April 2021 – March 2022

Duty of Candour Annual Report

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

Name & address of service:	Kings Park Hospital Polmaise, Stirling, FK7 9PU Ross Hall Hospital 221 Crookston Road, Glasgow, G52 3NQ Albyn Hospital 21-24 Albyn Place Aberdeen AB10 1RW	
Date of report:	25 April 2022	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	Yes Circle Health Group implemented their Duty of Candour policy in 2017 in line with the statutory duty under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as amended ("Duty of Candour") to act in an open and transparent way with patients in relation to their care and treatment. The Circle Health Group Duty of Candour policy was last updated March 2021. This was cascaded to staff. When the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour staff were updated. In addition – we provide teaching sessions to newly inducted staff and consultants as well as ongoing reorientation sessions to existing staff and consultants.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

How many times have you/your service implemented the duty of candour procedure this financial year? 1	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (April 2021 - March 2022)
A person died	2
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	Nil
A person's treatment increased	5
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	7

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	Yes
What lessons did you learn?	That an apology to the patient or their relatives does not necessarily imply we have done something wrong but is the correct course of action if a patient's treatment has increased as a result of the incident.
What learning & improvements have been put in place as a result?	Ongoing monitoring of these incidents to ensure compliance with our policy, The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	We share learnings through safety bulletins, comm cells, daily discussions as well clinical and medical governance.
Could any further improvements be made?	No
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	Guidance and templates are included in Circle Healthcare's Duty of Candour policy. In addition, we provide coaching, support, learnings from our reporting system and documented escalation mechanisms.
What support do you have available for people involved in invoking the procedure and those who might be affected?	An open culture and to ensure the reporting of events as either statutory or profession DOC
Please note anything else that you feel may be applicable to report.	Nil