Dear Colleagues

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 sets out that a responsible person that provides a health, care, or social work service during a financial year must prepare an annual report, as soon as reasonably practicable after the end of that financial year. The report must be published in a manner that is publicly accessible. For instance, on an organisation's website.

Please find enclosed a Duty of Candour reporting template that practices may utilise if they wish (Appendix B). The new organisational Duty of Candour on health, care and social work services came into effect on 1 April 2018 therefore reports are now due for completion. The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm.

This duty requires organisations to follow a Duty of Candour procedure which will include:

* + notifying the person affected
	+ apologising and offering a meeting to give an account of what happened
	+ reviewing the incident and
	+ offering support to those affected.

For an example of when Duty of Candour is triggered, see Appendix A.

**Recording duty of candour incidents**

These reports should be published in a public domain e.g. website as well as notifying Scottish Ministers at the dutyofcandour@gov.uk address.

Two websites which you may find useful are**:**

<https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour/services> and [http://www.knowledge.scot.nhs.uk/adverse-events/duty-of-candour.aspx](https://eur03.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.knowledge.scot.nhs.uk%2Fadverse-events%2Fduty-of-candour.aspx&data=02%7C01%7C%7C7c0dfc67f48445ccc8ab08d6ccb36cc0%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1%7C0%7C636921469438259090&sdata=Ywo4aacDViuJKqLy2Rdh%2Bhjc8AEsyompr%2BkRSzyLltQ%3D&reserved=0)

Responsible persons should devise ways of recording duty of candour incidents in a manner which they believe meets their statutory responsibilities. Independent contractors, including GPs, need to devise appropriate recording tools for duty of candour incidents which are consistent with their own mechanisms for recording adverse events.

The quarterly complaints returns to the Board also ask for details of any incidents that triggered Duty of Candour.

* APPENDIX A: DUTY OF CANDOUR – GENERAL PRACTICE EXAMPLE

Healthcare Improvement Scotland’s Duty of Candour short life working group has developed illustrative examples of incidents that may, or may not, activate the Duty of Candour procedure. The example listed below is for illustrative purposes only. The conclusion represents the views of the short life working group on this specific scenario. It is the responsibility for each organisation to have a local decision making process that considers, on a case-by-case basis, whether the duty of candour procedure will be activated for an individual incident.

|  |
| --- |
| Public health |
| A health visitor in a GP practice noticed that the fridge storing childhood immunisation vaccines was warmer than usual – closer inspection revealed that the fridge had stopped working. Daily recordings of the fridge temperature had not been undertaken for 5 days and therefore maintenance of the cold chain could not be guaranteed since the last recording. Records indicated that 50 children had received a vaccine in the interim period. There was no indication that any recipient had been harmed as a consequence of receiving the vaccine(s). However, an inadequate immune response, as a result of the ineffective vaccine could result in the unprotected individual being at risk of infection, and harm as a consequence of said infection, at a future point. The effect of the cold chain failure was vaccine specific, and therefore the potency of each vaccine affected was assessed, to establish who may have been given sub-potent vaccine and may require remedial vaccination. Specific vaccines given to 5 children were found to be sub-potent and those children required to be re-vaccinated. **The organisation decided to** **activate the DoC procedure for the 5 children who needed to have further vaccinations.**  | ***No alternative example available for this scenario.*** |

* APPENDIX B: TEMPLATE FOR GP PRACTICE REPORT FOR DUTY OF CANDOUR

**Duty of candour**

**Template annual report**

As an independent contractor provider of health care in Scotland, your duty of candour responsibilities require you to publish an annual report of unintended or unexpected incidents that have occurred during the year as soon as practicable after the end of the financial year.

 *You must publish a report even if you have no incidents to include.*

The report must be published in a manner that is publicly accessible. For instance, on your website or up on a notice board.

You can use this template to prepare your annual report. It allows you to report any incidents without identifying the individual(s) concerned.

NOTE: the text in red should help you identify what you need to include in your report and must be deleted before publishing it.

You must publish your reports and send a notification email to dutyofcandour@gov.scot.

 *You do not need to submit the reports themselves to Scottish Government.*

**Duty of candour annual report**

**Year ending [***date***]**

To fulfil our duty of candour responsibilities, this report describes the unintended or unexpected incidents that occurred at our practice during the last year.

Practice: *Name and address of practice*

Responsible person: *Usually the lead GP*

Date of report:

Aims and objectives of the practice

*Describe the aims and objectives of your practice – for example to provide high-quality general medical services to our patients and to improve the general health of the population etc*

Duty of candour responsibilities and process

*You should describe how you have made your team aware of their duty of candour responsibilities and the systems/processes that you have in place to respond – for example:*

We have held team meetings to discuss our duty of candour responsibilities should an unintended or unexpected incident occur. The team is aware of and understands the practice adverse incident (duty of candour) protocol, which describes what to do when something goes wrong. The protocol identifies the practice contact, who should be notified of all incidents and near misses (along with NHS Ayrshire and Arran Primary Care Team on the quarterly complaints submissions from the practice) and will conduct an investigation, if necessary.

Unexpected or unintended incidents

An examples of thi is given in Appendix A.

**NOTE**: where an incident did not occur, you should report ‘0’. If there are less than 5 incidents, suggested wording would be “we have had fewer than 5 incidents”

Action taken

I confirm that for the following incidents the duty of candour protocol was followed:

* *List the incidents where you followed your protocol and you have records to support this – if <5 incidents, this requires generalisation to prevent individual cases being identified.*

The practice protocol was not followed for the following incidents:

* *List the incidents where you did not follow your protocol and explain the consequences*

Lessons learnt

*Explain:*

* *The lessons learnt as a result of the incident*
* *Any changes to procedures or improvements that you have put in place*
* *Learning needs that you have identified*
* *Changes made to your duty of candour protocol as a result of the incidents*

*You should also add:*

* *Who you shared the lessons with and how – for example, at a practice meeting or at individual meetings*
* *Whether you can make any further improvements and when*
* *Whether any further support was needed by those affected by the incident and what action you took*
* *What have been the challenges around DOC and what has been done to overcome them.*
* *Anything else that you feel may be applicable*.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hope you find this information helpful in preparing your annual Duty of Candour report if you have not already done so.

Kind regards

John Jacqui

**John Freestone Jacqui McCall**

**AMD – Primary Care Primary Care Manager**