THURSO & HALKIRK MEDICAL PRACTICE
69 Princes Street, THURSO, Caithness KW14 7DH
Tel: 01847 893154

DUTY OF CANDOUR ANNUAL REPORT 2018/2019

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 we have operated the duty of candour procedures during the time between 1 April 2018 and 31 March 2019.

2. About the Thurso & Halkirk Medical Practice

The Thurso & Halkirk Medical Practice serves a practice population of 6200 patients across the Thurso and surrounding area.

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 2018 and 31 March 2019, there were zero 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.

Over the time period for this report we carried out and concluded five 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.

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	Nil
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	Nil
A person's treatment increased	Nil
The structure of a person's body changed	Nil
A person's life expectancy shortened	Nil
A person's sensory, motor or intellectual functions was impaired for 28 days or more	Nil
A person experienced pain or psychological harm for 28 days or more	Nil
A person needed health treatment in order to prevent them dying	Nil
A person needing health treatment in order to prevent other injuries as listed above	Nil
TOTAL	Nil

4. To what extent did the Thurso & Halkirk Medical Practice follow the duty of candour procedure?

We followed the correct procedure and identified zero incidents in the year 2018/2019. If we had identified any relevant incidents we would have 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 discussed with our Practice team and the procedure implemented immediately once an incident has been identified. Through this process 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 the Practice Manager ensures the recommendations are implemented. These are followed up until conclusion.

Staff receive training on adverse event management and incident reporting as part of their induction. Discussion will take place during appraisal review where necessary. All significant event reviews are passed to the Practice Manager for onward discussion with the management team and a decision made on the need to trigger the duty of candour procedure. All members of staff have completed the Duty of Candour LearnPro module. An annual discussion takes place with all staff members to review significant events, complaints and any incident that may have been investigated under the duty of candour procedure. We know that adverse events can be distressing for staff as well as people who receive care and support our staff through the investigation process.

6. What has changed as a result?

We have made a number of changes following review of adverse events.

Nil – no incident identified as falling under the Duty of Candour procedure during the year 2018/2019. Changes have been made resulting from other significant adverse event reviews.

7. Other information

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the organisational duty of candour requirements. All staff have been made aware of the Duty of Candour principles. All staff have completed the Duty of Candour LearnPro module.

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:

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Contact: Christine Tait (Practice Manager) or Jennifer Nicol (Assistant Practice Manager)