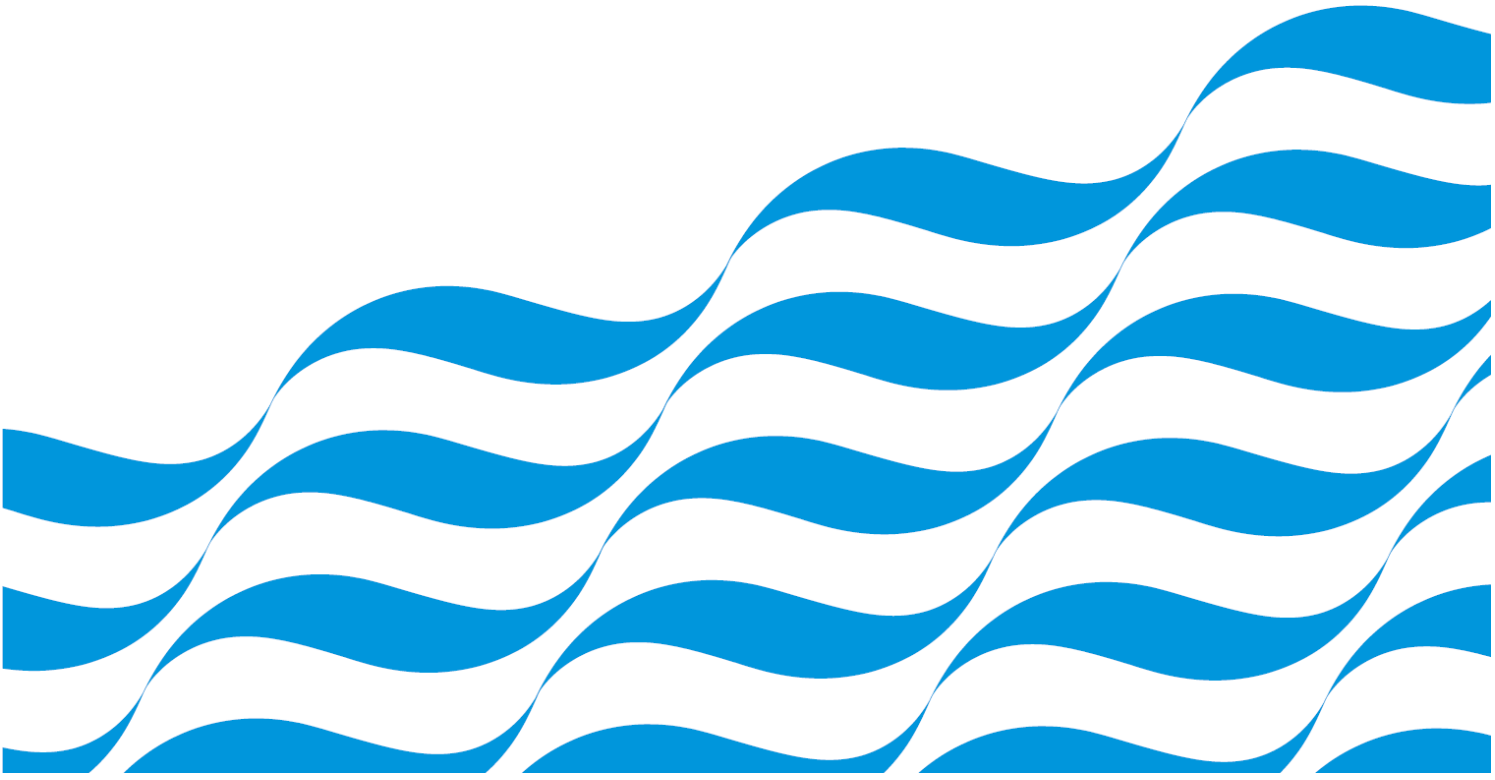
NHS
Fife

Annual Organisational Duty of Candour Report 2023-2024



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www.nhsfife.org

Contents

1. Introduction and background

NHS Fife

NHS Fife serves a population of approximately 368,000 people. Our vision is to deliver excellent care and improve population health and wellbeing for the people of Fife[1]. In delivering care we aim to deliver safe, effective, person-centred care in an organisation which listens, learns and improves.[1] Supporting of this is our commitment to our organisational values of:

Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations during the period 1 April 2023 to 31 March 2024 (2023/2024). NHS Fife identified events mostly through the adverse event management processes; mainly through the significant adverse event review (SAER) process. The organisation adopts a consistent approach to the identification, reporting and review of all adverse events. This is reflected through the local NHS Fife Adverse Events Policy which is aligned with a national framework[2]. At the heart of the policy is a culture of reporting, learning, apologising and improving.

The target is to complete SAERs within 90 days. However, due complexity of investigations and the commitment to deliver a thorough investigation this timescale is sometimes not achieved. Focused improvement work is underway to improve our compliance with this target. Consequently there are a number of events reported during this period which are currently under review and which may be reported as activating organisational DoC. It is therefore possible that the number of reported DoC events may be higher than stated in this report. Only those events with a confirmed decision have been included in this report.

A look back at years 1 (2018/2019 to 5(2022/2023) is also included in this report. Previous years are included for completeness as DoC applied to cases which concluded review after the submission of respective annual reports. Also contained in appendix 1-7 are organisational DoC reports from the seven-health board managed general practices in NHS Fife.

[1] NHS Fife Clinical Governance Strategic Framework 2023-2025

Organisational Duty of Candour

As of 1 April 2018, all health and social care services in Scotland have an organisational Duty of Candour. The 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.

The Organisational Duty of Candour guidance[3] 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; and
- The patient/relative is given the opportunity to raise questions they wish to be considered and answered as part of the investigation

NHS Fife has a process for the decision making for activating organisational DoC 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. This process is summarised in the following:

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

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

Supporting Patients and Families

Patients and families are at the centre of all that we do. We recognise how distressing is for patient and families when there is an adverse event. A process has been implemented to improve our engagement with patient and families and sets out the expectations of a key contact being appointed for the patient/family where there has been a significant adverse event in our care. Resources have been developed providing guidance for a key contact role, and a patient/family leaflet on the significant adverse events purpose and process. This approach helps create standardisation across the organisation and provide consistence to patients and families where significant adverse events reviews are taking place.

[1] NHS Fife Population Health and Wellbeing Strategy 2023-2028

[2] Learning from adverse events through reporting and review: A national framework for Scotland, revised July2018, NHS Fife review all adverse events.

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

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

Between 1 April 2023 and 31 March 2024, there were 28 adverse events reported where DoC applied. The main categories of event which activated DoC during this period were:

- [1] Patient Fall
- [2] Tissue Viability
- [3] Other clinical events
- [4] Surgical Complications

Table 1 details the outcomes which were reported across NHS Fife after 1 April 2023 to 31 March 2024.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred 2023/2024
The death of the person	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5
An increase in the person's treatment	17
Changes to the structure of the person's body	<5
The shortening of the life expectancy of the person	<5
An impairment to 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	0
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 medications being required to additional night's stay in hospital.

Summary of Years 1-6

Table 2 sets out the events where DoC applied in 2018/19, 2019/20, 2020/21, 2021/22, 2022/23 and 2023/24. This additional information is being included for completeness as DoC was applicable to events which concluded review after respective annual reports were submitted.

The number of events where DoC applied in year 1 is higher than the subsequent years. This can be attributed to the development of learning and understanding of the application of DoC Regulations.

Table 2

Number of Duty of Candour events in each report year	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22	Year 5 22/23	Year 6 23/24
Number of events where DoC applied and where included in respective annual report	46	28	27	36	33	29
Number of events where DoC applied and where not included in annual report	10	10	4	8	5	TBD **
Total number of events where DoC applied	56	38	31	44	38	TBD **

**To Be Determined (TBD) - Will be included in 24/25 annual report

Table 3 sets out the DoC outcomes for the six year period. The most common outcome which triggered DoC is an increase in the person's treatment.

Table 3

	Number of times this occurred					
Duty of Candour outcome arising from an unexpected or unintended incident	Year 1 18/19	Year 2 19/20	Year 3 20/21	Year 4 21/22	Year 5 22/23	Year 6 23/24
The death of the person	<5	<5	<5	7	<5	<5
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5	<5	<5	<5	<5	<5
An increase in the person's treatment	34	21	13	24	26	17
Changes to the structure of the person's body	<5	<5	<5	0	<5	<5
The shortening of the life expectancy of the person	<5	<5	<5	<5	<5	<5
An impairment to 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	<5	0	0	0	0	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	8	<5	<5	<5	<5	0
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	7	<5	<5	<5	<5

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

Of the 29 identified cases, each one was reviewed to assess for compliance with the procedure for the following elements:

- Providing an apology
- 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
- Giving consideration to support and assistance for the relevant person/ and or staff

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
- Reviewing all cases
- Offering support and assistance

Improvement since last year has been made in:

- Arranging the meeting following offer to meet

Areas for improvement:

- Providing the patient with a timely written apology

We recognise that witnessing or being involved in an adverse event can be distressing for staffas well as people who receive care. Support is available for all staff through our line management structures 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 DoC procedure.

The policy contains a section on implementing the organisational DoC, 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.

Clinical teams make the recommendation that Duty of Candour is activated with the final decision made by the Medical Director.

To support implementation of DoC, staff are encouraged to complete the NHS Education Scotland online learning module. This has been made available to staff through TURAS. 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 have we changed and improved as a result?

Further to reviews of DoC events in 2023/2024 the following changes have been implemented:

Reducing Falls

- Care assurance audits on falls and spot checks on falls documentation were carried out to ensure proper procedures are followed for patients at risk of falls
- Falls training was undertaken across many ward areas
- Falls reviewed at ward level to identify themes and trends and inform quality improvement work
- Learning from falls incidents was shared across ward areas and awareness of the falls pathway raised
- New falls toolkit implemented

Reducing Harm from Pressure Ulcers

- Audits of comfort round completion were undertaken to ensure correct procedure is undertaken for those at risk of pressure ulcers
- Ongoing documentation audit to ensure quality and evidence based care prescribing for pressure ulcers
- Refresher training in pressure ulcers including skin care, use of 4AT and comfort round assessment was undertaken to improve pressure ulcer management. Supported by the Tissue Viability Team
- Learning from pressure ulcer incidents was shared

Maternity Improvements

- Training package developed on best practice for undertaking and recording of vaginal examinations in pregnancy

Deteriorating Patient Improvements

- Education and training undertaken on the importance of maintain accurate fluid balance records and acting on significant fluid deficits, FEWS and the deteriorating patient
- Shared learning within planned care of medication incidents
- DNACPR and reversible events and management of choking episodes education
- Safety huddles introduced on nightshift to improve patient safety and communication

Paediatric Improvements

- Online paediatric diabetic training session developed – to support early recognition of diabetes in children and complications

Given the delays described in this report it is anticipated that more changes will be implemented following conclusion of events which are still under review. These will be captured in the 2024/2025 annual report.

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

Board Medical Director Office
NHS Fife
Queen Margaret Hospital
Whitefield Road
Dunfermline
KY12 0SU

Telephone:
01592 648077

Appendix 1: Kennoway Medical Group

Kennoway Medical Group
The Health Centre
Jordan Lane
Kennoway
KY8 5JZ
Tel: 01333 350241
Email: Fife.F20856Kennoway@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 31 March 2024

Kennoway Medical Group provides Health Care to patients within the Kennoway and Levenmouth area (to include: Baintown Windygates, Star of Markinch, Milton of Balgonie, Leven, Coaltown of Burnturk and Cults Hill). The Medical Groups 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 2023 and 31 March 2024)
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 Kennoway Medical Group 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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Linburn Road Health Centre

Linburn Road Health Centre
124 Nith Street
Dunfermline, KY11 4LT
Email: Fife.F20502LinburnRoad@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 31 March 2024

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?	<5

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 2023 and 31 March 2024)
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	<5
Total	**<5**

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, Cliniciansand staff set up a learning review. This allows everyone involved toreview what happened and identify changes for the future.
Information about our Policies and Procedures	See NHS Fife Policies and Procedures available on Blink (joinblink.com)
What has changed as a result?	We have learnt the importance of arranging appropriate follow up. That any recurrence of a breast lump in the same place should be a high index of suspicion for an underlying pathology. To be just as suspicious of lumps in the breast of men as women. We have made an effort to actively book follow up appointment with patients when we think it is important to review to make sure resolution of symptoms. To be open with patients about what would need done if there isn't resolution of their symptoms. We have referred more patients to the breast clinic after their first appointment with symptoms that previously we might have treated differently.
Other Information	N/A

Appendix 3: Methilhaven Medical Practice

Methilhaven Medical Practice
Randolph Wemyss Hospital,
Wellesley Road
Buckhaven KY8 1HU
Tel: 01333 426913
Email: fife.f21505methilhaven@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 31 March 2024

Methilhaven Surgery provides Health Care to patients within the Methil, Buckhaven, and Levenmouth 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 2022 and 31 March 2023)
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 Methilhaven MedicalPractice follow theduty 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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 4: The Links Practice

The Links Practice
Masterton Health Centre
74 Somerville Street
Burntisland
Fife, KY3 9DF
Tel: 01592 873321
Email: Fife.F20184LinksPractice@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 1 December 2023

Our Practice serves a population of 1953 patients within the Burntisland, Kinghorn, Aberdour 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 2022 and 31 March 2023)
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 The Links Practice follow theduty 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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 5: Valleyfield Medical Practice

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

Duty of Candour Report
Report period: 1 April 2023 to 1 November 2023

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 2022 and 31 March 2024)
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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 6: Park Road Medical Practice

Park Road Medical Practice
The Health Centre
Park Road, Rosyth
Fife, KY11 2SE
Email: Fife.F21760ParkRoad@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 31 March 2024

Park Road Medical Practice provides Health Care to patients within the Rosyth, Dunfermline within our boundary, Inverkeithing, North Queensferry, Aberdour, Dalgety Bay, Limekilns, and historical patients registered in Crossford areas. The Medical Practice'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 2022 and 31 March 2024)
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 Park Road 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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 7: Kinghorn Medical Practice

Kinghorn Medical Practice
Rossland Place
Kinghorn
Fife
KY3 9RT
Email: fife.f20907kinghorn@nhs.scot

Duty of Candour Report
Report period: 1 April 2023 to 1 December 2023

Kinghorn Medical Practice provides general medical services to around 3360 registered patients residing within the practice boundary which encompasses Burntisland, Kinghorn and the bottom part of Kirkcaldy and surrounding rural areas. Our mission is to provide a personal quality service making the best use of available resources.

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 2022 and 31 March 2024)
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 Kinghorn 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 Blink (joinblink.com)
What has changed as a result?	N/A
Other Information	N/A

We provide accessible communication on request in a variety of formats including for people who are speakers of community languages, who need Easy Read versions, who speak BSL, read Braille or use Audio formats.

Our 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.EqualityandHumanRights@nhs.scot or phone **01592 729130**

NHS Fife
Queen Margaret Hospital,
Whitefield Road,
Dunfermline,
KY12 0SU

www.nhsfife.org