Duty of Candour Annual Report Template

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:	The Edinburgh Clinic 40 Colinton Road Edinburgh EH10 5BT	
Date of report:	17/04/2019	
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?	DoC is written within section 6.11 of the reporting and management of incidents policy. Mandatory Duty of Candour e-learning completed annually by all staff Duty of Candour training slides available for all staff to access on Aspen Healthcare portal	
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 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?	NA
What lessons did you learn?	NA
What learning & improvements have been put in place as a result?	NA
Did this result is a change / update to your duty of candour policy / procedure?	NA
How did you share lessons learned and who with?	NA
Could any further improvements be made?	NA
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?	We have not had any incidents or issues that have involved duty of candour. All staff receive training on duty of candour. Our reporting system picks up if any incidents are reportable and this cascades into our quality governance reporting. DoC is part of our overall approach to managing incidents and integral to our approach and builds on our being open framework. Staff would be supported by a senior manager and all apologies would be offered verbally and in-person and ideally involve the clinician if appropriate.
What support do you have available for people involved in invoking the procedure and those who might be affected?	NA
Please note anything else that you feel may be applicable to report.	NA