

Moray Coast Medical Practice Duty of Candour Annual Report 2018/19

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 Moray Coast Medical Practice has operated the duty of candour procedure during the time between 1 April 2018 and 31st March 2019.

2. About Moray Coast Medical Practice

Moray Coast Medical Practice serves a population of 10100 people across Lossiemouth, Burghead and Hopeman.

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

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

Between 1st April 2018 and 31st March 2019 there were no 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 related directly to the natural course of someone's illness or underlying condition.

Moray Coast Medical Practice sought to identify these incidents through our significant event management procedures. Over the time period for this report we carried out and concluded several 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 not harm to patient or service users, but there has been a significant impact to service or care delivery; in some cases, this may be a positive impact that we seek to exploit formally through a process of change.

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

Type of unexpected or unintended incident	Number of times this happened 1.4.18-31.3.19
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A persons treatment increased	0
The structure of a persons body changed	0

A persons life expectancy shortened	0
A persons 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

4. To what extent did Moray Coast Medical Practice follow the duty of candour procedure?

As is often the case, the practice learned about significant events via a complaint rather than identifying the incident independently.

5. Information about our policies and procedures

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

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. These are followed up until conclusion

6. 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 out existing adverse event management processes to include organisational duty of candour requirements. We are taking steps to be proactive in reporting and recording events that may result in an adverse event rather than waiting for an event to take place.

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 then please contact The Practice Manager.