Scottish Borders Council

Organisational Duty of Candour Procedure

2023

Introduction

The Duty of Candour came into effect on 1st April 2018. It applies to all organisations that provide Health Services, Care Services or Social Work services in Scotland.

Duty of Candour sets out the procedure that organisations providing Health Services, Care Services and Social Work services in Scotland are required to follow where there has been an unintended or unexpected incident that results in death or harm.

When harm occurs the focus is on;

- Personal contact with those affected
- Support and a process of review
- Meaningful action which is informed by the principles of learning and continuous improvement

In order to ensure consistency in applying the Duty of Candour procedure, it is important that incidents are monitored, recorded and reported by all relevant organisations.

Duty of Candour underpins the Scottish Government's commitment to openness and learning which is vital to the provision of safe, effective and person-centred health and social care.

The below guidance sets out our approach to Duty of Candour:

When must the duty of candour procedure be activated?

The duty of candour procedure must be activated by an organisation as soon as reasonably practicable after becoming aware that an unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person and, in the reasonable opinion of a registered health professional not involved in the incident, that the incident appears to have resulted in or could result in the following:

A. The death of the person
B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm")
C. Harm which is not severe harm but which results in one or more of the following;

    - An increase in the person's treatment;
    - Changes to the structure of the person's body;
    - The shortening of the life expectancy of the person;
    - An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days;
    - The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.

D. The person requires treatment by a registered health professional in order to prevent:
    - The death of the person;
    - Any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph B or C.

The incident must have directly caused the harm or potential harm. The harm must not be caused by the natural course of a person's illness or underlying condition.

The view of the registered health professional

When an unintended or unexpected incident occurs, a registered health professional must give their view on the incident, and whether it appears to have resulted or could result in one of the outcomes detailed above.

The organisation must ensure that the registered health professional who gives the opinion mentioned above, following an unintended or expected incident, is not someone who was involved in the incident. However, the health professional could work for the organisation.

Although it is up to Scottish Borders Council to determine the most appropriate way of obtaining the views of a registered health professional not involved in the incident, it is likely that health professionals will require organisations to provide them with the following core information in the first instance:

- What was the incident?
- What was the outcome?
- What illnesses and underlying condition did/does the person have?

In circumstances where there is not a registered health professional working within the organisation where the incident occurred, registered health professionals with an existing involvement with the relevant person should be contacted where possible. However, they must not have been involved in the incident. Health services can provide assistance in identifying a registered health professional who would be able to provide the required view in such circumstances.

If there are difficulties in identifying a registered health professional, Healthcare Improvement Scotland or the Care Inspectorate can be contacted for advice on routes to be considered.

Where more than one organisation needs to be involved in the duty of candour procedure

The duty of candour procedure is the legal responsibility of the organisation who provided the health service, care service or social work service in which the incident occurred. (the "responsible person").
Other health and social care providers may have been involved in the provision of care and services to the client, but they are not responsible persons (organisations) in respect of that incident.

It is often the case that a range of organisations are involved in the episode of treatment or care where the unexpected or unintended incident occurred. Although they are not responsible persons in terms of the legislation, they may need to become involved in providing information as part of a review or in providing support for relevant persons coping with the personal impact of death or harm arising from the unintended or unexpected incident. In rare circumstances, several responsible persons may each decide to activate the duty of candour procedure for multiple incidents. In such circumstances, responsible persons should seek to communicate with each other, emphasising co-operation and ensuring a co-ordinated approach in their communications with the relevant person.

Where more than one organisation needs to be involved in the duty of candour review, all parties are expected to co-operate fully throughout the duty of candour procedure and share lessons learned and necessary actions identified by the procedure.

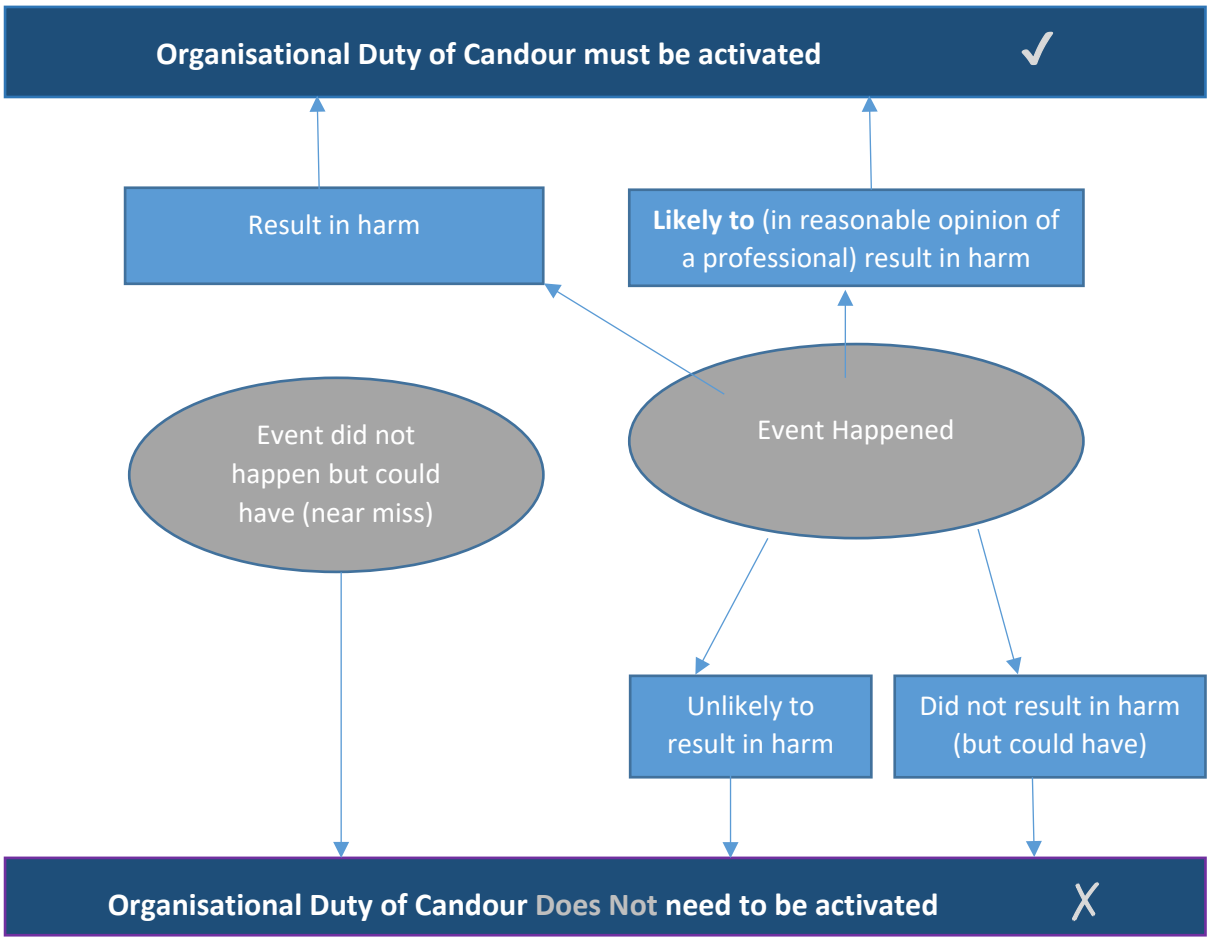
Where this is the case, the relevant person must be informed as part of the notification process, that the organisation where the incident occurred is the responsible person, as defined by the legislation, who will carry out the procedure.

What is the procedure start date?

The procedure start date is the date that Scottish Borders Council receives confirmation from a registered health professional that, in their reasonable opinion, an unintended or unexpected incident appears to have resulted in, or could result I, an outcome listed above and that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

What does 'could result' mean and how is that decision to be made?

If the registered health professional thinks that it is unlikely that harm will occur, then the duty of candour procedure need not be activated for that incident. The diagram below sets out the decision making process in more detail



Notification

The duty of candour legislation states that the relevant person should be notified as soon as reasonably practicable but it should be considered good practice to notify the relevant person within 10 working days of the procedure start date.

This notification can be by various methods including telephone, face to face or by letter. It is important to remember that where a duty of candour procedure start date is more than a

month after the incident, the organisation must provide the relevant person with an explanation of why this is.

Communication with relevant person

The organisation must take reasonable steps to find out the relevant person's preferred method of communication. They must also take reasonable steps to ensure that communication with the relevant person is in a manner that they can understand.

Apology

In addition to any apology given at the time, the relevant person must be offered a written apology, and provided with one if they wish. This can be by electronic communication if that is the relevant person's preferred means of communication.

Section 23(1) of the Act states that "an 'apology' means a statement of sorrow or regret in respect of the unintended or unexpected incident." The Act sets out that 'an apology' or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty."

Further guidance on making an apology as part of the duty of candour procedure and the form this might take is set out in Annex D. Further information can also be found on the Little Things Make a Big Difference website: http://www.knowledge.scot.nhs.uk/making-a-difference/resourcesaspx

The written apology should be personal and be provided at an appropriate time during the duty of candour procedure, taking account of the facts and circumstances in relation to the particular incident.

There may still be misconceptions and misunderstanding that the provision of an apology equates to an admission of liability and that organisations should never offer apologies for this reason – but that is not correct.

Meeting

The responsible person within Scottish Borders Council must invite the relevant person to attend a meeting and give them the opportunity to ask questions in advance. The organisation must take reasonable steps to ensure that the meeting is accessible to the relevant person, having regards to their needs and individuals required or requested to support them.

The meeting must include:

- a verbal account of the incident;
- an explanation of any further steps that will be taken by the organisation to investigate the circumstances which it considers led or contributed to the incident;
- an opportunity for the relevant person to ask questions about the incident;
- an opportunity for the relevant person to express their views about the incident; and
- the provision of information to the relevant person about any legal, regulatory or review procedures that are being followed in respect of the incident in addition to the procedure.

After the meeting the relevant person must be provided with:

- a note of the meeting;
- contact details of an individual member of staff acting on behalf of the organisation whom the relevant person may contact in respect of the procedure.

If the relevant person does not wish to, or is unable to attend the meeting, the organisation must still provide them with the information set out above (other than a note of the meeting) if the relevant person wishes it.

The review

The relevant service within Scottish Borders Council must carry out a review of the circumstances which they consider led or contributed to the unintended or unexpected incident. The legislation does not specify the manner in which the review is undertaken, but it is likely that this will be one of a range of review processes that are already undertaken such as an adverse event review, a significant case review of the sort undertaken by child, adult and public protection committees or a morbidity or mortality review.

Best practice requires that reviews involve clinical and care professionals with the relevant subject matter expertise, as appropriate.

In the case where the review is not completed within three months of the procedure start date, the organisation must provide the relevant person with an explanation of the reason for the delay in completing the review.

In carrying out the review, the views of the relevant person must be sought and be taken into account. This will be best implemented through the development of a supportive relationship with the relevant person and arrangements that ensure review processes consider the views of the relevant person and are able to demonstrate the way in which these views (which are likely to reflect what matters most) have been taken account of.

Scottish Borders Council must prepare a written report of the review, which must include:

- a description of the manner in which the review was carried out;
- a statement of any actions to be taken by the organisation for the purpose of improving the quality of service it provides and sharing leaning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services; and
- a list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.

This provides the organisation with an opportunity to demonstrate that the views of relevant persons have been considered and that a review has been conducted that has focused on systems analysis that takes account of best practice in review and investigation of human factors.

The legal requirement to include details of the dates when each element of the duty of candour procedure took place is included to provide an overview of the process within the organisation from the point that they decide to activate the duty of candour procedure to the point the review is concluded.

Where possible, written reports on reviews should be written in a manner that minimises the need for extensive redaction.

Scottish Borders Council must offer to send the relevant person:

- a copy of the written report of the review;
- details of any further information about actions taken for the purpose of improving the quality of service provided by the organisation or other health, care or social work services; and
- details of any services or support which may be able to provide assistance or support to the relevant person, taking into account their needs.

Records

Scottish Borders Council must keep a written record for each incident to which the duty of candour procedure is applied, including a copy of every document or piece of correspondence relating to the application of the duty of candour procedure to the incident. The written record should be retained by the organisation in accordance with relevant local policies and procedures.

Reporting and Monitoring

The Act sets out that a responsible person that provides a health, care, or social work service during a financial year must prepare an annual report, as soon as reasonable practicable after the end of that financial year. This will be signed off by the Chief Social Work Officer.

All duty of candour incidents will be logged in the LEXI system to ensure accurate reporting can be delivered.

The report must include:

- information about the number and nature of incidents to which the duty of candour procedure has applied in relation to a health service, a care service or a social work service provided by the responsible person;
- an assessment of the extent to which the responsible person carried out the duty of candour;
- information about the responsible person's policies and procedures in relation to the duty of candour, including information about procedures for identifying and reporting incidents, and support available to staff and to persons affected by incidents;
- information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty of candour has applied;
- such other information as the responsible person thinks fit.

The report must not mention the name of any individual, or contain any information that could identify any individual.

The report must be published in a manner that is publicly accessible. For instance, on Scottish Borders Council's website.

When Scottish Borders Council has published a report, they must notify:

- The Care Inspectorate, in the case of a report published by an organisation which provides a care service or a social work service. The Care Inspectorate will ask for information about whether or not care services have published their duty of candour report in the first set of Annual Returns following the end of the financial year after which the report must be published.
- Healthcare Improvement Scotland must be notified when an incident occurs with an organisation which provides an independent healthcare service (within the meaning of section 10F(1) of the NHS (Scotland) Act 1978). This can be submitted via the eForms system;
- The Scottish Ministers, must be notified when an incident occurs with any other organisation which provides a health service. Please send the notification to dutyofcandour@gov.scot
- The Annual report will also be brought to council.

Training and Support

Training

All relevant staff will be made aware of the Duty of Candour through the induction process.. The training is available as eLearning and consists of two parts:

Service Managers, Team leaders, Assistant Team Leaders and Supervisors must complete the online training.A Duty of Candour eLearning module which is hosted on the NHS TURAS website:

http://www.knowledge.scot.nhs.uk/scormplayer.aspx?pkgurl=%2fecomscormplayer%2fdutyofcandour%2f

Employees may be asked to show evidence that they have completed the elearning module.

The relevant persons must be provided with details of needs-based services or support. The establishment should consider the relevance of services and support such as counselling, bereavement support and independent advocacy.

Through meetings and discussion with relevant persons, Scottish Borders Council should determine the impact of the unintended or unexpected event on their health and wellbeing. This will assist with identification of their needs and the way in which services or support might provide them with assistance.

Scottish Borders Council must provide any of their employees who were involved in the incident with details of any services or support of which the organisation is aware which may be able to provide assistance or support to any such employee, taking into account the circumstances relating to the incident; and the employee's needs. This may take the form of debriefing or direct support.

All employees have the responsibility to report all accidents/incidents using the SBC incident reporting system (Lexi) and to inform their managers of any incident/accident that has resulted in minor or serious harm.

All staff in Health & Social Care and in any other department which is subject to the Duty of Candour are must be aware of the Duty of Candour procedure.

Service Managers, Team leaders, Assistant Team Leaders and Supervisors are responsible for implementing the procedure where appropriate.

Other staff acting as investigators of incidents of harm have the responsibility to ensure that the procedure is implemented if the investigation discloses that is appropriate.

Group Managers and Service Managers will monitor the implementation of this procedure and ensure that the procedure is invoked in appropriate circumstances.

Duty of Candour Checklist

Step 1: Identifying and Contacting the Relevant Person

☐ Do you know who the relevant person is in respect of this incident?

☐ Is their preferred method of communication already known? If not, this needs to be determined and noted.

☐ Has it been possible to make contact with them? If not, a note should be made of the attempts that have been made to make contact.

Step 2: Notify Relevant Person

☐ Provide the relevant person with an account of the incident and what actions are going to be taken (Note that if it is more than a month since the incident then we must explain why).

Step 3: Arrange a Meeting

☐ Arrange/offer a meeting and provide the person with the opportunity to ask questions in advance of the meeting.

At the meeting (or through communication if not desired):

- ☐ Apologise, if not already.
- ☐ Tell the person what happened.
- ☐ Tell them what further steps are being taken.
- ☐ Give the relevant person the opportunity to ask further questions and express their views.

☐ Tell them about any other processes that might be on-going.

☐ Provide them with a note of the meeting and details on how to contact a person within the organisation.

Step 4: Carry out a Review

☐ Start a review – remember to seek the views of the relevant person.

☐ Prepare a report – to include the manner it has been carried out.

☐ Ensure that report focus is on improving quality and sharing learning.

☐ Report to include the actions taken in respect of the duty of candour procedure.

☐ Offer to send the relevant person a copy of the review report – remember to let them know of any further actions subsequently.

☐ Make sure that a written apology is offered.

<u>Throughout</u> – Support and Assistance for Relevant Person and Staff

☐ Consider and give relevant person support or assistance available to them.

☐ Staff to receive training and guidance on all requirements of the procedure.

☐ Employees to be provided with details of services or support relating to their needs arising from the incident.

Definitions as set out in the Health (Tobacco, Nicotine, etc. And Care) (Scotland) Act 2016 and the implementing regulations: The Duty of Candour Procedure (Scotland) Regulations 2018.

"**The Act"** means the Health (Tobacco, Nicotine, etc. and Care) (Scotland) Act 2016.

"The 1978 Act" means the National Health Service (Scotland) Act 1978.

"The Regulations" mean the Duty of Candour Procedure (Scotland) Regulations 2018.

"care service" has the meaning given by section 47(1) of the Public Services Reform (Scotland) Act 2010, except that it does not include a service mentioned in paragraph (k) of that section (child minding).

"health service" means services under the health service continued under section 1 of the 1978 Act, and an independent healthcare service mentioned in section 10F(1) of the 1978 Act.

"incident" means the unintended or unexpected incident by virtue of which section 21(2) of the Act applies to a person.

"the procedure" means the actions set out in regulations 2 to 7 of the Duty of Candour Procedure (Scotland) Regulations 2018.

"registered health professional" means a member of a profession to which section 60(2) of the Health Act 1999 applies.

These are the professions regulated by:

Medical Act 1983

Dentists Act 1984

Opticians Act 1989

Osteopaths Act 1993

Chiropractors Act 1994

Pharmacy Order 2010] and the Pharmacy (Northern Ireland) Order 1976,]

Nursing and Midwifery Order 2001],

Health Professions Order 2001

Hearing Aid Council Act 1968 as relates to dispensers of hearing aids,]

any other profession regulated by an Order in Council under this section.

"relevant person, as set out in section 22(3) of the Act" means the person who has received the health service, the care service or the social work service, or where that person has died, or is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided, a person acting on behalf of that person.

"responsible person", as set out in section 25 of the Act, means:

- a Health Board constituted under section 2(1) of the 1978 Act;
- a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service;

• the Common Services Agency for the Scottish Health Service constituted under section 10(1) of the 1978 Act;

• a person (other than an individual) providing an independent healthcare service mentioned in section 10F(1) of the 1978 Act;

• a local authority;

• a person (other than an individual) who provides a care service;

• an individual who provides a care service and who employs, or has otherwise made arrangements with, other persons to assist with the provision of that service (unless the assistance in providing that service is merely incidental to the carrying out of other activities);

• a person (other than an individual) who provides a social work service.

"social work services" has the meaning given by section 48 of the Public Services Reform (Scotland) Act 2010.

"written" includes electronic communication, as defined in section 15(1) of the Electronic Communications Act 2003.

FAQs

https://www.gov.scot/publications/duty-of-candour-frequently-asked-questions/