DUTY OF CANDOUR ANNUAL REPORT
2019-20

NHS Ayrshire & Arran Duty of Candour Annual Report 2019-20

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 in our services. This report describes how NHS Ayrshire & Arran has operated the duty of candour between 1 April 2019 and 31 March 2020.

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 three Acute Hospital sites, University Hospitals Ayr and Crosshouse and Woodland View 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.

NHS Ayrshire & Arran have integrated Duty of Candour into their Management of Adverse Events Policy and determined that a minimum of a Local Management Team Review will be commissioned to review the circumstances of the event to identify any learning and ensure the requirements of Duty of Candour are applied.

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

Between 1 April 2019 and 31 March 2020, there were 73 instances where the duty of candour applied. 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 condition. Table 1 below provides a breakdown of the application of Duty of Candour.

Reason Duty of Candour is Activated	Total
An increase in the person's treatment (significant increase - refer to Risk Matrix for guidance)	31
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	19
Death of the person	6

Changes to the structure of the person's body	5
Treatment by a registered healthcare professional in order to prevent injury to the person which, if left untreated, would lead to one or more of the outcomes listed	4
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 shortening of the life expectancy of the person	2
Treatment by a registered healthcare professional in order to prevent the death of the person	2
Permanent lessening of bodily, sensory, motor, physiological or intellectual functions	1
Total	**73**

Table 1: Duty of Candour 1st April 2019 – 31st March 2020

NHS Ayrshire & Arran identified these incidents through our adverse event management process. Over the time period for this report a total of 356 adverse events were escalated to the appropriate Adverse Event Review Group to determine the appropriate level of review; this resulted in commissioning of 31 Significant Adverse Event Analysis and Reviews (SAER) and 97 Local Management Team Reviews (LMTR). These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

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 Management of Adverse Events Policy.

Once an incident has been identified as triggering the requirements of Duty of Candour by the Reviewer/Final Approver of the adverse event, an escalation is triggered within the internal system and a report is submitted to the Directorate Adverse Event Review Group which will then review the detail of the SBAR and determine the level of review to be undertaken 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 identified. Both the Local Management Team Review and Significant Adverse Event Review processes include the steps indicated above and a formal report is produced for these events.

A defined guidance for application of Duty of Candour in relation to Grade 3 and 4 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 management policy. Through our adverse event management process we can identify events that trigger the Duty of Candour procedure. Our adverse event management policy contains a section on implementing the duty of candour. Where Duty of Candour applies, a minimum Local Management Team Review will be undertaken.

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 local management teams develop improvement plans to meet these recommendations.

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 has 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.

5.0 What has improved as a result?

We have made a number of changes following review of the duty of candour events. There are three key changes listed below that we would like to highlight:

- We have developed an action plan for implementation across the organisation in relation to pressure ulcers with the actions as follows;
  - All registered and unregistered staff to attend the Fundamentals of Care study as part of role specific mandatory training requirement.
  - An audit of nursing notes and SSKIN bundle rounding charts to be undertaken on a monthly basis using the audit tool developed by Clinical Improvement for a minimum of six months in accordance with the Pressure Ulcer Audit through the Clinical Portal.

- Review of care and comfort bundle documentation to be carried out in conjunction with the Clinical Improvement team.
- All nursing staff to attend the tissue viability session or view the associated DVD in relation to ‘how to complete the SSKIN bundle’.
- All nursing staff to complete ‘Foot for Thought’ and ‘Top to Toe’ skin inspection mini videos.
- All nursing staff to complete the National Education for Scotland (NES) ‘Prevention Management of Pressure Ulcers’, this is on LearnPro under CPD tab.
- Senior Charge Nurses to ensure all staff have read and understood the requirements identified in Learning Summary 2020-004 ‘Potential for incorrect recording of acquired pressure ulcers’ and ensure that the actions identified have been implemented.

- An event happened where the wrong strength of intra-ocular lens was inserted during cataract surgery which resulted in the patient having to receive further surgery. A Standard Operating Procedure was developed and implemented to ensure that the lens dioptre is checked by the scrub/circulating nurse and operating surgeon prior to surgery start and a further Standard Operating Procedure was also implemented to ensure that the implanted lens, as recorded on the sticker in the operative note, is checked against the information recorded in the cataract notes prior to the patient leaving theatre (the sign-out) and again prior to the patient being discharged home.

- Within Mental Health Services all urgent referrals to the CMHT will be monitored over the next 6 months to ensure that patients are offered same day/next day appointment OR where status is changed this is documented in Care Partner and the GP emailed AND that a further appointment has been made within 7 days.

6.0 Other information

This is the second 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: Prof Hazel Borland, Nurse Director, telephone 01292 513002.