Duty of Candour Annual Report

1 April 2020 – 31 March 2021

Report Prepared by:	
Joanne Forrest	Clinical Risk Coordinator
Report Approved by:	
Julie Campbell	Quality Improvement Facilitator: Patient Safety
Laura Jones	Head of Clinical Governance & Quality
Lynn McCallum	Medical Director
Report Date:	
23 August 2021	

Information about the NHS Board

NHS Borders provides a wide range of healthcare services through numerous locations throughout the Scottish Borders. NHS Borders incorporates an acute hospital (BGH) together with 4 Community Hospitals and 5 Mental Health units. Our purpose is to improve the health of our population and deliver healthcare services that meet the needs of the Borders community.

The organisational Duty of Candour (DoC) legislation has been in place since April 2018 when the Scottish Government introduced statutory organisational Duty of Candour legislation in Scotland.

NHS Borders

NHS Borders is one of the smaller health boards in Scotland with a population of 115,000 across rural and urban communities. We employ approximately 3,500 staff and have one main acute hospital, 4 community hospitals and 5 mental health units. Safe Patient Care is paramount within NHS Borders and our Corporate Objectives.

Number and Nature of Duty of Candour incidents

For the period 1 April 2020 to 31 March 2021 there were 8 significant adverse events which activated the organisational DoC. These are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

For the 8 significant adverse events the following reviews were carried out:

Type of Review	No. of Reviews
Significant Adverse Event Review (SAER)	4
Management Review	2
Duty of Candour Report	2

NHS Borders identified these incidents through the adverse event management process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Table 1 demonstrates the breakdown of incidents which activated the DoC:

Nature of unexpected or unintended incident where Duty of Candour applies	**Number**
A person died	2
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	3
Changes to the structure of the person's body	0
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	1
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.	1
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.	1

To what extent did NHS Borders carry out the duty of candour procedure?

The correct procedure was carried out in all instances in relation to the management reviews and significant adverse events reviews. In relation to one SAER the relatives were contacted, however, did not wish to have any part in the review process, this was still counted as compliance.

When undertaking the fall reviews and Duty of Candour reports all patients / next of kin were contacted, full explanation and apology provided. Due to COVID-19 pandemic it was not in some cases appropriate to offer a further meeting.

Information about our policies and procedures

Every adverse event in NHS Borders is reported through Datix, adverse event reporting system. There is a DoC section which allows us to evaluate the adverse events to assess whether or not DoC has been activated in relation to the level of harm caused to a patient.

Since the DoC legislation was introduced our Datix system has prompted first and final approvers to consider the application of the duty and record the decision and actions taken. Part of this section has now been made mandatory so that it cannot be left blank. When DoC has been activated as 'yes' or 'unsure' an alert email is automatically sent to the Patient Safety inbox for review and to provide an opportunity to offer guidance / support to approvers.

The Adverse Event Management Policy was reviewed in January 2020 incorporating the DoC legislation. In addition, a Significant Adverse Event Guidance (including Duty of Candour) has been produced to support Lead Reviewers with a specific section detailing 'Involving patient, relative and representatives and applying the Duty of Candour (DoC) which covers the DoC process.

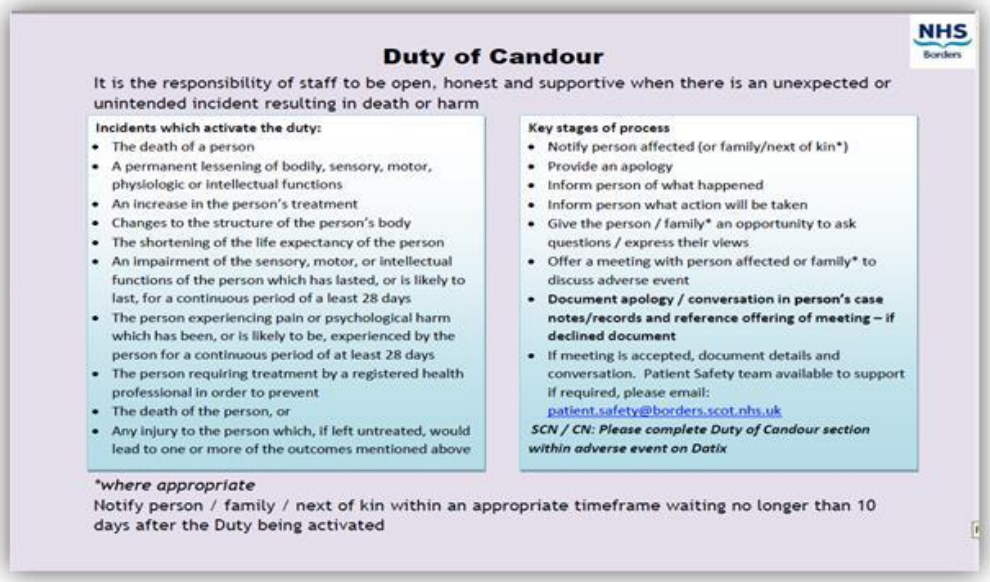
For Level 1 Significant Adverse Event Reviews together with Level 2 Management Review there is a section 'Patient / Family Involvement and the Duty of Candour' providing the opportunity to document the communication between the patient or relevant person and the Lead Reviewer.

For Level 2 Fall Review Tool and Pressure Ulcer Investigation Tool there is a DoC section which provides the opportunity for staff to record the explanation and apology given to the patient / relevant person, this is reviewed and approved by a senior member of staff.

Where an adverse event activates the DoC, however, does not require a level 1 or 2 review a DoC report requires to be completed by the final approval. A DoC checklist is available to support this report together with a template letter of apology to support the service.

If a decision is made by the Lead Reviewer or Commissioning Manger not to contact the patient or relevant other person a clear explanation of this must be documented.

In addition, a number of other processes have been embedded to ensure that NHS Borders deliver what is required in relation to the DoC. For Significant Adverse Event Reviews and Management Reviews a Lead Reviewer guidance document has been developed including short bite sized Lead Reviewer training films together. In addition, an SAE Toolkit has been developed and an NHS Education Scotland Duty of Candour eLearning module is available. A DoC support tool is also embedded within our Datix system to support staff when completing an adverse event as detailed in picture below:



COVID-19 Pandemic

In March 2020 all patient / families / relevant person were written to by the Chief Executive to advise NHS Borders were focusing all their efforts in dealing with COVID-19 and were unable to progress with the review at this time. Reassurance was provided that the review was important to the Board and will inform them when we were able to resume the review.

In June 2020 a resume review letter from the Patient Safety team was sent to the relevant person informing them of the stage of their review together with asking them if they would still like to be involved.

Understandably, the timeframe in which it took to review cases increased due to the ongoing pressures of dealing with the COVID-19 pandemic. The Board is still dealing with this in relation to staff wellbeing and workload capacity in supporting all SAE reviews.

As NHS Borders is a small Board all of the Patient Safety Team moved to work on the wards supporting them during the first wave of the COVID-19 pandemic. The Risk Team supported Clinical Governance & Quality and implemented a new process to support Datix to work together with the Patient Safety Team and Work and Wellbeing. The 'Data Checkers' system which is now embedded in the teams daily workload to support the quality checking of adverse events on NHS Borders electronic adverse event recording system (Datix) by implementing a weekly rota between the teams and improve data quality fed into the Health Board. Data checkers are only responsible for checking accurate completion of adverse event forms. When the DoC section may apply an email is sent to the Patient Safety inbox for the Topic Specialists to escalate further with the ward / departments. A Guidance for The Checking of Adverse Events on Datix was produced to support the relevant departments.

NHS Borders has undertaken significant work to consider how the DoC should be applied to cases of COVID-19 developed in a healthcare setting during the pandemic. As part of this work NHS Borders requested a discussion through the NHS Scotland Medical Directors meeting with the Central Legal Office as invited speakers. In addition, NHS Borders raised this matter directly with the Scottish Government and through the national adverse event network seeking guidance.

Consideration was given as to whether nosocomial spread of COVID-19 was unexpected and it was felt that this would be an expected event when community prevalence on COVID-19 was at elevated levels. Many measures were put in place to minimise the risk of spread and these measures changed over time as the evidence based developed and guidelines were adjusted. The NHS Borders Infection Control and Prevention team reviewed the minutes of all Incident Management Teams formed to oversee the management of COVID-19 outbreaks and could not identify failings in personal protective equipment or infection control practice which were directly attributable to specific outbreaks. The DoC has not been applied to nosocomial cases to date where no direct cause and effect could be identified.

Learning for the future

Due to work capacity for Lead Reviewers and Peer Reviewers innovative small bite sized films were produced to support the review process and enacting duty of candour. These are readily available for all staff.

Reviews carried out for the 8 cases have led to individual actions to revise systems and process to minimise the potential for error.