



Purpose

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:	Medigold Health, Medigold Ho NN4 7BF	ouse, Queensbridge, Northampton,
Date of report:	08/04/2024	
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?	All staff are aware of and have access to the Duty of Candour Policy and Procedure. Feedback/Complaint responses are handled by Customer Care Department who monitor response times and outcomes. Complaints and Feedback are reviewed on a monthly basis in Clinical Governance meeting where lessons learned, training opportunities and quality improvements are initiated.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	✓ YES	ON

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 to 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	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	
Total	0	



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?	Not required
What lessons did you learn?	Not required
What learning & improvements have been put in place as a result?	Not required
Did this result is a change / update to your duty of candour policy / procedure?	Not required
How did you share lessons learned and who with?	Not required
Could any further improvements be made?	Not required
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?	Not required
What support do you have available for people involved in invoking the procedure and those who might be affected?	Not required
Please note anything else that you feel may be applicable to report.	Not required

Signed and Approved Chief Medical Officer

San Vogelfix

Dr Sam Valanejad Deputy Chief Medical Officer