GLASGOW
EAST END COMMUNITY
CARERS

The 'duty of candour'

The duty of candour

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour.

The Act and the Regulations require organisations providing health services, care services and social work services in Scotland to follow a formalised procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The purpose of this new duty is to ensure that providers are open, honest, supportive and providing a person-centred approach.

Our legal obligations

1. Duty of Candour Procedure

As a provider of an independent social care service, we are required to develop and implement a duty of candour policy that describes how we/our staff will act in the event of an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The key stages of the policy must include:

- • Notify the person affected (or family/relative where appropriate).
- • Provide an apology.
- • Carry out a review into the circumstances that led to the incident;
- • Offer a meeting with the person affected and/or their family, where appropriate.
- • Provide the person affected with an account of the incident.
- • Provide information about further steps taken.
- • Provide support to staff notifying the person affected by the incident.
- • Prepare and publish an annual duty of candour report (see below).

Preparing the duty of candour procedure:

We will consider the following points when preparing the duty of candour procedure and annual report:

- • How we will identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21 of the Act?
- • We are satisfied our staff understand their responsibilities and we have systems in place to respond effectively?
- • Who do we need to engage with to satisfy ourselves we can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
- • What systems we have in place to support staff to provide an apology in a person-centred way and how we support staff to enable them to do this?
- • Do our current systems and processes provide the information required to report on the Duty of Candour?
- • How we will align our duty of candour annual report with other reports we are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?
- • What training and education we have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations.
- • What we have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
- • How we currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

2. Duty of candour annual report

We must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where we have applied the duty of candour. This annual report will be published on our website.

NB: Even if you do not implement the duty of candour procedure in a given year, you are still required to produce a short report that contains information about staff training on the duty of candour obligations

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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.

Name & address of service:	Glasgow East End Community Carers Ltd, 26 Penston Road, Queenslie, Glasgow G33 4AG
Date of report:	7th April 2024 (for the period 1st April 2023 – 31st March 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?	The values and attitudes of the team is underpinned by adherence to the Scottish Social Services Council's Code of practice for Social Service workers and employees. Staff are aware of the importance of candour through induction training where they learn all the policies and procedures of the organisation
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES

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.

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 23 - March 24)
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

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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 applicable as there have been no instances of implementing Duty of Candour in the above-noted circumstances. However all social care professionals have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong
What lessons did you learn?	Not applicable as there are no incidents to report for this period. However following any incident, an immediate investigation is carried out by the Homecare manager or their deputy, risk assessments are created and updated as appropriate and if appropriate information is added to the Outcome based support plan
What learning & improvements have been put in place as a result?	Not applicable
Did this result is a change / update to your duty of candour policy / procedure?	Not applicable - policy / procedure remains the same after review
How did you share lessons learned and who with?	Anmy lessons learned would be shared at a communications meeting. If a procedure is required to be altered due to a new learning, this would be revised and we would ensure staff were aware at supervision meetings
Could any further improvements be made?	Not that we are aware of at present
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?	In terms of our policy, the Homecare manager or their deputy takes responsibility for ensuring an apology is delivered where necessary. They are supported by their colleagues and the Chief Executive Officer
What support do you have available for people involved in invoking the procedure and those who might be affected?	There is always a Manager on call and if necessary, the Chief Executive Officer will be contacted for advice/guidance. All staff have access to the organisations policies and procedures
Please note anything else that you feel may be applicable to report.	Nothing at this time but we will continue to review, monitor and delevop our policy