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:	Optical Express, First Floor, 200 St Vincent Street, Glasgow, G2 5SG	
Date of report:	31 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?	We have a robust policy and procedure detailing staff responsibilities in relation to Duty of Candour, both professional and statutory responsibilities. The policy is accessible to all staff via our Intranet site. We keep up to date with changes in regulation to ensure our policy is kept up to date. The policy describes the procedure to invoke a Duty of Candour process and how we manage the process internally and together with the patient and/or those affected. Our mandatory training includes Duty of Candour information. We periodically include Duty of Candour as an agenda point during local Team Meetings to refresh our knowledge.	
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 2022 - March 2023)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	1
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	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. Procedure appropriately followed
What lessons did you learn?	Not lessons – root cause of the significant adverse event did not have any learnings.
What learning & improvements have been put in place as a result?	Not applicable.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Not applicable this year. We have a comprehensive information sharing system so that in the event of an avoidable serious incident, we share the circumstances, root cause, identify any failings in care and treatment, and update control measures and/or policy where applicable. We share this information nationally to ensure that we all have the opportunity to learn from such events.
Could any further improvements be made?	Not applicable.
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?	Our policy describes the system in place when the Duty of Candour process has been invoked. The statutory process is managed by Senior Managers in our Clinical Services team rather than locally based clinical teams. The local team would provide information to the Clinical Services team regarding the incident, including root cause analysis. Our legal team would support the Case Manager. One patient facing Case Manager would be appointed so the patient and/or those affected received consistency of information and person centred care. The Case Manager would meet the patient/those affected face to face so the patient/those affected would feel they have been listened to and have received a face to face expression of regret. We would include and involve anyone at local level who has an existing and positive relationship with the patient/those affected so the patient has that personalised link to the local clinic.
What support do you have available for people involved in invoking the procedure and those who might be affected?	If a local clinical (or manager) team member is involved in invoking the process, they are supported by the Case Manager who would be a Senior Manager and a Clinician. The Legal Team and Human Resources team would support all staff/people affected as a result of the incident and process with resources as well as professional and emotional support.
Please note anything else that you feel may be applicable to report.	During this reporting year (April 22 to March 23) we have had one case of unilateral endophthalmitis (eye infection) at day 7 post surgery.