Organisational Duty of Candour Report

2019/2020

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Organisational Duty of Candour:

On 01 April 2018 the statutory Organisational Duty of Candour legislation came into force. The purpose of this new organisational duty of candour is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event which has resulted in death or harm (as defined in the act). The requirements of this legislation are that people involved in an event understand what has happened, receive an apology and that the organisation learns from the events.

How many events happened to which the Duty of Candour applies?

Across NHS Borders the DoC is most likely to apply to significant adverse events (SAE's) graded with a major or extreme outcome. The DoC may apply in other circumstances where the level of harm was not considered significant enough to meet the criteria for a major or extreme outcome on Datix, although these instances are likely to less common. The duty of Candour may also apply in relation to complaints raised through the Patient Experience Team.

For the period 01 April 2019 to 31 March 2020 there were 59 SAE's and 15 instances where the application of the organisational DoC was recorded on Datix. All of these were unintended events that resulted in harm as defined by the act. Details of the outcomes in relation to DoC are in the table (1) below.

Type of unexpected or unintended event	Number of Events 01 April 2019 - 31 March 2020
A person died	Less than or equal to 5
A person had their treatment increased	6
The structure of a person's body was changed	Less than or equal to 5
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	Less than or equal to 5
A person needing health treatment in order to prevent other injuries as listed above	0

Of these 15 cases, most were graded with either a major or extreme outcome and a level 1 or level 2 review was undertaken. Table (2) provides a simple overview:

		Total number of reviews completed or underway	
Major or extreme grading	Level 1 review	Significant Adverse Event Review (SAER)s completed	2
		Significant Adverse Event Review (SAER)s underway	3
	Level 2 review	Management Reviews completed	2
		Fall Reviews completed	3
		Pressure Ulcer Investigations completed	1
Minor or moderate grading	Level 3 review	Initial Review and Duty of Candour Reports completed	4
	Total		15

There were no complaints received by the Patient Experience Team that required the application of the DoC during this period.

To what extent did NHS Borders follow the Duty of Candour Procedure?

The application of the duty of candour requires a number of steps to be completed:

1. The relevant person was notified of the event that activated the duty of candour
2. The relevant person was offered an apology:
    a) face to face
    b) written
3. The relevant person was provided with an explanation of how the event occurred?
4. There was a meeting with the relevant person or it was offered
5. Notes or minutes of that meeting are offered to the relevant person
6. The relevant person was offered a copy of the report

The table below (3) provides details on each case to this effect.

No.	Type of Review	DoC Requirements Met						
		1	2 a	2 b	3	4	5	6
a	SAER	✓	✓	✓	✓	✓	✓	✓
b	SAER	✓	✓	✓	✓	✓	✓	✓
c	Management Review	✓	✓	✓	✓	✓	X	X
d	Management Review	✓	✓	✓	✓	✓	X	X
e	Fall Review	✓	X	X	X	X	X	X
f	Fall Review	✓	X	X	X	X	X	X
g	Fall Review	✓	✓	X	✓	✓	X	X
h	Pressure Ulcer Investigation	✓	X	X	✓	✓	X	X
i	Initial Review	✓	✓	X	✓	✓	X	X
j	Initial Review & Doc Report	✓	✓	X	✓	✓	X	X
k	Initial Review & Doc Report	✓	✓	X	✓	✓	X	X
l	Initial Review & Doc Report	✓	✓	X	✓	✓	✓	X

No.	Type of Review	DoC Requirements Met						
		1	2 a	2 b	3	4	5	6
a	SAER	✓	✓	✓	✓	✓	✓	✓
b	SAER	✓	✓	✓	✓	✓	✓	✓
c	Management Review	✓	✓	✓	✓	✓	X	X
d	Management Review	✓	✓	✓	✓	✓	X	X
e	Fall Review	✓	X	X	X	X	X	X
f	Fall Review	✓	X	X	X	X	X	X
g	Fall Review	✓	✓	X	✓	✓	X	X
h	Pressure Ulcer Investigation	✓	X	X	✓	✓	X	X
i	Initial Review	✓	✓	X	✓	✓	X	X
j	Initial Review & Doc Report	✓	✓	X	✓	✓	X	X
k	Initial Review & Doc Report	✓	✓	X	✓	✓	X	X
l	Initial Review & Doc Report	✓	✓	X	✓	✓	✓	X

NHS Borders is confident that where a level 1 SAER Review is completed all of the Duty of Candour requirements can readily be met. Each case has been reviewed where NHS Borders either did not fully follow procedure or where it was not recorded that the correct procedure had been followed.

In relation to table (3) above:

a) NHS Borders were fully compliant with all requirements under the DoC
b) NHS Borders were fully compliant with all requirements under the DoC
c) It cannot be evidenced that either a note of the meeting or a copy of the report was offered to the relevant person
d) It cannot be evidenced that either a note of the meeting or a copy of the report was offered to the relevant person
e) The Fall Review Tool used at that time did not explicitly refer to the Duty of Candour and did not include prompts to ensure that an apology

and explanation were offered and recorded – this has since been revised. There is active work underway to ensure it becomes routine practice for clinical staff to offer a copy of the review tool to the relevant person

f) The Fall Review Tool used at that time did not explicitly refer to the Duty of Candour and did not include prompts to ensure that an apology and explanation were offered and recorded – this has since been revised. There is active work underway to ensure it becomes routine practice for clinical staff to offer a copy of the review tool to the relevant person
g) The revised Fall Review Tool was used but the reviewer did not indicate whether any written information was offered to the relevant person
h) The Pressure Ulcer Investigation Tool used at that time did not prompt documentation of patient and family engagement – this has since been revised. Again, There is active work underway to ensure it becomes routine practice for clinical staff to offer a copy of the review tool to the relevant person
i) At the time there was no specific documentation in place to prompt additional actions to be competed
j) The DoC report is yet to be completed
k) It cannot be evidenced that either a note of the meeting or a copy of the report was offered to the relevant person
l) The DoC report is yet to be completed

Information about our Policies and Procedures

Every adverse event in NHS Borders is reported through Datix which enables us to record, identify, and report on events which fall under the Duty of Candour (DoC).

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. However the sections requiring dates and information to be added are often still lacking detail.

There is an eLearning module on LearnPro that explains what the Duty of Candour provisions mean for NHS Borders, its staff and partners. The need for additional face-to-face training for clinicians and managers is clear and there is a plan for developing and delivering a programme of educational workshops (via MS Teams) for SAE Lead Reviewers that will also include the implementation of the DoC. This will commence in December 2020.

The Adverse Event Management Policy was reviewed in January this year for the purpose of incorporating the DoC legislation into it. In addition, a Significant Adverse Event (SAE) guidance document is in use which includes

details of how reviewers can apply the DoC and the linked SAE Toolkit (containing a selection of review tools and templates) contains prompts for staff to ensure the duty has been considered or applied. These review tools will be evaluated again based the outcomes of the data gathered for this report to promote improved application of the DoC. Further consideration will be given to the Duty of Candour report template in particular and whether or not this contains sufficient prompts to ensure that all of the DoC requirements are met.

Within the SAE Toolkit there are also a selection of letter templates that can be personalised for patients, families, and carers to provide them with:

a) Information relating to the adverse event to which the DoC applies,

b) Inviting them to meet with the Lead Reviewer,

c) To be sent out in conjunction with an approved report

d) Offering a formal written apology

There are also information leaflets that can be sent with the first or second letter explaining the SAER process and also the Duty of Candour.

Also within the SAE Toolkit, there are template letters to be sent to staff requesting their involvement in a review (usually a level 1 SAER). These letters are also intended to be individualised and should be sent along with a leaflet outlining the process and providing them with information on where they can access support.

In addition a number of other processes have been instigated or amended to ensure that NHS Borders deliver what is required in relation to the DoC. These include:

- A database has been set up to allow the Patient Safety Team to track the actions completed for each adverse event that activates the DoC.

- A second Staff Share communication has been sent out to all Datix First and Final Approvers (on 10 September 2020) to remind them of their responsibility in relation to the completion of this section on Datix. This email also included a checklist (taken from the Adverse Event Management Policy) to guide approvers in taking all necessary steps to ensure the DoC requirements are met.

- A system has been set up to alert the Patient Safety Team is a 'Yes' or 'Unsure' option has been selected by an approver . This allows a check to take place regarding the accuracy of this response and an opportunity to offer guidance or support regarding the next steps.

- Weekly SAE updates are sent by email by the Patient safety Team to the four clinical boards (Mental Health, Primary & Community Services, Planned Care and Commissioning and Unscheduled Care). These updates now include a column to indicate if the DoC is triggered or may be triggered and what actions are still outstanding.

- The Duty of candour is now a core feature on each of NHS Borders' clinical boards' governance agenda's.

- Coaching for Senior Charge Nurses in the completion of the Fall Review Tool and the Pressure Ulcer Investigation Tool in inpatient areas and community nursing teams.

There is still room for improvement in the way that NHS Borders document whether a summary of any meetings that takes place with patients, families or carers in relation to the DoC has been provided. Similarly, NHS Borders need to do better in demonstrating that a copy of any report completed has been offered to the relevant person and that the process of doing so is effectively coordinated by the Patient Safety Team.

Other information:

Although this is the second year of the Duty of Candour being in operation, NHS Borders are on a cycle of continuous reflection, learning, and growth. NHS Borders recognise that some processes require further work and refinement and are committed as an organisation to achieving this.

NHS Borders has published this report on its website and has notified Scottish Ministers as required.