NHS
Eileanan Siar
Western Isles

DUTY OF CANDOUR
ANNUAL REPORT
1st April 2019 – 31st March 2020

Responsible Officer -
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1 INTRODUCTION

The Health (Tobacco, Nicotine etc. and Care) Scotland Act 2016 ("The Act") introduced an organisational Duty of Candour on health, care and social work services. The Act is supplemented by the Duty of Candour Procedure (Scotland) Regulations 2018, which highlight the procedure to be followed whenever a Duty of Candour incident has been identified.

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the Duty of Candour is implemented in our services.

This short report describes how NHS Western Isles has operated the Duty of Candour during the time between 1 April 2019 and 31 March 2020.

2 NHS WESTERN ISLES

NHS Western Isles is the organisation responsible for providing healthcare to the population of the Western Isles, which is made up of approximately 26,500 people. We employ around 1030 staff.

Who we are and what we do…

As a Health Board, our mission statement is to be 'the best at what we do' and our overall purpose is: ***'to protect, promote and improve the health and wellbeing of the Western Isles population and to ensure the reliability and delivery of sustainable and safe healthcare and services'.***

NHS Western Isles works alongside mainland Health Boards and other local organisations, including the local authority and third sector (voluntary) organisations, to provide a wide range of healthcare services to the local population. Where possible, services are provided locally, in the Western Isles, but for specific procedures and more specialist services, we work with mainland partners to provide services in other areas.

There are three hospitals run by NHS Western Isles. The largest is the Western Isles Hospital, a Rural General Hospital located in Stornoway. Western Isles Hospital was opened in 1992 with a range of hospital acute specialities, maternity and psychiatry. The hospital also includes diagnostic facilities, day hospital, laboratory, Allied Health Professionals and other services.

Ospadal Uibhist agus Bharraigh (Uist and Barra Hospital) is located in Benbecula, and was opened in 2001. It provides a local service for the population of the Southern Isles. The hospital has 15 beds, and provides care of the elderly, GP Acute and Midwifery led maternity services. Many of the Consultants from the Western Isles Hospital, and some from mainland Health Boards, visit the Uist and Barra Hospital to provide outpatient services.

St Brendan's Hospital, with 5 beds, is located in Castlebay on the Isle of Barra and is in a shared building with a local authority care home facility. It is supported by the local GP Practice to provide care of the elderly and other services.

In addition, NHS Western Isles commissions services from other NHS Boards, for example Ear Nose & Throat (ENT) Surgery, Dermatology, Respiratory Medicine, Child Psychiatry, Rheumatology, specialised Paediatrics, Ophthalmology, Oral Surgery, Neurology, Oncology and Urology.

3 POLICIES & PROCEDURES

All adverse events and near misses are reported through the NHS Western Isles Risk Management system (Datix), as set out within the revised draft Framework and Procedures for Reporting, Managing and Learning from Adverse Events.
This system has been further developed to include a section on the Duty of Candour which is triggered if staff record that the adverse event reported has the potential to trigger the Duty of Candour procedure.

Furthermore all our category 1, 2 and 3 adverse events are reviewed in accordance with our Framework to understand what happened and to establish if there any actions to be included in the improvement plan that can be taken to prevent/ minimise a recurrence and/ or improve patient care.
The level of review depends on the severity of the event as well as the potential for learning.

The following time frames must be followed for reviewing adverse events:

Category 1 – Commission review within 10 working days of the adverse event being reported on to Datix. Commence and close review (report submitted for approval within 90 working days of adverse event being reported on to Datix. Final approval should take place as soon as possible and no later than 30 working days from report submission.

Category 2 – Commence review within 10 working days of the adverse event reported on to Datix. Close review (report submitted for approval within 30 working days of the adverse event reported on Datix).

Category 3 – Adverse event approved and closed within 10 working days of adverse event reported on to Datix.

4 TRAINING

Members of staff responsible for inputting adverse events onto Datix and also for reviewing and investigating adverse events receive training on the use of the Datix reporting system. Clinicians are also encouraged to complete the Duty of Candour Learnpro e-learning module.

Currently 47 members of staff have successfully completed the module.
The proposed risk management training plan for 2020 will target all front line clinical staff with regard to completion of the Duty of Candour e learning module.

5 DUTY OF CANDOUR – Governance & Monitoring

The Risk Manager currently reviews all adverse events reported on to Datix and monitors activity relevant to the Duty of Candour process. All potential adverse events identified for the Duty of Candour will be escalated by the Risk Manager via the line management process to the medical or nursing director.

Furthermore, the following information sources are also utilised in order to identify potential Duty of Candour adverse events.

Category 1 and 2 adverse event reviews
Significant Adverse Event reviews
Complaints
Patient adverse events reported to the Health and Safety executive as RIDDOR
Child protection/ contact issues
Patient adverse events reported to Health Protection Scotland

6 DUTY OF CANDOUR – Adverse Events

At the time of this report we have had 1 adverse event reported which fulfilled the criteria for the Duty of Candour.

The outcome of the adverse event was in the category intra operatively with the subcategory being other intra operatively.

NHS Western Isles followed the correct procedure for the Duty of Candour in following up this Category 1 Adverse Event.

This means that we informed the family affected and offered to meet with them. An information leaflet on the Duty of Candour was also made available to the family.

A Significant Adverse Event Review was undertaken as per our draft Framework for Adverse Event Reporting, Management and Learning. We kept the family affected informed of the progress of all the stages of the review through a designated approved contact.
On completion of the review a meeting was held with the family along with the staff who led on the review and the SAER commissioning director to inform them of the review outcome. Information relating to the review was shared with the family and a letter of apology was sent to them.

A quality improvement plan was developed with actions set based on the recommendations from the Significant Adverse Event Review.
Progress with the improvement plan will be monitored by our Learning Review Group. The improvement plan will be quality assured by our Health and Care Governance Committee.

7 FURTHER INFORMATION

This the second year of the Duty of Candour being in place, has been another year of learning and refining of our existing adverse event management systems and processes to include the assessment and recording of potential Duty of Candour adverse events. In addition to this, we have further developed the Datix reporting system along with the Duty of Candour guidance highlighting the responsibilities of staff and the procedure to be followed when undertaking the Duty of Candour process.

As required we have placed the report on our website and informed Scottish Ministers.

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