DUTY OF CANDOUR
ANNUAL REPORT
2023-2024

NHS Ayrshire & Arran Duty of Candour Annual Report 2023-2024

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 / harm or intervention is required to prevent death / harm as defined in the Act and does not relate directly to the natural course of someone's illness or underlying conditions, the people affected understand what has happened, receive an apology and that our organisation learns how to improve for the future.

An important part of the Duty is the provision of an annual report detailing how the Duty of Candour has been implemented across the organisation and the number of times the Duty of Candour has been applicable. This report describes how NHS Ayrshire & Arran has fulfilled its' responsibilities in the triggering of Duty of Candour for adverse events which occurred between 1 April 2023 and 31 March 2024.

1. 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. Number and Nature of Duty of Candour incidents

Of the 8913 reported adverse events which occurred between 1 April 2023 and 31 March 2024, 446 patient / service user adverse events were escalated for consideration of Duty of Candour through our adverse event management process. 122 events (1.4% of total number of annual reported adverse events) were reviewed by the relevant Directorate Adverse Event Review Group (AERG) confirmed to be Duty of Candour applicable. 21 events resulted in the commissioning of a Significant Adverse Event Analysis and Review (SAER) and 101 events resulted in the commissioning of a Local Management Team Review (LMTR).

Table 1 below provides a breakdown of the number and nature of Duty of Candour application:-

Nature of unexpected or unintended incidents which Duty of Candour was applicable	**Number**
Death of the person	12
A permanent lessening of bodily, sensory, motor, physiological or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	19
Changes to the structure of the person's body	2
The shortening of the life expectancy of the person	2

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	0
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.	86
The person required treatment by a registered health professional in order to prevent:	
The death of the person	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	**122**

Table 1: Number and Nature of Duty of Candour Application 1 April 2023 – 31 March 2024

3. To what extent did NHS Ayrshire & Arran follow the Duty of Candour procedure?

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

Once an adverse event has been identified as potentially triggering Duty of Candour by the Reviewer/Final Approver, an escalation email is generated within the local reporting system and an Adverse Event Review Level Decision Making SBAR is submitted to the relevant Directorate AERG who will determine whether or not Duty of Candour is applicable and the level of review to be undertaken. This decision is based on the:

- adverse event
- content of the Adverse Event Decision Making SBAR
- NHS Ayrshire & Arran's agreed 'Never Events' list
- NHS Ayrshire & Arran's Adverse Event Policy
- specialist knowledge of the subject experts of the AERG

Where Duty of Candour is applicable, all necessary actions 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 next of kin where appropriate);
- Provide a verbal apology with follow up in writing;
- Carry out a review into the circumstances leading to the adverse event;
- Offer and arrange a meeting with the person affected (or next of kin where appropriate) and address any questions they have;
- Provide the person affected with detail of the review findings;
- Provide information about improvement actions; and
- Make available, or provide information about, support to persons affected by the adverse event.

NHS Ayrshire & Arran has committed to commissioning a minimum of a LMTR where Duty of Candour has been confirmed. Both the SAER and LMTR processes include the

steps indicated above 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, Grade 4, Suspected Deeper Tissue Injury and Ungradable pressure ulcers, acquired under our care was implemented in alignment with Healthcare Improvement Scotland's Pressure Ulcer Standards.

4. 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 where potential Duty of Candour is applicable. Our current Adverse Event Policy contains a section on implementing the Duty of Candour. Following consultation, a stand-alone Duty of Candour Policy has been agreed and will be developed during the 2024 Adverse Event Policy review.

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 is a member of the Review Team) 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 NHS National Education for Scotland : Duty of Candour training module is available to all staff via the 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 process 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. 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 examples below of learning applied following reviews:-

Example 1

Event Summary
Loss of controlled airway causing patient to become acutely hypoxic and subsequently die.

Learning Identified
- Improve documentation for handover to Intensive Care Unit.
- Improve use of UK National Tracheostomy Safety Project Bedhead Sign and Algorithm.
- Consideration to be given to the location of these potentially complex patients with a future service reconfiguration.
- A program to ensure skill maintenance and development to be considered in light of increasing site specialisation.

Example 2

Event Summary
A patient being treated for a pulmonary embolism (PE) became more clinically unwell and had a cardiac arrest and subsequently died.

Learning Identified
- Consultant teams to share learning with wider team at Morbidity and Mortality meetings.
- Ensure nursing staff are aware how and when to escalate unwell patients.
- Ensure all patients out with their designated ward are added to the boarders list.
- Any ward which has patients under joint medical and surgical care should be extra vigilant to ensure that this is highlighted on the whiteboard and boarders list.

Example 3

Event Summary
A septal haematoma was missed resulting in abscess formation and septal necrosis which will require ongoing treatment. A failure to recognise a rarely seen presentation resulted in delayed treatment. Once the problem was recognised, all treatment was appropriate but occurred too late to prevent complications.

Learning Identified
An ongoing and repeated educational program aimed at Ear Nose and Throat (ENT) emergencies delivered at both junior and senior level ED teaching. This will cover all ENT emergencies that are likely to be seen in the Emergency Department. It would be anticipated that the first session would occur within a six month period from this review with a recurrence of approximately every 18 months at a senior level and six months at a junior level.

6. Other information

This is the sixth 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 published this report on our public website.

This Duty of Candour Annual Report 2023-2024 will have an addendum produced later in the year (2024) which will include detail of any additional adverse events where Duty of Candour applies. This is to address the adverse event reviews which are not yet concluded at the time of publishing this report.

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