The ‘duty of candour’

The duty of candour

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.

The Act and the Regulations require organisations providing health services, care services and social work services in Scotland to follow a formalised procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

Our legal obligations

1. Duty of Candour Procedure

As a provider of an independent health care service, we are required to develop and implement a duty of candour policy that describes how we/our staff will act in the event of an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The key stages of the policy must include:

Notify the person affected (or family/relative where appropriate);
Provide an apology;
Carry out a review into the circumstances that led to the incident;
Offer a meeting with the person affected and/or their family, where appropriate;
Provide the person affected with an account of the incident;
Provide information about further steps taken;
Provide support to staff notifying the person affected by the incident;
Prepare and publish an annual duty of candour report (see below).

Further guidance on when the duty must be implemented can be found in the Scottish Government Duty of Candour Guidance and the dedicated webpage.

Preparing the duty of candour procedure:

We will consider the following points when preparing the duty of candour procedure and annual report:

How we will identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21 of the Act?

We are satisfied our staff understand their responsibilities and we have systems in place to respond effectively?

Who do we need to engage with to satisfy ourselves we can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?

What systems we have in place to support staff to provide an apology in a person-centred way and how we support staff to enable them to do this?

Do our current systems and processes provide the information required to report on the Duty of Candour?

How we will align our duty of candour annual report with other reports we are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?

What training and education we have at present that will support the implementation of the Duty?

This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations.

What we have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?

How we currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

**Please refer to the Duty of Candour Guidance for more detailed guidance.*

2. Duty of candour annual report

We must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where we have applied the duty of candour. This annual report will be published on our website. As this is the first year of trading, the Duty of Candour report relates to the period from start of trading on 1st April 2020 to 30th Sept 2020.

NB: *Even if you do not implement the duty of candour procedure in a given year, you are still required to produce a short report that contains information about staff training on the duty of candour obligations.*

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 triggered duty of Candour within our service.

Name & address of service:	Signature Medical Ltd, 79 West Regent Street, Glasgow, G2 2AW	
Date of report:	1st April 2020 to 30th Sept 2020.	
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?	Duty of Candour underpins our communication with patients and families following every incident, whether it requires implementation or not. Staff are introduced to Duty of Candour regulation.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	**YES**	~~NO~~

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 18 - March 19)
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

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?	N/A as there have been no instances of implementing Duty of Candour in the above-noted circumstances. However, all healthcare professionals have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong.
What lessons did you learn?	N/A - as there are no incidents to report for this period. However, following any incident, an immediate investigation is carried out by the Medical Director, risk assessments are created and updated as appropriate, named nurse is put in place if necessary. If appropriate information is added to the safety brief shared at each handover report.
What learning & improvements have been put in place as a result?	N/A
Did this result is a change / update to your duty of candour policy / procedure?	N/A. Our Duty of Candour policy was created in April 2019 and reviewed again in May 2020
How did you share lessons learned and who with?	Any lessons learned would be shared at the Management meeting, Any slips, trips and falls, including those which have not resulted in harm as defined under Duty of Candour will also be discussed.
Could any further improvements be made?	Not that we are aware of at present.
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?	In terms of our policy, the Medical Director takes responsibility for ensuring any apology is delivered when necessary.
What support do you have available for people involved in invoking the procedure and those who might be affected?	There is always an Operations Director in the clinic and the Medical Director can be contacted if needed.
Please note anything else that you feel may be applicable to report.	Nothing at this time but we will continue to review, monitor and develop our policy.