DUTY OF CANDOUR ANNUAL REPORT – 1.4.2019 to 31.3.2020

Introduction
Under the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 all health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This report describes how CrossReach has operated the duty of candour during the time 1 April 2019 and 31 March 2020.

About CrossReach
CrossReach, Social Care of the Church of Scotland, is a social care provider working across Scotland to provide care and support services to people with a diverse range of support needs. CrossReach provides services to older people, adults and children with learning disabilities, counselling services, supporting people with mental health issues, support people who are homeless, support people with substance misuse issues along with many more.

Our mission statement is;

"In Christ's name we seek to support people to achieve the highest quality of life which they are capable of achieving at any given time"

How many incidents occurred which Duty of Candour applied?
Between 1 April 2019 and 31 March 2020 there were 2 incidents where duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the nature course of someone's illness or underlying condition.

CrossReach identified these issues through our internal procedures such as adult support and protection and accident, incident and near miss. Over the period an additional 2 incidents were assessed to determine if they met the threshold for duty of candour, however it was assessed that they did not. Even though these 2 cases did not meet the trigger for duty of candour they were still fully investigated and any learning identified to minimise the risk of a similar situation reoccurring but the fully duty of candour process was not followed.

A breakdown of the 2 duty of candour incidents is detailed below;

Type of unexpected or unintended incident (not relating to the natural course of a person's illness or underlying conditions)	**Number of times this happened between 1 April 2019 and 31 March 2020**
A person died	1
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions.	Nil
A person's treatment increased	Nil
The structure of a person's body changed	Nil
A person's life expectancy shortened	Nil

A person's sensory, motor or intellectual functions was impaired for 28 days or more	Nil
A person experienced pain or psychological harm for 28 days or more	Nil
A person needed health treatment in order to prevent them dying	Nil
A person needed health treatment in order to prevent other injuries as listed above	1 (broken bones)
Total	2

To what extent did CrossReach follow the duty of candour procedure?
Duty of candour protocol followed and appropriate regulatory bodies were notified and we informed the people affected, apologised to them, offered to meet with them and shared a copy of our report with them. In each case, we reviewed what had happened and what went wrong to try and learn for the future to minimise the risk of a similar situation reoccurring in that service or any other. Where relevant this learning was shared either across the services, the service area or the whole organisation.

Policies and Procedures
All services have a copy of the Duty of Candour Policy and the NHS e-learning module on Duty of Candour is mandatory for all managers and staff supporting people who use our services. This allows operational staff to identify duty of candour incidents. In addition the central reporting of all adult/care protection issues and accidents, incidents and near misses means that the Business Partner – Quality, Compliance and Improvement and the Health and Safety Manager are a second line in identifying any duty of candour issues which may not already have been identified by operational staff. In addition, the fact that Care Inspectorate notifications ask Registered Managers to confirm whether the incident is duty of candour or not forces managers to make that initial assessment.

All incidents that have the potential to trigger duty of candour are assessed by at least one of our internal medical practitioners.

Duty of Candour incidents are handled by the relevant Head of Service, who instructs the investigation, meets with the Relevant Person(s), shares the report including learning and offers an apology. The Head of Service will also identify learning and determine the most appropriate way for the learning to be shared.

What has changed as a result?
Every case is assessed on its individual circumstances so there is no blanket approach to the sharing of learning is universally applied. However, any identified outcome will be implemented and any learning shared within the service as quickly as possible, and if appropriate, the whole organisation.

Other information
This is the second CrossReach duty of candour report and we continue to embed and refine existing procedures to include duty of candour and share any relevant identified learning outcomes.

If you would like more information about this report then please contact the Business Partner – Quality, Compliance and Improvement – 0131 657 2000.