COAST HEALTH

Annual Duty of Candour Report - 1st April 2018 to 31st March 2019

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 that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how NHS X has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

1. About Coast Health

Coast Health serves a population of 5,000 people in the East Neuk of Fife.
Our aim is to provide high quality care for every person who uses our services, and where possible help people to receive care at home or in a homely setting.

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

Between 1 April 2018 and 31 March 2019, 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 directory to the natural course of someone's illness or underlying condition.

Coast Health identified these incidents through our adverse event management process. Over the time period for this report we carried out 6 significant adverse event reviews. 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.

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

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	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 Coast Health follow the duty of candour procedure?

As there have been no incidents this year we have not had to follow the duty of candour procedure but we have used this year to learn about the duty of candour and what we need to do if an incident occurs. This means, when an incident is identified, we will inform the people affected, apologise to them, and offer to meet with them. In each case, we will review what happened and what went wrong to try and learn for the future.

3. Information about our policies and procedures

Every adverse event is reported through Significant Event analysis. Through analysis 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 management team develop improvement plans to meet these recommendations.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction, so that they understand when it applies and how to trigger the duty. Additional training is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

5. What has changed as a result?

No changes have been made this year as we have not identified any duty of candour events.

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 our existing adverse event management processes to include the duty of candour outcomes. 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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