

Duty of Candour Annual Report 2024/25



Bield colleagues working in a Care Inspectorate registered service must be open and honest with customers when something that goes wrong with their care causes or has the potential to cause, harm or distress. We must tell the customer, apologise, offer appropriate remedy or support and fully explain the effects to the customer.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered the duty of Candour within our service.

This short report describes how our care service has operated the Duty of Candour during the time between 1 April 2024 and 31 March 2025.

Name and address of service	Bield Housing and Care, Edinburgh
Date of Report	01.04.23 – 31.03.24
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?	<p>The values and attitudes of Bield colleagues are underpinned by our core values:</p> <ul style="list-style-type: none">• Honesty• Equality and Diversity• Ambition• Dignity• Integrity• Caring• Kindness <p>Colleagues are aware of the importance of candour in the implementation of our policy.</p> <p>Colleagues complete the Duty of Candour module on NHS Education Scotland and undergo internal training on our own policy and procedures.</p>
Do you have a Duty of Candour Policy or written duty of candour procedure?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Incident Reporting

Type of unexpected or unintended incident	Number of times this year
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic, or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Shortening of the patient's life expectancy	0
Someone's sensory, motor, or intellectual function is impaired for 28 days or more	0
Someone experience pain or psychological harm for 28 days or more	0
A person needed health treatment to prevent them from dying or the harm listed above	0

About the policy and process

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over-reporting of duty of candour?	N/A
What lessons did you learn?	N/A
What learning & improvements have been put in place as a result?	N/A
Did this result in a change/update to your duty of candour policy/procedure?	N/A
How did you share lessons learned and who with?	N/A
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?	<p>HR colleagues are available to provide support to colleagues providing an apology</p> <p>Training specifically on offering an apology is mandatory.</p>
What support do you have available for people involved in invoking the procedure and those who might be affected?	<p>Training is mandatory for relevant colleagues</p> <p>Resources are available to colleagues on a specific intranet page.</p> <p>Support is available to those involved through support and supervision.</p> <p>An employee support helpline is available for colleagues affected by incidents at work.</p>
Please note anything else that you feel may apply to the report.	N/A