DUTY OF CANDOUR ANNUAL REPORT
2021-22

NHS Ayrshire & Arran Duty of Candour Annual Report 2021-22

All health and social care services in Scotland have a 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.

An important part of this duty is that we provide an annual report about how the Duty of Candour is implemented and the number of times Duty of Candour has been triggered within our organisation. This report describes how NHS Ayrshire & Arran has operated the Duty of Candour between 1 April 2021 and 31 March 2022.

1.0 About NHS Ayrshire & Arran

NHS Ayrshire & Arran serves a population of around 376,000 people and employs in the region of 10,500 staff. The Board provides a full range of primary and secondary clinical services covering the mainland of Ayrshire and the islands of Arran and Cumbrae and three Local Authority areas of North, South and East Ayrshire.

The Board currently operates over two Acute Hospital sites, University Hospitals Ayr and Crosshouse, and 70 community based healthcare settings including GP practices.

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.

2.0 Number and Nature of Duty of Candour incidents

Between 1 April 2021 and 31 March 2022 there were 208 instances where the Duty of Candour was triggered. These are unintended or unexpected events 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 conditions. Table 1 below provides a breakdown of the application of Duty of Candour.

Nature of unexpected or unintended incidents which triggered Duty of Candour	**Number**
A person died	13
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	109
Changes to the structure of the person's body	34
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	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.	25

The person required treatment by a registered health professional in order to prevent:	
The person dying	2
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	21
Total	**208**

Table 1: Duty of Candour 1st April 2021 – 31st March 2022

NHS Ayrshire & Arran identified these events through our adverse event management process. Of the 208 adverse events that were determined by the relevant Directorate Adverse Event Review Group that Duty of Candour was applicable, 18 resulted in the commissioning of a Significant Adverse Event Analysis and Review (SAER) and 190 Local Management Team Reviews (LMTR) for 2021/22.

3.0 To what extent did NHS Ayrshire & Arran follow Duty of Candour procedure?

NHS Ayrshire & Arran has a robust process for the identification and management of events where Duty of Candour is triggered; this process is integrated within the Adverse Events Policy.

Once an adverse event has been identified as potentially triggering Duty of Candour by the Reviewer/Final Approver, an escalation is generated within the local reporting system and a review level decision making SBAR is submitted to the relevant Directorate Adverse Event Review Group who will determine whether or not Duty of Candour is triggered and the level of review to be undertaken. This decision is based on the adverse event, the content of the SBAR, the NHS Ayrshire & Arran agreed 'never events' list, the flowchart for Maternal Death and Stillbirths found in the Adverse Event Policy Application Guidance and the specialist knowledge of the advisors of the group.

Where Duty of Candour is triggered, all necessary action will be taken in accordance with the Duty of Candour procedure. The key stages of the procedure include the requirement to:

- Notify the person affected (or family/relative where appropriate);
- Provide an apology;
- Carry out a review into the circumstances leading to the incident;
- Offer and arrange a meeting with the person affected and/or their family, where appropriate;
- Provide the person affected with an account of the incident;
- Provide information about further steps taken; and
- Make available, or provide information about, support to persons affected by the incident.

NHS Ayrshire & Arran has committed to commissioning a minimum of a Local Management Team Review (LMTR) where Duty of Candour has been triggered. Both the Local Management Team Review and Significant Adverse Event Review processes include the steps indicated above will be commissioned and a formal report is produced to identify and implement any learning.

A defined guidance for application of Duty of Candour in relation to Grade 3, 4, suspected deeper tissue and upgradeable pressure ulcers acquired under our care was implemented in alignment with Healthcare Improvement Scotland's Pressure Ulcer Standards.

4.0 Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our Adverse Event Policy. Through our adverse event management process we can identify events that trigger Duty of Candour. Our Adverse Event Policy contains a section on implementing the Duty of Candour. A stand-alone Duty of Candour Policy will be developed during 2022 / early 2023.

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 improvement plans are developed to meet these recommendations.

Patients and/or families are allocated a family contact who provide regular contact with the patient / family to share information and updates on the progress of the review. The contact person has the required skills to respectfully disclose sensitive information and answer questions or concerns the patient / family may have. The NES : Duty of Candour training module is available to all staff via NHS Learn Pro System which provides guidance and supportive tools around providing a person centred apology and planning and preparing for subsequent discussions.

All staff who review and finally approve adverse events receive training on adverse event management and the implementation of the Duty of Candour prior to being given access to the adverse event reporting system, so that they understand when it applies and how to trigger the duty. In addition, NHS Ayrshire & Arran have robust governance arrangements to monitor all reported adverse events to provide further assurance that any events which may have triggered Duty of Candour are identified.

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 and staff care.

5.0 What has improved as a result?

We have identified a number of learning and/or improvements following review of the duty of candour events.

There are two key examples of learning below that we would like to highlight following review:-

An inpatient was placed on a textured modified diet following a speech and language therapy (SLT) assessment. The patient choked on meat which was not consistent with the level of diet and sadly passed away.

The review team identified a lack of congruence in the understanding of the terminology used to describe the recommendations made following the SLT assessment and an action plan has been developed with the following recommendations to reflect the approach required to address this gap:-

- The Board must develop and implement a Dysphagia Policy across all areas of clinical care.
- Design and implement formal training for all staff who are involved in ordering, preparation and serving modified diet foods.
- Design and implement a local assurance process within each ward providing assurance that all aspects of the mealtime process is being complied with. Criteria should include checking at least two meal services per week with performance reports being submitted to NHS Ayrshire and Arran's Area Nutritional Steering Group.
- A programme of independent audit on mealtime process should be implemented.
- Review and revise meal cards to ensure that the terminology is consistent with IDDSI standards.
- Review Pre-Planned Maintenance (PPM) Programme to ensure a robust process is in place for identifying equipment, asset recording, ensuring that there is a visible indicator to demonstrate that the equipment is in date for its PPM, advising services of equipment that cannot be located and report on completion performance through the appropriate governance groups.

Two patients attended the Haematology day unit on the same day to have planned transfusion of packed red cell concentrate (RCC). The patients had the same first name but different surnames. An adverse event occurred where one of the patients was given the RCC transfusion intended for the other patient in error. The error was discovered within 30 minutes and, although this could have led to severe consequences, they suffered no physical ill effects. The error occurred in the bedside administration of the blood component during the checking process. The Root Cause was found to be a breakdown in the bedside checking process prior to administration.

Following review an action plan has been developed with the following recommendations:

- Review compliance of 2 registered nurse blood product support checking process.
- Develop and provide an update to all staff involved in requesting and administering blood products on checking processes and non-compliance consequences.
- Ensure that Safe Transfusion Practice training is up to date in all relevant staff within the affected clinical area.
- Ensure that staff ordering blood products on Trak Care have the appropriate training and support to carry out this task.
- An Organisational Learning Summary should be circulated to all areas of the organisation involved in transfusion of blood products.

6.0 Other information

This is the fourth year of the Duty of Candour being in operation and it has been another year of learning and refining our existing adverse event management process to include the Duty of Candour outcomes. Our learning continues to be refined in terms of application of Duty of Candour. As required, we have submitted this report to Scottish Ministers and we have also placed it on our public website.

If you would like more information about this report, please contact us using these details: Jennifer Wilson, Nurse Director. Telephone 01292 513674 or email Jennifer.Wilson2@aapct.scot.nhs.uk