INTRODUCTION
As service providers, all healthcare staff have a responsibility to be open and honest when things go wrong. In June 2016, the Nursing & Midwifery Council together with the General Medical Council issued a joint statement in recognition of this professional duty of candour. It stipulates that healthcare professionals should offer an apology to the patient (and/or their advocate), offer a solution to remediate the situation, explain the short- and long-term implications and participate in organisational procedures enabling be open and honest, with support from the organization. Following the 2013 Francis report, this has been effected into legislation both in England (2014) and more recently in Scotland (2015) which is in the process of being implemented.

The “second victim” effect, whereby the healthcare provider(s) involved suffer adverse consequences to their psychological and physical wellbeing is a well-documented occurrence after clinical incidents. In a Royal College of Physicians survey 60–75% of participants described sleep disturbance, anxiety or stress after adverse event. It has been suggest that reasons could include a lack of confidence in established organisation protocols for clinical incidents.

METHODS
A baseline survey of 33 junior and medical doctors in the acute medical division of a Scottish district general hospital (Royal Alexandra Hospital) assessed awareness of the GMC duty of candour, experiences of medical error and the disclosure of such, the desire for open forum discussions and the frequency at which these should occur. Monthly meetings were then commenced, in which one or two junior doctors volunteered to present adverse incidents to an audience of supportive colleagues. Feedback was collected at each meeting, detailing outcome measures including knowledge of the duty of candour and the MMS framework, satisfaction of disclosure rate, rate of apprehension of disclosure (i) to patients and (ii) to colleagues, likelihood to present at a future meeting.

AIMS
In December 2015, a prospective observational study was piloted which explores a model for providing a supportive environment for incident disclosure with a view to:
• To pilot blame free Duty of Candour Forum
• To raise awareness about MMSF
• To contribute to body of knowledge regarding doctor’s experiences of disclosing adverse incidents.

The overarching aim was to test a structured supportive method to address and flip these errors into a potentially positive outcome.

RESULTS
Most acute medical staff turn to friends and colleagues for support as a result of an adverse event. Engaging them in a learning process using MMSF as a tool and a regular forum to discuss these errors has a potential of increasing their assertiveness and confidence and creating a resilient medical workforce.

REFERENCES