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:	Marie Curie 133 Balornock Road Glasgow G21 3US	
Date of report:	29th March 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?	We have a national Duty of Candour policy and local procedure in place. This forms part of our incident reporting procedure. The Charity have run Duty of Candour workshops for Senior Managers and some staff attended the NHS and Hospice UK workshops	
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 2018 - March 2019)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	3
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	2
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries as listed above	0
Total	Affected 3 patients

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?	From all incidents, we identified that we had appropriate systems and processes in place to minimise the risk. One incident was patient choice to mobilise independently which resulted in a fracture, the second incident the staff member failed to follow procedure and the third incident, there was a sudden onset of delirium which resulted in the patient mobilising without requesting assistance.
What learning & improvements have been put in place as a result?	We provide education to patients and reiterate the risks of them not contacting staff for assistance but recognise that we are unable to limit patient's freedom in respect of mobilising, if that is their choice and they have capacity. The second and third incidents are still to be discussed the Marie Curie national SUI panel review in May 2019.
Did this result is a change / update to your duty of candour policy / procedure?	No changes
How did you share lessons learned and who with?	These incidents were discussed at the following meetings: • Allocation meeting • Medicines Management • Quality • Falls • Divisional Quality
Could any further improvements be made?	None 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?	We have communication skills training and clinical skills training which covers Duty of Candour. Senior Staff provide support the teams to provide an apology if required or requested by the staff member
What support do you have available for people involved in invoking the procedure and those who might be affected?	There is always a Senior Manager and Consultant on call. This can be escalated to Divisional General Manager/Executive Lead if necessary. Staff have access to the intranet to access all policies. There is also a printed copy of the policies in the clinical areas.
Please note anything else that you feel may be applicable to report.	