Organisational Duty of Candour Report

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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?

Between 01 April 2018 and 31 March 2019 there were four events which come under the organisational duty of candour. All of these were unintended events that resulted in harm as defined by the act. Details of the outcomes in relation to duty of candour are in the table below

Each event was reported on the electronic adverse event reporting system (Datix) and managed in accordance with the adverse event policy.

Type of unexpected or unintended event	**Number of times this happened (01 April 2018 to 31 Mar 2019)**
A person died	0
A person had their treatment increased	**2**
The structure of a person's body was changed	0
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	**2**
A person needing health treatment in order to prevent other injuries as listed above	0

Information about our policies and procedures

Every adverse event in NHS Borders is reported through an electronic reporting system called Datix. Through this electronic adverse event system we can record, identify and report on events which fall under the Duty of Candour.

Where a Significant Adverse Event Review (SAER) is carried out, this already fulfils all the criteria of the organisational duty of candour. This is the case for three of the identified events. For adverse events which do not prompt an SAER the adverse event reporting system itself has a section that is to be completed which should make practitioners think about duty of candour.

In all the cases referred to above NHS Borders Organisational Duty of Candour was fulfilled. The people affected were informed and received apologies on behalf of the organisation. In all cases appropriate levels of review were carried out to identify any opportunities for learning or putting preventative measures in place.

The area in which we do not perform so well is in the completion of the Duty of Candour section in the electronic adverse event reporting system. Staff are usually unsure whether an event comes under the Duty of Candour and often leave it blank. This highlights a need for further training and guidance when it comes to Duty of Candour. The adverse event management policy, processes and guidance are currently being updated to reflect NHS Borders' responsibility in relation to the Duty of Candour legislation. Once these reviews are complete a training plan will be put in place.

Other information.

This is the first year of duty of candour being in operation. It has been a year of learning which will continue as we reflect and refine our processes.

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