The 'duty of candour': your legal obligations

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).

The purpose of this new duty is to ensure that providers are open, honest, supportive and providing a person-centred approach.

Your legal obligations

1. Duty of Candour Procedure

As a provider of an independent health care service you are required to develop and implement a duty of candour policy that describes how you/your 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 the procedure you will follow to:

- → 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.

Guidance: points to consider when preparing your duty of candour procedure and annual report

Preparing your duty of candour procedure*

- How will you identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21?
- Have you satisfied yourself that you (and your staff, if you employ staff) understand your responsibilities and have systems in place to respond effectively?
- Who do you need to engage with to satisfy yourselves you can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
- 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?
- Do your current systems and processes provide you with the information required to report on the Duty of Candour?
- How will you align your duty of candour annual report with other reports you are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?
- What training and education do you 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. You should also consider national training that is available freely to your staff such as e-learning opportunities.
- What support do you have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
- How do you 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

You must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where you have applied the duty of candour. Your annual report should be published on your website, if you have one, or make other suitable arrangements to communicate the duty of candour report to people who use your services.

Your first annual report must be prepared in April 2019, so it is important to start planning for this now. To help you we have provided a report template (below) for you to use/adapt.

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 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:	Nuffield Health Edinburgh Hospital, 40 Colinton Road Edinburgh, EH10 5BT	
Date of report:	13/07/2023	
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?	Yes Nuffield Health have implemented a Duty of Candour policy 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. The Nuffield Health Duty of Candour Policy was last updated May 2022. As part of a larger organisation, we have access to training resources accessed through our internal Nuffield Intranet. This Duty of Candour training is delivered through the Academy online portal and candidate attendance is tracked through our Human Resource function. Staff training stats (including compliance) is shared on a weekly basis. Staff who are viewed as not being compliant are encouraged to complete the training and given the time to do so.	
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 (Jan 22 -Dec 22)
A person died	Nil
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	Nil
A person's treatment increased	1
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	Nil
A person needing health treatment in order to prevent other injuries	Nil

as listed above	
Total	1

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 apologising and demonstrating transparency does not imply fault. It considers the patients experience and demonstrates empathy
What learning & improvements have been put in place as a result?	1. The patient had a suprachoroidal haemorrhage (bleeding inside the eye). When a haemorrhage occurs, the best action is to stop surgery, admit the patient, and wait for the bleeding to stop before completing the operation another day. 2. To continue monitoring these events for trend analysis and to identify areas for improvement. The likelihood of such incidents is low and we need to learn from these events in order to better improve patient outcomes
Did this result is a change / update to your duty of candour policy / procedure?	The Edinburgh Hospital has undergone a period of change. The ownership of the site has transferred from Aspen to Nuffield. We have amended our policy to reflect this change, considering the nuanced differences between NHS England duty of candour and NHS Scotland.
How did you share lessons learned and who with?	Post incident debrief with team Datix incident that was then discussed and shared at Heads of Department Meeting, Governance Meeting, Medical Advisory Committee and shared at Group level in our incident feedback and quarterly report meetings.
Could any further improvements be made?	Yes, since aligning to Nuffield we now have a clear templated process for triggering duty of candour; including a pathway that looks to support patient and staff member alike. This p
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?	A Policy that provides a structured approach to Duty of Candour Training on duty of candour available through the online training system, The Academy. Accountable and supportive senior management team. Skilled multi-disciplinary teams to assist in the investigation and decision making. Systems to track and update progress A responsive and supportive human resources function to provide additional support if required
What support do you have available for people involved in invoking the procedure and those who might be affected?	A Policy that provides a structured approach to Duty of Candour Training on duty of candour available through The Academy. Accountable senior management teams Skilled multi-disciplinary teams to assist in the investigation and decision making. Systems to track and update progress A responsive and supportive human resources function to provide a additional support if required

Please note anything else that you feel may be applicable to report.	Duty of candour was carried out on three occasions. On reflection it was realised that this was carried out based on Nuffield Health's grading of low harm when an incident occurs. Of the 3 occasions where duty of candour was triggered only 1 was truly a duty of candour incident as defined by the Scottish Government Duty of Candour policy.