

1. Introduction

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 are informed by the organisation what has been learned and how improvements for the future will be made.

An important part of this duty is that we publish an annual report which describes how NHS Highland has operated the duty of candour procedures during the time between 1 April 2019 and 31 March 2020.

2. About NHS Highland

Foyers Medical Practice serves a population of 952 people across in a large area on the Eastern shores of Loch Ness from Dores and Inverarnie in the North to Whitebridge in the south.

Our aim is to provide high quality care for every person who uses our services.

3. How many incidents happened to which the duty of candour applies?

Between 1 April 2019 and 31 March 2020, there were 0 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

Foyers Medical Practice identifies incidents through a system of Multi-disciplinary clinical meetings where Significant Event Analyses are shared and discussed collectively. Over the time period for this report we carried out and concluded 3 significant event analyses. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm. Significant event analyses are also undertaken where there is no harm to patients or service users, but there has been a significant impact to service or care delivery.

We identify through the significant event analysis process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Table 1. – Not Applicable as no Duty of Candour incidents to report.

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

4. To what extent did Foyers Medical Practice follow the duty of candour procedure? - Not Applicable

When we realised the events listed above had happened, we followed the correct procedure in [xx] occasions ([xx]% of the time). This means we informed the people affected; apologised to them; offered to meet with them; reviewed what happened and what could have been better and fed back the findings to the people affected if this was their wish.

5. Information about our policies and procedures

Every SEA event is reported through our local reporting system. Through our SEA management procedures we can identify incidents that trigger the duty of candour procedure.

Each adverse event is reviewed to understand what happened and how we might 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 adverse event review, and identified members of the team take action to implement these recommendations. These are followed up until conclusion.

Staff receive training on adverse event management and incident reporting as part of their induction. Discussions took place throughout 2019/20 to highlight the procedures for escalating cases which had the potential to meet duty of candour. The clinical team meets every week to oversee the investigation of SAEs.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management personnel, colleagues and via NHS occupational health.

6. What has changed as a result?

We have made a number of changes following review of adverse events which have been identified as meeting the criteria of duty of candour. Please see the following cases as examples:

Not applicable

7. Other information

This is the second year of the duty of candour being in operation.

We continue to learn and have a lead clinician for Duty of Candour and our SEA templates have been amended to reflect this requirement and trigger further appropriate action.

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

If you would like more information about this report, please contact us using these details: Tel : 01456 486224