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:	Nuffield Health Glasgow Hospital 25 Beaconsfield Rd, Glasgow G12 0PJ	
Date of report:	31st March 2023	
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?	RADAR – Incident reporting. All incidents have the Duty of Candour statement with YES/NO function. This cannot be missed at the incident reporting stage as the system will not allow the incident to be closed without selection of YES/NO options being confirmed. The RADAR system is then audited for accuracy with hot feedback and amendments as necessary. All incidents are logged, reviewed, and reported via the Quality Forum, Heads of Department Forum, departmental team meetings, Medical Advisory Committee meetings. All incidents including Duty of Candour are discussed within staff members one to one meetings and Consultant appraisals. With trends identified escalated for review to explore training needs and practice privileges. Online Academy training. Promotion of Health Improvement Scotland guidance for Duty of Candour. Promotion of TURAS training module – Duty of Candour for the Director of Clinical Services, Quality Manager, Clinical Heads of Department, and clinical teams. Review of clinical incidents to ensure where appropriate Consultant colleagues and team members are following the principles of Duty of Candour.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	This is a Nuffield Health Policy which refers to the NHS England guidance for Duty of Candour therefore Health Improvement Scotland guidance resource is used onsite to regulate Duty of Candour.

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 22 - March 23)
A person died	2
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	2
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	4

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, in each of the 4 reportable duty of candour events the reporting clinician and responsible Consultant followed the duty of candour process including documentation of patient conversations within the patients' medical notes and incident reporting systems.
What lessons did you learn?	Further distribution of Practice Privilege Policy within medical society to reiterate the importance of practicing in accordance with Nuffield Health guidelines. Importance of ensuring best practice guidelines are followed and reiteration of the speak out campaign. Review and redesign of theatre brief and debrief to ensure a learning culture is fostered and promoted.
What learning & improvements have been put in place as a result?	Homepage | Centre for Perioperative Care (cpoc.org.uk) Pilot site for new Nuffield Health Speak Out campaign including team culture training on subjects like "banter" reinforcing the expectation for effective communication amongst colleagues. Speciality Service meeting to review service provision and further alignment of best practice standards.
Did this result is a change / update to your duty of candour policy / procedure?	There have been no policy changes or updates to the Duty of Candour policy as a result of the 4 reportable duty of Candour events or any other reported incident. Health Improvement Scotland duty of Candour guidance has been followed in each of the 4 reportable Duty of Candour events.

How did you share lessons learned and who with?	Debrief following the incident with team involved. Shared learn paper for team and corporate learning. Discussion at Safety Huddle. Documentation including lessons learned on Datix/RADAR incident reporting systems.
Could any further improvements be made?	Ongoing review, quality improvement and audit supported by the Quality Manager to assess and support the CPOC standards. Implementation of preoperative assessment exclusion criteria to support level 1 care available within the Nuffield Health Glasgow Hospital site.
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?	Duty of Candour letter template. Promotion and implementation of shared learning involving patients and relatives. PSIF launch and staff online training. Meetings offered to patients who are unhappy with their care or suffer an unexpected complication during their care journey followed with an outcome letter.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Debrief template to support learning culture. RADR incident reporting systems Occupational Health Services Wellbeing services Line manager support Private Medical Insurance Access to Wellbeing sites to support holistic wellbeing.
Please note anything else that you feel may be applicable to report.	Glasgow Hospital has an assigned Human Resource partner