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:	**YourGP Group Ltd** Waterside House, 19 Hawthornbank Lane, Edinburgh, EH4 3BH 53 Dundas Street, Edinburgh, EH3 6RS	
Date of report:	1st May 2026	
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 ***Duty of Candour and Being Open*** policy, which all staff and practitioners are required to read and sign that they have acknowledged and understood the policy.	
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 2025 - March 2026)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
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
Other: experienced psychological distress	1
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?	We identified a weakness in communication handling that led directly to this event.
What learning & improvements have been put in place as a result?	Standards of Practice have been updated. New patient questionnaires have been adopted to ask consent specifically in communication. Staff training update.
Did this result in a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Policy review & sign off by all staff Training carried out and documented
Could any further improvements be made?	N/A
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?	The ***Duty of Candour and Being Open*** policy outlines the principle of apology and provides guidance on how to handle a potential incident.
What support do you have available for people involved in invoking the procedure and those who might be affected?	The ***Duty of Candour and Being Open*** policy states that an appropriately nominated person at YourGP, the Practice Manager, will handle communication with the patient, to ensure the patient or relevant person has a point of contact to handle any questions or concerns throughout the process.
Please note anything else that you feel may be applicable to report.	N/A