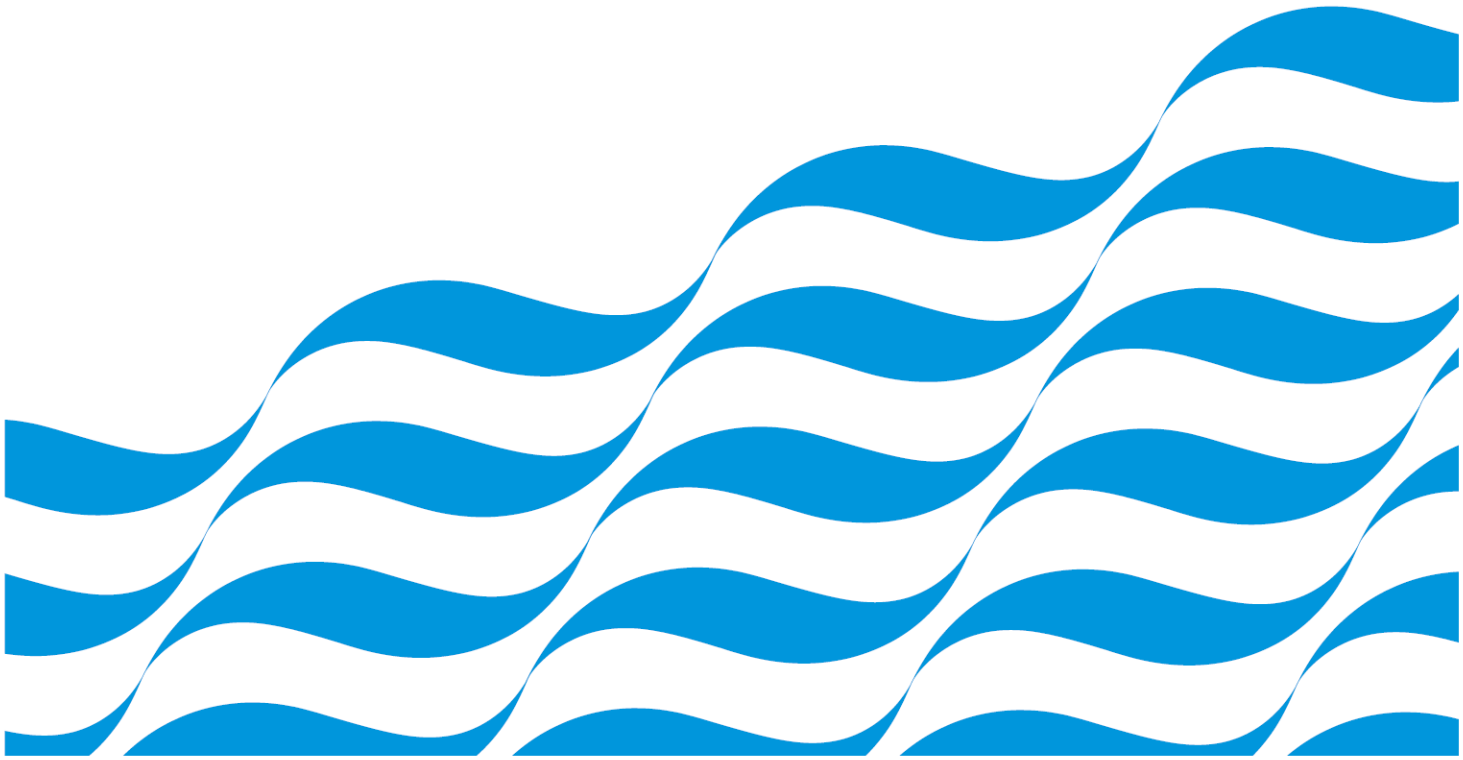
Annual Organisational Duty of Candour Report 2019-20



Published August 2020

www.nhsfife.org

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1. Introduction and background

NHS Fife

NHS Fife serves a population of approximately 368,000 people. Our vision is to enable the people of Fife to live long and healthy lives. We strive to achieve this by transforming health and care in Fife to be the best.[1]

As of 1 April 2018, all health and social care services in Scotland have an organisational Duty of Candour (DoC). The overall purpose of the duty of candour is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended event that results in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition. This is a legal requirement which means that when such events occur, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to be followed is set out in the Duty of Candour (Scotland) Regulations 2018.

This report describes how NHS Fife has implemented the duty of candour during the period 1 April 2019 to 31 March 2020**.** This includes as attached in appendix 1-4 reports from the four health board managed general practices in NHS Fife.

The Organisational Duty of Candour guidance[2] outlines the procedure which must be a followed as soon as reasonably practicable after an organisation becomes aware that:

- an individual who has received health care has been the subject of an unintended or unexpected incident and
- in the reasonable opinion of a registered health professional not involved in the incident:
  - **(a)** the incident appears to have resulted in or could result in any of the outcomes below (see Table 1).
  - **(b)** the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

This means if a patient suffers from an unintended or unexpected harm as a result of an adverse event then the following should happen:

- The patient or relative is notified and an apology is offered.
- An investigation is undertaken.
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation.

[1] NHS Fife Strategic Framework. 2015.

[2] Organisational Duty of Candour guidance. The Scottish Government. March 2018

- On completion of the investigation the findings and report are offered to be shared with the patient or relative.
- A meeting is offered.
- Throughout the review and investigation support is to be offered to the people affected which may included staff members involved.

The outcome for organisations is to learn from the investigation and make changes identified as part of the review.

2. How many adverse events happened to which the duty of candour applies?

Between 1 April 2019 and 31 March 2020, there were 28 adverse events where the duty of candour applied.

NHS Fife identified these events mostly through its adverse event management processes. The organisation supports a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events policy and is in accordance with a national framework[3].

There are a number of events reported during this period, which are currently under review. It is not know at this time whether these require to be reported as activating organisational duty of candour. It is possible therefore that the number maybe higher than reported in this report.

This report will only include those events with a confirmed decision.

NHS Fife has an embedded process for the decision making for activating organisational duty of candour and ensuring all necessary actions are undertaken in accordance with national guidance. On review, any event which is considered to activate duty of candour, is escalated to the Board Medical Director for ratification and confirmation of decision.

From March 2019 due to the response required by NHS Fife to the emerging Covid-19 pandemic, a pause on reviews happened, and a number of reviews have been delayed and started later than normal. This has been monitored since March 2020 with processes in place to ensure reviews are progressed and completed.

Table 1 details the outcomes which have occurred across NHS Fife after 1 April 2019 to 31 March 2020.

[3] Learning from adverse events through reporting and review: A national framework for Scotland, revised July 2018, NHS Fife review all adverse events.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred
The death of the person	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5
An increase in the person's treatment	18
The shortening of the life expectancy of the person	<5
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 requiring treatment by a registered health professional in order to prevent: • the death of the person, or • any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above	5

The most common outcome which these events have resulted in is an increase in the person's treatment. This can range from additional antibiotics required to additional nights stay in hospital

3. To what extent did NHS Fife follow the duty of candour procedure?

Of the 28 identified cases, each one was reviewed to assess for compliance with the procedure on the following elements:

- An apology was given.
- Patient and or relative were notified and informed of the adverse event.
- 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, which is arranged if required.

Overall NHS Fife has carried out the procedure in each case. A number of areas of strength have been identified. These are:

- notifying the person and providing details of the incident
- provision of an apology, and
- Reviewing all cases.

It should be noted that there are a number of occasions when the patient circumstances affected the timing of sharing the findings; and the patient or relative specifically requested they did not wish to receive any further information in relation to the review or event. In such instances, these cases are included as compliant.

We know that witnessing or being involved in an adverse event can be distressing for staff as well as people who receive care. Support is available for all staff through our line management structure as well as through Staff Wellbeing and Safety.

4. Information about our policies and procedures

Every adverse event which occurs is reported through our local reporting system as set out in our Adverse Events policy and associated processes. Through these, we can identify events that activate the duty of candour procedure.

The policy contains a section on implementing the organisational duty of candour, and a detailed section about supporting staff and persons affected by the adverse events, with examples of the types of support available.

Each adverse event is reviewed to understand what happened and the actions we can take to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the review, and local management teams develop action plans to meet these recommendations.

The decision on whether an event activates the duty of candour procedure has been taken by senior clinical staff including the Board Medical Director, Board Director of Nursing, Director of Pharmacy, Associate Medical and Nurse Directors, Associate Director of Allied Health Professionals, Clinical Directors and Heads of Nursing.

To support implementation of duty of candour, staff are encouraged to complete the NHS Education Scotland on line learning module. This has been made available to staff through the intranet. In addition to the above policy to ensure our practice and services are safe, the organisation has clinical policies and procedures. These are reviewed regularly to ensure they remain up to date and reflective of current practices. Training and education are made available to all staff through mandatory programmes and developmental opportunities relating to specific areas of interest or area of work.

5. What has changed as a result?

We have made several changes following review of the duty of candour events. These are some of the changes to be highlighted:

- The current pre-operative marking procedures in theatres have been reviewed and revised to include specific reference to marking of lumps, or cysts or raised areas.
- Review of the pathway for emergency endoscopies.
- Introduction of a visual warning sticker and associated process for catheters post surgery.
- A departmental standard operating procedure has been developed for significant radiological findings to ensure these are identified and managed in a timely manner.

If you would like more information about this report, please contact

Board Medical Director Office
NHS Fife
Hayfield House
Hayfield Road
Victoria Hospital
Kirkcaldy
KY2 5AH
Telephone: 01592 648077

Appendix 1: Linburn Road Health Centre

Linburn Road Health Centre
124 Nith Street
Dunfermline, KY11 4LT
Tel: 01383 733490
Fax: 01383 748758
Email: Fife-UHB.F20502LinburnRoad@nhs.net

Fife Health & Social Care Partnership
Supporting the people of Fife together

Duty of Candour Report

Report period: 1 April 2019 to 31 March 2020

Completed by: Sharon Duncan, Practice Manager (Job Share)

Linburn Road Health Centre provides Health Care to patients within the Dunfermline and Rosyth area. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2019 and 31 March 2020)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	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	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Linburn Road Health Centre follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on http://intranet.fife.scot.nhs.uk/

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Lochgelly Medical Practice

Lochgelly Medical Practice
David Street
Lochgelly, KY5 9QZ
Advanced Nurse Practitioner: Corinne Cairns
Tel: 01592 780277

Fife Health & Social Care Partnership
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Duty of Candour Report

Report period: 1 October 2019 to 31 March 2020

Completed by: Charlene Davidson, Practice Manager

Lochgelly Medical Practice provides Health Care to patients within the Lochgelly, Cardenden, Cowdenbeath, Ballingry areas. The aim of Lochgelly Medical Practice is to offer all patients with the practice an excellent health care service.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 October 2019 and 31 March 2020)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	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	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Lochgelly Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on http://intranet.fife.scot.nhs.uk/

What has changed as a result?	N/A

Other Information	N/A

Appendix 3: The Links Practice

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF
Tel: 01592 873321
Fax: 01592 871338

Dr J A Duncan
M.B.,Ch.B.,D.C.H., M.R.C.G.P.

Dr C Fleming
M.B., Ch.B., M.R.C.G.P.

This short report describes how our care service has operated the duty of candour during the time between 1 April 2019 to 31 March 2020. We hope you find this report useful.

Our Practice serves a population of 1875 patients within the Burntisland, Kinghorn, Aberdour area.

How many Incidents happened to which the duty of Candour applies?

In the last year, there have been no incidents to which the duty of candour applied.

Information about our policies and procedures.

Where something has happened that triggers the duty of candour, our staff report this to the Practice Manager who has responsibility for ensuring that the Duty of candour procedure is followed. The Practice Manager records the incident and reports as necessary the Health Board. When an incident has happened, the Manager and staff set up a learning review. This allows everyone involved to review what happened and identifies changes for the future.

If you would like more information about The Links Practice, please contact us using these details.

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife
KY3 9JD

Tel: 01592 873321
Email: Fife-UHB.F20184LinksPractice@nhs.net

Appendix 4: Valleyfield Medical Practice

Valleyfield Medical Practice
Chapel Street, High Valleyfield
Fife, KY12 8SJ
Tel: 01383 880511
Email: Fife-UHB.F20729valleyfield@nhs.net

Duty of Candour Report

Report period: 1 April 2019 to 31 March 2020

Completed by: Michelle Parker, Practice Manager

Valleyfield Medical Practice provides Health Care to patients within the High Valleyfield, Low Valleyfield, Culross, Torryburn, Newmills, Cairneyhill and Crossford. The Health Centre's aim is to provide high quality care for every person who uses our services.

How many incidents happened to which duty of candour applies?	0

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2018 and 31 March 2019)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	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	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**0**

To what extent did Valleyfield Medical Practice follow the duty of candour procedure?	All Staff are aware of the NHS Fife Complaints and Significant Event procedures and will report any incidents to the Practice Managers or Senior Members of Staff. Incidents falling into the category of Duty of Candour will be the responsibility of the Practice Manager to ensure that the correct procedures are followed. The Practice Manager will record the incident and investigate as necessary. Procedures to be followed: a. to notify the person affected (or family/relative where appropriate) b. to provide an apology c. to carry out a review into the circumstances leading to the incident d. to offer and arrange a meeting with the person affected and/or their family, where appropriate e. to provide the person affected with an account of the incident f. to provide information about further steps taken g. to make available, or provide information about, support to persons affected by the incident h. to prepare and publish an annual report on the duty of candour When an incident has happened, the Practice Managers, Clinicians and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on http://intranet.fife.scot.nhs.uk/

What has changed as a result?	N/A

Other Information	N/A

NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages, who require Easy Read versions, who speak BSL, read Braille or use Audio formats.

NHS Fife SMS text service number 07805800005 is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife-UHB.EqualityandHumanRights@nhs.net or phone 01592 729130

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