Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

NHS SCOTLAND

Circle Health Group
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 and address of service:	Albyn Hospital 21-24 Albyn Place, Aberdeen, AB10 1RW Kings Park Hospital Polmaise Road, Stirling, FK7 9JH Ross Hall Hospital 221 Crookston Road, Glasgow, G52 3NQ Ross Hall Clinic – Braehead Kings Inch Place, Renfrew, PA4 8WF
Date of report:	8 May 2024
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 ("Circle") 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. This was cascaded to staff and updated when the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 ("the act") and The Duty of Candour Procedure (Scotland) Regulations 2018 ("the regulations") came into force. In addition, we provide teaching sessions to newly inducted staff and Consultants, as well as ongoing re-orientation sessions to existing staff and Consultants. Circle's duty of candour policy was last updated in March 2021.
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?	
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 2023 – March 2024)**
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	12
The structure of a person's body changed	1
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	3
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**16**

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 and improvements have been put in place as a result?	Each patient safety incident is reviewed to understand what happened, why it 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. All significant patient safety incidents are reviewed by the patient safety incident response group ("PSIRG") to determine the level of review. Recommendations are made as part of the adverse event review and hospital management teams develop improvement plans to meet these recommendations. Ongoing monitoring of these incidents occurs 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 and daily discussions as well as clinical and medical governance committee meetings. This is supported through our governance and assurance framework (“GAF”) and learnings are shared ward to board.
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’s duty of candour policy. In addition, we provide coaching, support, learnings from our reporting system and documented escalation mechanisms. Training on adverse event management and implementation of duty of candour is available for staff to access to ensure they understand when it applies and how to trigger the duty. Additional online training and guidance is also available and, for those who are our key risk contacts in the hospitals, we provide development sessions. Staff can access professional advice from the PSIRG. All regulated healthcare professionals have a personal duty of care, which includes: • A duty to be open and honest with patients in your care, or those close to them, if something goes wrong. This includes offering an apology. • A duty to be open and honest with your organisation and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.
What support do you have available for people involved in invoking the procedure and those who might be affected?	We know that patient safety incidents can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure, through the practice of ‘hot debriefs’ as well as through occupational health. A focus on staff wellbeing has extended the offer of pastoral support and psychological therapy to all staff. People who are affected by unintended or unexpected incidents are supported primarily by their line managers and, where appropriate, by senior managers, with support from the PSIRG.
Please note anything else that you feel may be applicable to report	Nil