DUTY OF CANDOUR ANNUAL REPORT
2020-21

NHS Ayrshire & Arran Duty of Candour Annual Report 2020-21

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 2020 and 31 March 2021.

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.

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 Number and Nature of Duty of Candour incidents

Between 1 April 2020 and 31 March 2021, there were 159 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.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	7
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	5

Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	86
Changes to the structure of the person's body	19
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	8
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
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	14
Total	**159**

Table 1: Duty of Candour 1st April 2020 – 31st March 2021

NHS Ayrshire & Arran identified these incidents through our adverse event management process. Of the 159 adverse events that were determined by the relevant appropriate Adverse Event Review Group that Duty of Candour was applicable; resulted in the commissioning of 10 Significant Adverse Event Analysis and Reviews (SAER) and 149 Local Management Team Reviews (LMTR) for 2020/21.

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, 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 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.

Patients and/or families are allocated a family contact who provide regular contact with the 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 or family may have.

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 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 three key examples of learning below that we would like to highlight following review:

A patient was having a nail bed haematoma drained using an electro-cautery device and ethyl chloride was used for anaesthesia. The ethyl chloride ignited while the device was 10 cm from the patient. An action plan has been developed with the following recommendations;

- Ayrshire Emergency Departments should provide education for relevant staff relating to the correct procedure for trephination of subungual haematomas.
- A poster or additional labelling, highlighting the flammable nature of ethyl chloride, should be displayed where the substance is stored within the ED.
- The organisation should consider re-emphasising the hazards of using flammable materials in close proximity to a potential ignition source.

A patient was admitted with a history of gallstone pancreatitis and underwent a laparoscopic cholecystectomy. Three days after discharge the patient was admitted to Inverclyde Hospital and had a laparotomy for severe sepsis due to bile leak. The patient was transferred to the Queen Elizabeth Hospital ITU post-operatively, where they died two days later from multi-organ failure. An action plan has been developed with the following recommendations;

- Patients with unusually high opioid analgesic requirements following gall bladder removal should have a CT scan prior to discharge.
- Patients who are not discharged within 24hrs of surgery because of ongoing pain should have a CT scan to identify any bile leak or bleeding.
- There should be a single patient information leaflet for laparoscopic gallbladder surgery on both sites. This information leaflet should include information on how to have direct advice from the surgical team after discharge, rather than using NHS 24 or GP services.

Patient developed sepsis associated to staphylococcus aureus bacteraemia from a peripheral venous cannula (PVC). An action plan has been developed with the following recommendations;

- Staff carrying out PVC insertion (Medical, Advanced Nurse Practitioners, Clinical Support Workers and Nurses) must have completed the cannulation and venepuncture training and competency framework;
- All competent staff must complete the PVC Insertion and Maintenance Documentation Bundle as per Guideline G084 – Insertion & Maintenance of PVC in Adults (16 years and over);
- Peripheral Vascular Catheter Insertion Bundle (PVCI) and Peripheral Vascular Catheter Maintenance Bundle (PVCM) audits must be completed weekly and compliance maintained at 100%.

Covid-19 Pandemic

Setting the context

Given the pressures that were experienced by NHS Scotland and the decision to place the NHS across Scotland on emergency footing on the 17th March 2020 there was an impact on every board's ability to meet the national timescales for Adverse Event reviews, which included Local Management Team Reviews (LMTRs) and Significant Adverse Event Reviews (SAERs). A proposal in how these were managed was approved by the Risk and Resilience Scrutiny and Assurance Group in March 2020.

Practical Actions Taken

The following actions were agreed;

- Continued to report adverse events and at the very least all consequence 4/5 and Duty of Candour Adverse Events were captured and the initial assessment completed as soon as possible;
- Adverse Event Review groups continued to meet on a weekly basis but via electronic platform instead of face to face;
- Continued to commission new LMTRs and SAERs, however the availability of clinical staff to lead and participate had reduced significantly. LMTR and SAER reviews that were already underway continued where possible;
- Communication was sent out to patients, families and staff involved in LMTRs and SAERs informing them of any delays and reiterating our commitment to review the event and confirming that we will communicate any changes or further delays that may occur as a result of COVID-19;
- Patient, Family and Staff feedback meetings were still undertaken but via electronic platforms, telephone and socially distanced meetings.

Whilst every effort was made to continue to progress the work on reviews, some reviews have exceeded our expected completion dates.

Learning for the future

Responding to the Covid-19 pandemic has meant changes to NHS Ayrshire & Arran's policies and processes, including activating the Duty of Candour procedure for unintended or unexpected incidents resulting or could result in harm or death.

The review of events to determine the application of Duty of Candour by the relevant Adverse Event Review groups will continue to meet via electronic platform instead of face to face and the best method for providing Patient, Family and Staff feedback meetings will also be considered.

6.0 Other information

This is the third 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, Interim Nurse Director, telephone 01292 513674.