NHS Highland

1. Introduction

The requirements of the legislation relating to organisational Duty of Candour apply to all health and social care services in Scotland. Where unintended or unexpected events happen as a consequence of care or service issues that result in death or harm as defined in the Act, there is a requirement to ensure that the people affected understand what has happened, receive an apology, and are informed by the organisation of what has been learned and how improvements for the future will be made.

As part of the duty we are required to publish an annual report which describes how NHS Highland has implemented and operated the duty of candour procedures over the previous year.

2. About NHS Highland

NHS Highland serves a population of 323,620 people across 32,500 square kilometres in the north and west of Scotland (mid year population estimate for 2022, National Records of Scotland), making it one of the largest and most sparsely populated Health Boards in the UK. Our operational front line services are provided through two distinct operational units – Highland Lead Agency and Argyll and Bute Health and Social Care Partnership.

Our aim is to provide high quality care for every person who uses our services, in hospitals, community, health and social care settings and in their own homes.

3. Number and Nature of Duty of Candour incidents

For duty of candour to apply, the patient/service user needs to have suffered a harm as defined below (not related to the natural course of someone's illness or underlying condition) AND for care or service issues to have contributed to this event i.e.

• A different plan and/or delivery of care may have resulted in a different outcome though uncertainty regarding impact on patient outcome/event.

• A different plan and/or delivery of care, on the balance of probability, would have been expected to result in a more favourable outcome, i.e. how the case was managed had a direct impact on the level of harm

Table 1

Nature of unexpected or unintended incident where Duty of Candour applies 1st April 2023 – 31st March 2024	**Number**
A person died	<5

A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	<5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	20
Changes to the structure of the person's body	<5
The shortening of the life expectancy of the person	<5
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.	<5
The person required treatment by a registered health professional in order to prevent:	
The person dying	<5
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
TOTAL	**30**

The figures declared by operational area and over the last 5 years can be seen below in Tables 2 and 3

Table 2

Numbers by Operational Area	
Argyll and Bute	3
HHSCP	9
Acute Services	18

Table 3

2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
15	22	53	36	29

Robust scrutiny of cases with a wide range of senior clinicians and managers in attendance has continued at weekly and monthly meetings in all operational units.

Some of the adverse events included in this report occurred prior to 1st April 2023 and were confirmed as duty of candour within 2023/2024. Adverse events which occurred within 2023/2024, where the investigation is ongoing and status of duty of candour has not yet been confirmed are not included in this years figures. These cases will be included in the 2024/2025 annual report.

4. To what extent did NHS Highland carry out the duty of candour procedure?

Of the 30 identified cases, each one was reviewed to assess for compliance for the following elements recognising if it was not considered appropriate or there was no response from the patient or relative following attempts to contact them this would still count as compliance.

- Patient and or relative were notified and informed of the adverse event
- Providing an apology
- A review was undertaken

- The opportunity for the patient or relative was given to ask any questions
- The review findings were shared
- An offer of a meeting

In 25 of the identified cases the requirements of the duty of candour procedure were mostly met. Of the remaining 5 cases - in 2 cases the requirements were partially met and in 3 cases it was not possible to determine to what extent the requirements of the act had been met. A greater emphasis on earlier communication and involvement of patients and relatives is a priority for the coming year.

Improvement since last year has been made in:

- Recording of the written apology sent to patients/family

Areas for improvement

- Emphasis on earlier communication and contact with patients/relatives.
- Ensuring a named person is identified to communicate with patients/relatives
- Documenting preferred method of communication
- Recording and documenting follow up meetings and output from these on the incident reporting system
- Signposting to support services

5. Information on policies and procedures

Adverse events are identified through the incident reporting system (Datix) and also through complaints received by the Feedback Team. Through our adverse event management procedures we can identify incidents that trigger duty of candour and the adverse event policy has the requirements for duty of candour embedded within it. The policy and procedures were updated in line with the re issue of the National Adverse Events Framework in December 2019. Complaints triaged as high level are considered for duty of candour and if activated this will be stated in the complaint response with the offer of a follow up meeting.

Each of the operational units have a weekly check-in meeting to identify cases which may trigger duty of candour and to establish what further investigation is required. The level of review depends on the severity of the event as well as the potential for learning. Monthly validation meetings also consider the output from investigations, ratify recommendations and confirm if Duty of Candour applies.

Staff have access to information on the intranet via our dedicated duty of candour page and training is available via the NES Education Scotland Duty of Candour e-learning module. For those staff frequently involved in the review process bespoke training can be provided by the CGST.

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We recognise that adverse events can be distressing for patients, families and staff and that the SAER and DoC process undoubtedly present challenges to the workforce both from a psychological and capacity perspective. Our chaplaincy service are happy to help patients, families and staff if they need assistance in dealing with a distressing event. Additional support is available for all staff through our line management structure as well as through Occupational Health.

6. What has changed as a result?

- Shared learning and feedback at Primary Care Forum on risks of instances where test results are communicated manually via email.
- Development of a Head Injury pathway for rural general hospital
- Develop a transfer checklist to ensure clinical assessment of patient just before transfer
- Review of the PICC/Midline service
- Implementation of a checklist for PICC and midline insertions
- Service Specifications and access criteria reviewed and shared for the Minor Injuries Unit / Urgent Care Centre
- Review arrangements for foreign nationals to contact +/- be contacted NHS24 using non UK numbers
- Review of medication storage location / systems within Minor Injuries Unit /Urgent Care Centre
- Review and update the Policy and Procedures for Non-Medical Prescribing (including competencies). Both prescribing and dispensing should be included
- Identify tissue viability link nurses across Medical Division.
- Provision of educational sessions on tissue viability
- Tissue viability quality improvement and education boards set up and maintained in ward areas

7. Additional Information

This is the 7th year of Duty of Candour being in operation and the organisation continues to learn and refine processes to ensure adherence to the requirements of the legislation.

Continue to develop and refine our existing adverse event management processes and procedures to embed the principles of organisational duty of candour requirements in line with national guidance.

Ensuring that a plan for communication with patients and relatives is clear and included as part of commissioning reviews and that a named person is identified.

Ensure appropriate early communication with patient and families where it is unclear whether the statutory duty of candour applies at the outset.

NHS Highland are moving to a new incident reporting system and this will allow a refresh of the recording of evidence of the key steps in the procedure particularly follow up meetings.

Continued discussion and collaboration with other Duty of Candour Leads through the Adverse Event Networking Group to achieve greater consistency in application of the Duty between health boards

Awaiting finalised and updated guidance from the Scottish Government

Continued training and updates to those involved in the Duty of Candour process

This report will be cascaded via the Clinical Governance reporting structure for internal information.

As required, we have advised Scottish Ministers of this report and we have also placed it on our website.

If you would like more information about this report, please contact us using these details:
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