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 & 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
Date of report:	23rd February 2026
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 has ensured that leaders and staff understand their responsibilities in relation to the statutory Duty of Candour (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) and that robust systems are in place to respond effectively. The Circle Health Group Duty of Candour policy was implemented in 2017 and was most recently updated in August 2024 (Version 4.0). This update ensured the policy remains current, aligned to regulatory requirements, and consistent with organisational governance processes. The revision included: • Updates and clarification of definitions • Alignment with the revised CHG Incident Management Policy and Patient Safety Incident Response Framework (PSIRF) • Expansion of Section 3 to include circumstances where Duty of Candour requirements cannot be discharged, with removal of the previous Section 4 to avoid duplication and improve clarity • Reformatting into the new CHG policy template • Inclusion of a template letter and checklist as appendices to support consistent and compliant application Understanding and effective implementation are supported through: • **Governance oversight:** Significant incidents are reviewed at the Corporate Patient Safety Incident Response Group, where the requirement for Duty of Candour is formally considered, confirmed, and clearly documented, including the rationale. • **Incident reporting system (Radar):** Duty of Candour is recorded within the electronic incident reporting system, enabling tracking, transparency, and audit.

	• **Corporate monitoring:** Compliance is reviewed monthly by the corporate team to ensure Duty of Candour has been applied appropriately and in a timely manner. • **Standardised tools and documentation:** The inclusion of a checklist and template letter supports staff to meet regulatory requirements consistently and ensures patients receive clear, open, and transparent communication. These arrangements provide assurance that staff understand their responsibilities and that structured systems are in place to ensure Duty of Candour is discharged appropriately and in line with statutory requirements.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	CHG QRpol11 Being Open and Duty of Candour V4.0 LEGpol1

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 (2025)
A person died	4
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	Nil
A person's treatment increased	46
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	2
A person needing health treatment in order to prevent other injuries as listed above	Nil
Total	52

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, all appropriate actions were taken and the Duty of Candour procedure was followed in line with organisational policy and statutory requirements.
What lessons did you learn?	Circle Health Group can confirm that the responsible person/s followed the organisational procedure in line with statutory requirements. The incident/s met the threshold for Duty of Candour, and this was recognised promptly following initial review and following discussion at Patient Safety Incident Response Group (PSIRG). The patient/s or next of kin were informed at the earliest appropriate opportunity with open and transparent discussions, during which:

	• A clear explanation of what had occurred was provided. • An apology was given in accordance with Duty of Candour requirements. • The known facts at that stage were shared. • The patient was advised that a proportionate investigation would be undertaken. • The patient was offered the opportunity to ask questions and receive ongoing updates. The process was undertaken in line with Circle Health Group's Duty of Candour policy and reflects our commitment to openness, transparency, and patient-centred care.
What learning & improvements have been put in place as a result?	Each patient safety incident is reviewed to establish what happened, why it happened, and how care can be improved in the future. Learning is shared across the hospital sites and Group-wide to strengthen systems and reduce the risk of recurrence. The level of response is proportionate to the severity of harm and the potential for organisational learning. All significant patient safety incidents are reviewed by the Patient Safety Incident Response Group (PSIRG), which confirms the level of harm and determines the appropriate level and type of response. As part of the PSIRG review: • Clear recommendations are made. • Hospital management teams are required to develop and implement improvement action plans aligned to those recommendations. • Actions are tracked and monitored to ensure completion and effectiveness. Learning is disseminated both hospital-wide and across the Group where wider organisational learning is identified, through Clinical Governance Committees and local governance forums to ensure shared understanding and consistent practice improvements. Ongoing monitoring is undertaken to ensure compliance with organisational policy, the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, and the Duty of Candour Procedure (Scotland) Regulations 2018. All significant patient safety incidents are returned to PSIRG following completion of the required investigation. This ensures robustness of the review process, confirms that recommendations have been appropriately addressed, and provides assurance that sites remain accountable for both the incident and the associated learning. Sites are required to present their findings to the panel, where further scrutiny and challenge may be applied as necessary.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Lessons learned are shared across Circle Health Group (CHG) using multiple communication and governance channels to ensure both local and Group-wide dissemination.

	Learning is shared through: • Safety bulletins circulated across the Group • Communication cells (comm cells) and daily safety discussions at site level • One-page learning summaries, designed to provide clear, concise key messages and actions • Clinical Governance and Medical Governance Committees, Learning from Deaths Committee • A newly developed SharePoint learning hub, accessible to all colleagues across Circle Health Group The one-page learning summaries have been particularly well received by Medical Advisory Committees (MACs), with evidence of onward sharing beyond Circle Health Group, supporting wider sector learning. In addition, learning from Never Events is reinforced through: • Never Event "lunch and learn" sessions • A newly introduced monthly Quality Improvement and Patient Safety Newsletter, promoting transparency, shared learning, and continuous improvement This multi-channel approach ensures learning reaches multidisciplinary teams, including clinical, medical, nursing, pharmacy, and operational colleagues, and supports embedding improvements into everyday practice.
Could any further improvements be made?	Quality improvement is a continuous and evolving process. We routinely review both our incidents and our methods of capturing and disseminating learning to identify opportunities to strengthen our approach further. We continually assess how learning is shared across the Group to ensure it is accessible, meaningful, and embedded into practice. Feedback on our shared learning mechanisms has been positive, particularly regarding the clarity and usability of our one-page summaries and newsletters. We remain committed to refining our processes where appropriate, ensuring that learning is not only communicated widely but also translated into measurable and sustainable improvements in patient safety.
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?	Circle Health Group supports colleagues to deliver apologies in a patient-centred, open, and compassionate manner through a structured framework aligned to statutory Duty of Candour requirements and incorporating the Four Steps of Engagement. Support mechanisms include: • Clear guidance and templates within the Circle Health Group Duty of Candour Policy, including step-by-step process guidance and written communication templates to ensure apologies are timely, appropriate, and compliant. • Coaching and senior support, corporately run training sessions for Directors of Clinical Services, Clinical Services Managers, and Quality & Risk Managers available to guide staff in preparing for and undertaking Duty of Candour conversations.

	• Learning from incident reporting, using themes identified through our reporting system to reinforce good practice and share examples of effective, patient-centred communication. • Documented escalation pathways, ensuring staff can promptly access senior clinical and governance advice where required. • Governance oversight, with review through the Patient Safety Incident Response Group (PSIRG) to ensure Duty of Candour obligations are met appropriately and consistently. This structured approach ensures staff are not expected to manage difficult conversations in isolation and are supported to communicate openly, empathetically, and professionally with patients and families.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Circle Health Group promotes an open and transparent culture to support the effective implementation of the Duty of Candour process. Staff are actively encouraged to report incidents and concerns, whether under the statutory or professional Duty of Candour, without fear of blame. This culture supports early escalation, openness, and learning. To support those involved in invoking the procedure, and those who may be affected, CHG has the following mechanisms in place: • Structured debriefs following incidents, enabling reflection, shared learning, and emotional support. • Clinical supervision, providing a formal opportunity for professional reflection and guidance. • Peer support, ensuring colleagues can access informal and formal support from experienced team members. • Management support, including access to senior clinical and operational leaders for advice and oversight. • Employee Assistance Programme (EAP) services, offering confidential wellbeing and psychological support where required. These systems ensure that staff involved in Duty of Candour processes are supported professionally and emotionally, and that patients and families are managed with compassion, openness, and appropriate follow-up.
Please note anything else that you feel may be applicable to report.	Nil