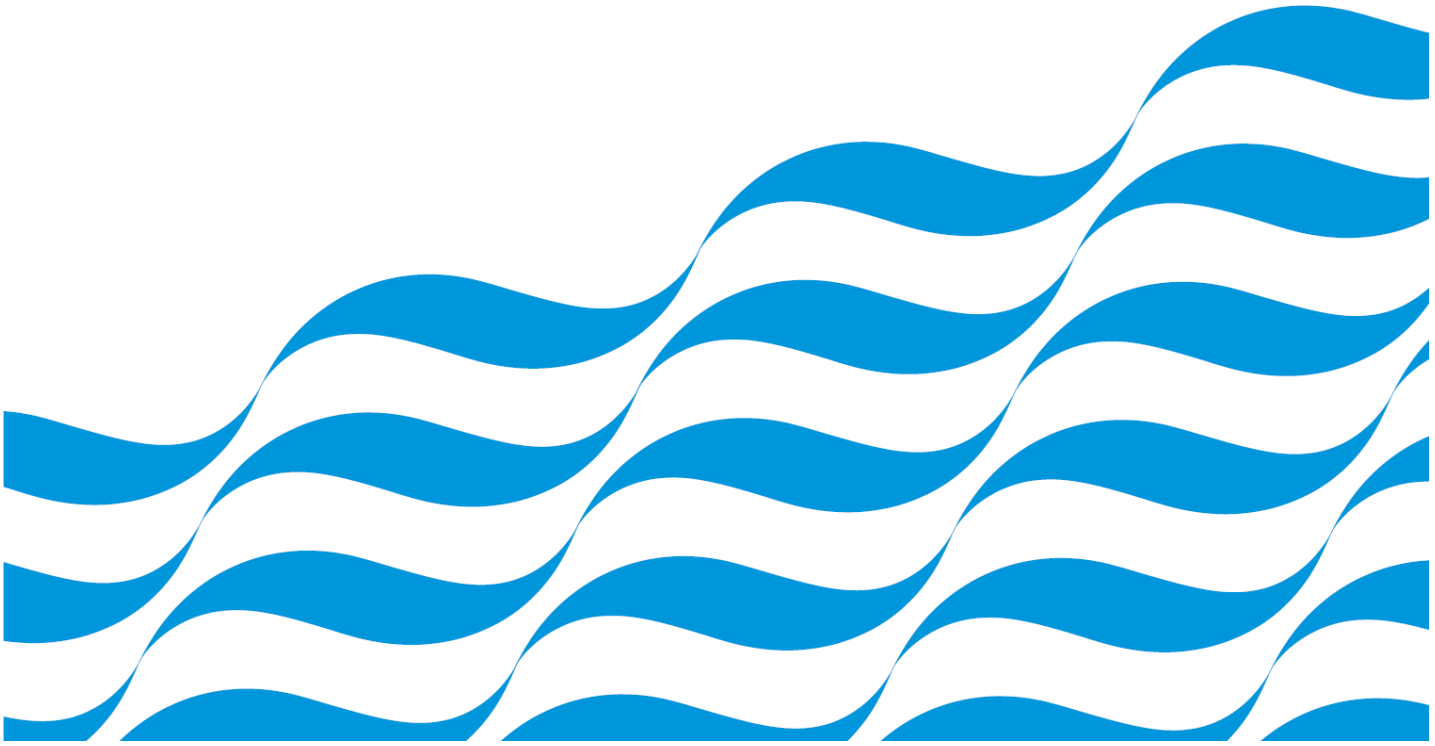
NHS
Fife

Annual Organisational Duty of Candour Report
2021-2022



www.nhsfife.org

Contents

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]

Content of Report

This report describes how NHS Fife has implemented the organisational Duty of Candour (Doc) Regulations during the period 1 April 2021 to 31 March 2022 (2021/2022). NHS Fife identified these events mostly through its adverse event management processes. 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 and which is aligned with a national framework[2].

The Covid-19 pandemic and the system pressures in proceeding years has resulted in a delay to the completion of adverse event reviews. This is reviewed regularly with processes in place to ensure reviews are progressed and completed. 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), 2 (2019/2020) and 3 (2020/2021) 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 1-4 are organisational DoC reports from the four health board managed general practices in NHS Fife.

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 an embedded 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.

[1] NHS Fife Strategic Framework. 2015.

[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 2021 and 31 March 2022, there were 36 adverse events reported where DoC applied. The main categories of event which activated DoC during this period were:

- Tissue Viability
- Theatre / Surgery Incidents
- Other clinical events

Table 1 details the outcomes which were reported across NHS Fife after 1 April 2021 to 31 March 2022.

Table 1

Duty of Candour outcome arising from an unexpected or unintended incident	Number of times this occurred 2021/2022
The death of the person	6
Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	<5
An increase in the person's treatment	20
Changes to the structure of the person's body	0
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	<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 night's stay in hospital.

Summary of Years 1-4

Table 2 sets out the events where DoC applied in 2018/2019, 2019/2020, 2020/2021 and 2021/2022. 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
Number of events where DoC applied and where included in respective annual report	46	28	27	36*
Number of events where DoC applied and where not included in annual report	10	10	<5	TBD **
Total number of events where DoC applied	56	38	31	TBD **

*1 event for 3 patients / *To Be Determined (TBD) - Will be included in 22/23 annual report

Table 3 sets out the DoC outcomes for the three year period. Across this period the most common outcome is an increase in the person's treatment.

Table 3

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

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

Of the 36 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:

- Providing the patient with a written apology

Areas for improvement which are attributable to the pressures in the system include:

- Arranging the meeting following offer to meet

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 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 on line 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, theorganisation 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 madeavailable 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?

Further to reviews of DoC events in 2021/2022 the following changes have been implemented:

- Tissue viability specialist nurses in partnership with the tissue viability link nurses identified pressure related ward level training and delivered the training to all ward staff. This included the accurate completion of wound care documentation and the importance of clear and accurate wound charts
- Review of the dietetic referral criteria for patients with pressure damage ensuring patients are referred
- Further supportive learning delivered to staff regarding correct identification/ grading of pressure ulcers
- Further education delivered on central venous catheter (CVC) care bundle
- Plaster cast referral form was reviewed to ensure patients who are high risk of pressure damage can be clearly identified
- Introduction of new monitoring chart for high dose insulin euglycaemic therapy
- Delivery of a further training session for stroke including review of four case studies
- The latent phase of labour guideline was reviewed to include bladder care and time frames for review to allow more flexibility to individual patient condition. The management of the latent phase of labour is now included in regular skill and drills in the Midwife-Led Unit
- In orthopaedic theatres when implants are being used the stop & check engagement between theatre staff is now carried out routinely before the list starts and at the various stages during the operation
- For complex patient transfers from critical care to ward level care Medical High Dependency Unit (MHDU) step down is now part of the consideration
- Post intravitreal injection therapy (IVT) patients who phone the Ophthalmology Dept with reported complications will now be seen in the Emergency Clinic for an urgent review
- An endometrial biopsy is now obtained in the post-menopausal bleeding clinic even when the scan suggests uterine polyp, with referral made to the hysteroscopy clinic to manage the polyp whilst awaiting the histology report.

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 2022/2023 annual report.

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.F20502LinburnRoad@nhs.scot

Duty of Candour Report

Report period: 1 April 2021 to 31 March 2022

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 2021 and 31 March 2022)
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 Blink (joinblink.com)

What has changed as a result?	N/A

Other Information	N/A

Appendix 2: Kinghorn Medical Practice

Kinghorn Medical Practice
Rossland Place
Kinghorn
Fife
KY3 9RT
Tel: 01592 890217

Duty of Candour Report

Report period: 1 October 2021 to 31 March 2022

Completed by: Fay Paterson, Practice Manager

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 some 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 October 2021 and 31 March 2022)
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 Blink (joinblink.com)

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

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

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

This short report describes how our care service has operated the duty of candour during the time between 1st April 2021 to 31st March 2022. We hope you find this report useful.

Our Practice serves a population of 1972 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 to 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.F20184LinksPractice@nhs.scot

Appendix 4: 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 2021 to 31 March 2022

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 2021 and 31 March 2022)
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 5: 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 2021 to 31 March 2022

Completed by: Tracy Simpson, Acting Practice Manager

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 2021 and 31 March 2022)
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

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.EqualityandHumanRights@nhs.scot or phone 01592 729130

NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

www.nhsfife.org

facebook.com/nhsfife
@nhsfife
youtube.com/nhsfife
@nhsfife