Duty of Candour

Annual Report for NHS Grampian

for 2020-2021

Contents

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Introduction

As a provider of health and social care services in Scotland, NHS Grampian has a legal duty of candour (DoC). This means that if an unintended or unexpected event happens that results in harm or death we must:

- make sure that those involved and affected understand what has happened and receive an apology from our organisation.
- learn as an organisation how to improve for the future.

These points are defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and the Duty of Candour (Scotland) Regulations 2018.

There are always some risks in providing health and social care services. From time to time, there are unintended or unexpected events that result in harm. When these happen, people want know what happened, what we'll do in response and what we'll do to stop these happening to anyone else.

NHS Grampian produces this annual report about how DoC works within our services. It covers the period from 1 April 2020 to 31 March 2021. Its layout is based on a template issued by the Healthcare Quality and Improvement Directorate of the Scottish Government.

This report only covers the DoC for services that NHS Grampian employs directly. These include:

- Services in Moray, Aberdeenshire and Aberdeen City
- Certain Dental practices
- GMED (who cover GP services in evenings and weekends)
- Ophthalmic services

It does not cover independent and contracted services not employed by us but who provide services for people who live in our area. This includes:

- Most general practices (GPs)
- Dentists
- Optometrists
- Pharmacies

They produce their own reports, which you can find either at their practices or on their websites.

About NHS Grampian

NHS Grampian provides healthcare services to the North East of Scotland. We cover the areas administered by Aberdeen, Aberdeenshire and Moray Councils.
We employ around 17,000 staff who deliver our services to 500,000 people, spread across 3,000 square miles of city, town, village and rural communities.
Most of our larger hospitals are in Aberdeen. Elgin in Moray is the site of Dr Gray's, the main general hospital in the west of Grampian.

There are 14 community hospitals, one in each of the main towns.
Our aim is to provide the highest quality care for everyone who uses our services. Where possible we aim to help people receive care at home or in a homely setting.

Number and Nature of Duty of Candour incidents

Outcome which caused DoC to be triggered

The death of the person	7
Severe harm	1
Harm which is not severe	31
Further treatment needed to prevent death or further harm	5
Uncategorised	18
Total	62

Note: Each category is defined in the legislation and more than one option can apply to any event.

DoC legislation states that we must complete the process within 90 working days, We also have to decide what level of investigation is necessary, to contact the individual concerned and start the investigation within a month of the incident triggering the DoC process.

We performed the appropriate level of review 74% of the time and completed 60% of reviews within the time scales set.

In every case, we reviewed what happened to try and learn for the future.

Information on policies and procedures

We record adverse events on a database called Datix. All our staff (except independent contractors and GPs who have their own systems) can access our intranet where they can report incidents on Datix.

Using Datix, complaints or audits we can identify incidents that trigger the DoC process. We review each adverse event to understand what happened and how we might learn and improve what we do. The level of review depends on how serious the event was as well as the potential for learning.

We make recommendations as part of these reviews and local teams develop improvement plans to meet these. We also have a group of senior staff members who meet regularly to discuss how the DoC process is going in their areas.
Before and after the DoC Act came into force, we educated our staff about the legislation and its importance. We developed ways to identify adverse events that triggered the act and regularly review these to make sure that they are fit for purpose. DoC can be triggered by the reasonable opinion of any registered health or social care practitioner. This means that different professionals may interpret the definitions produced in the DoC Act differently. In the advent of support being needed help is provided from the sectors various governance groups.

For example, in our Acute sector, all DoC decisions are reviewed and confirmed at their weekly clinical risk meeting. This can slightly delay the start of the process but ensures that the correct decision is reached.

In Aberdeenshire further decision and support comes from professional and clinical leads within Aberdeenshire. Here the decision on whether an incident is or isn't DoC is taken to local teams and local managers with the appropriate support from profession and clinical leads. This is work in progress and they are working with location managers to support the decision being made locally whilst recognising that, at times, additional discussion with professional/clinical needs will be required.

In the Aberdeen City partnership the DOC process is now embedded as part of their management of clinical and care risks through local clinical and care risk management processes. Here staff can choose the unsure option when reporting incidents that may be DoC. Weekly Health and Social Care Partnership Clinical and Care Risk management (CCRM) meetings consider these and provide advice.

We emphasise that the process of reviewing an adverse event and instigating a level 1 or 2 investigation supports DoC, so DoC being agreed after the event should not hold up the process of engaging with family and commencing an Adverse Event Review.

Across Grampian we follow the national guidelines to assess whether the duty of candour procedure should be activated.

Support for Staff involved in DoC incidents

Support for is available to staff who are involved in unintended or unexpected incidents. Interdepartmental support and partnership support alongside the wider psychological support is available. The psychology hub is open to all staff and our occupational health service can be accessed directly by staff or a management referral made.

There are also debrief facilitators within NHSG.

Support for persons/families

There are various ways in which we support those affected. Regular contact and communication with an identified contact from the team reviewing the case to ensure they are kept fully informed.

Support is available as appropriate from primary care and community colleagues and signposting to appropriate external agencies e.g. third sector.

Changes, learning and/or improvements to services and patient outcomes as a result of activating the duty of candour procedure and the required reviews that have taken place.

We have attempted to learn from every adverse event. Examples of changes made are

- Within acute children's services deteriorating patient programme was initiated. This included: an advanced nurse practitioner seconded for 6 months to lead the work; documentation reviewed and streamlined; Paediatric early warning refresher training for all nursing staff across Royal Aberdeen Children's Hospital and implementation of nurse escalation processes to consultant staff. Further changes included ward round checklist and reconfiguration of consultant rota to provide more senior support to trainee medical staff. The progress and updates of these are reported monthly to the Operational Management Team and also to the Mortality and Morbidity monthly meetings.
- Midwifery services implemented education and training of staff to provide women with evidence and quality information regarding place of birth. Transfer times, mode and transfer rates from the community midwife unit are now available and shared with women to enable an informed decision regarding where to birth. A Quality Improvement project is currently underway in Dr Grays Midwife undertaking a 'Place of Birth' project. This involves auditing conversations had with women around on choosing where to give birth. Ongoing training is being provided for Community Midwives.
- Chlorhexidine spray bottles have been removed from the labour ward, Education has been provided to pharmacists, midwives and anaesthetists regarding its use.
- Education around the use of the Modified Early Obstetric Warning Scores charts (MEOWS) has been increased. Their use is audited monthly. 'Tea Trolley Training' is provided regularly on meows and meows escalation. Health care support workers in the postnatal wards received one to one training as part of a test of change last year which helped build confidence in talking maternal observations as part of their daily roles.
- Importance of ensuring post-patient falls reviews are embedded as standard practice and learning shared with other ward areas.
- Improvements related to handover of care in terms of information received from transferring ward including review of handover documentation.
- Training ward based nursing staff – e.g. new fluid prescription/recording charts, red day reviews, skin bundles.

- Documentation – training and reinforcing good practice around completeness of admission documents, timely entries (including medical staff).
- Processes put in place to minimise disruptions during medication rounds.
- Change in process to the transportation of patient records between sites and storage processes while records are being moved.
- Improvements to processes to support people who are managed out with specialty ward area including ensuring the risk assessments are up to date.
- Updates for district nurses on pressure ulcer risk, management and recording of pressure ulcers and associated documentation including completion of educational modules.

Covid-19 Pandemic

The pandemic put unprecedented pressure on our staff and many routine services had to be halted or were delayed. Investigating adverse events is a very important part of our care but it is resource heavy. We received advice towards the end of the second Covid wave from Health Protection Scotland that we must continue to investigate our adverse events and to try to complete them as quickly as possible recognising that with the situation we were dealing with at the time may mean that timescales may slip.

NHS Grampian reviewed it's completion of reviews timescales to enable people to focus on the pandemic response. Adverse Event Reviews still occurred and opportunities for learning were shared within services.

We continued to use the national guidance as to when the Duty should be activated. We also sought legal opinion as to which situations because of the pandemic may or may not trigger the Duty.

There were periods when the operational pressures took precedence over starting an investigation but at all times we made a priority of keeping those affected informed. The main issues encountered were around capacity to complete reviews in a timely way, due to a number of factors including some of the key staff who have expertise around reviews being unavailable due to deployment elsewhere or capacity to take on this activity.

Staff turnover more generally has meant that we have lost some of this expertise within some areas of the workforce. We have recognised the need for further training across the organisation to strengthen our capacity in this regard. Online educational modules will assist with this, supported by follow up Q&A sessions with colleagues experienced in carrying out reviews to supplement the eLearning.

Provision of Healthcare Services

As we remobilise services, we may see instances of harm linked to delays in care. Some of these may trigger the DoC. There has been a lot of learning during the pandemic and ongoing. For example, in our Allied Health Professional services, we

have continued to review our Critical services criteria in light of the experience from the first wave, to inform which services can be paused and adapted. An example of this is that the critical presentations for the podiatry service was expanded as the longer timeframe of the pandemic meant that some other clinical presentations did require to be seen to prevent deterioration and/or harm.

Throughout the pandemic we have tried to maintain communication with existing service users who had their treatment paused and with the wider public to support them to self-manage and also to come forward should there be a deterioration in their symptoms. There is continued whole system learning regarding how we might strengthen this and ensure ongoing public messaging regarding how they can access services and support.

Practical Actions Taken

Involving the relevant person or relatives was altered as face to face meetings were discouraged or prohibited during the pandemic. This impacted on our usual processes around communication, however use of either telephone calls or the option of video conferencing was used to ensure good communication was maintained.

We have continued to use video conferencing as part of communication strategy if appropriate.

Learning for the future

Responding to the Covid-19 pandemic has meant changes to some of our policies and processes, including activating the duty of candour procedure. Our clinical and care governance arrangements in some sectors continued during the pandemic however the frequency of some of our supporting meetings were reduced at various stages. However we recognise early engagement and ongoing communication with patient/family is key and our systems and processes are aimed at delivering this.

Our processes have withstood a severe test and this gives us reassurance but we continue to monitor them and acknowledge that there are always improvements that can be made. It is the sustainability of the changes that is the main challenge along with sharing and embedding learning across wider system and we are committed to achieving such.

Dr Steve Stott
Associate Medical Director for Clinical Quality Assurance & Improvement

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