2021.

No obvious reason for this reduction has been identified. 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 2021 and were confirmed as duty of candour within 2021/2022. Adverse events which occurred within 2021/2022, where the status of duty of candour has not yet been confirmed are not included in this years figures. These cases will be included in the 2022/2023 annual report.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	6
A person suffered permanent lessening of bodily, sensory, motor, physiological	2

or intellectual functions	
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	2
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	2
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.	2
The person required treatment by a registered health professional in order to prevent:	
The person dying	
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	
TOTAL	36

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

In 24 out of the 36 identified cases the requirements of the duty of candour procedure were either fully or partially met. In the remaining 12 cases we were not able to determine to what extent the requirements of the act had been met. In 32 of the cases contact was made with patients/families.

The review of the data for this report has highlighted a gap in the way contact and communication with families is documented and recorded on Datix.

A test of change of returning duty of candour letters to weekly check in meetings and ensuring these are subsequently uploaded onto Datix has commenced.

As in previous years all 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.

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.

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.

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 is 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 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?

- Upgraded reporting platform for radiological reporting on 'Vue' and use of standardised template in 3 sections so that the main findings from radiological examinations are explicit to the referring clinicians in the conclusion

- Case review paper completed highlighting a rare complication of procedure by one of the surgical teams to be shared with academic journal for learning

- Standard Operating Procedure developed for patients undergoing operations or injections involving ocular muscles

- Development and implementation of a Naso Gastric tube bundle in ITU

- Development of a set of principles and criteria to define patients who are suitable for Near Me appointments

- Patient Safety alerts circulated for Naso Gastric tube placement and Hypoactive Delirium as an indicator in the deteriorating patient

- Short Life Working Group developed to progress ongoing work on fluid balance management in Acute

7. Covid-19 Pandemic

The procedure for activating duty of candour has not significantly altered in NHS Highland during the COVID pandemic. Investigation of adverse events continued as did the weekly and monthly meetings to validate and ratify the findings of these investigations.

Hospital outbreaks and other issues related to COVID were largely investigated and actioned by the Infection Control Team. Advice to declaring duty of candour in relation to COVID 19 was sought from the Central Legal Office.

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.

Documentation of our contact and communication with patients and families when duty of candour is declared needs to be more consistently documented on the datix system

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

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