DUTY OF CANDOUR

REPORTING AND MONITORING SUB-GROUP

REPORT ON DISCUSSIONS AND FINAL RECOMMENDATIONS

1.0 BACKGROUND

The Duty of Candour Reporting and Monitoring Group was established to advise on how the annual duty of candour reports should be structured, presented and monitored. The group comprised representatives from the Care Inspectorate, Healthcare Improvement Scotland, Scottish Care, Coalition of Care and Support Providers Scotland, NHS National Services Scotland, and a number of health boards.

Its primary remit was to advise on guidance outlining the activities that will take place to ensure that the reports required by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 are produced. The guidance was to be in relation to the content of the report and any guidance the group wished to provide in respect of the way in which the Care Inspectorate and HIS may wish to consider information within the reports, including links with other work and processes of these bodies.

The group met in May, July, September, November, December 2016 and January 2017.

2.0 GUIDING PRINCIPLES

From the outset, the group identified a number of guiding principles which should inform guidance on reporting and monitoring. These were that:

- the system of monitoring should be proportionate
- there should be no unnecessary duplication with existing approaches
- there should be interoperability across the health and social sectors – especially around language – so that sector-wide conclusions can be easily drawn by monitoring bodies
- the system of monitoring should be capable of being evaluated itself
- there should be a person-centred approach across the pathway of care to ensure that reports focused on the experiences of people, not just processes.

These principles have informed the recommendations made by the group.

3.0 RECOMMENDATIONS

After discussion, the group recommends the following.

Recording duty of candour incidents

3.1 Responsible persons should devise ways of recording duty of candour incidents in a manner which they believe meets their statutory responsibilities, but the Scottish Government guidance should recommend that:

a) NHS boards, local authority social work departments, and independent contractors should devise appropriate recording tools for duty of candour incidents which are consistent with their own mechanisms for recording adverse events
b) Independent healthcare services and social care services should record duty of candour incidents using a suitably-amended version of the electronic notification systems required by Healthcare Improvement Scotland and the Care Inspectorate to record adverse events

The Scottish Government should continue to support wide awareness raising about this issue with responsible persons at an early stage.

3.2 Healthcare Improvement Scotland and the Care Inspectorate should make the necessary changes to their eForms systems to allow duty of candour incidents to be recorded as such.

Creating and publishing the annual report

3.3 Scottish Government guidance should recommend that responsible persons complete a report with the points set out in Section 5.0 of this paper, using a template report set out in Section 6.0 - 10.0 as appropriate. These reports are designed to support responsible persons to produce a report which reflects their own circumstances.

3.4 The Scottish Government guidance should include information about how to deal with incidents when small numbers of incidents have taken place, in order to ensure that people cannot be identified from the report. The guidance should make clear whether or not to follow NHS conventions around deductive identification in respect of an incidence of 5 or less, or whether in these circumstances to provide actual numbers. The presumption should be for as much transparency as possible.

3.5 The Scottish Government guidance should include information on how to produce a null report, where no duty of candour events have taken place. Section 10 provides a sample null report.

3.6 NHS boards and local authority social work departments should publish annual duty of candour reports on their website and notify the relevant monitoring body that they have done so by email.

3.7 Relevant Scottish Government representatives across the independent contractor groups should be invited to develop options and agree what is in guidance, in order to ensure that proportionate and appropriate reporting and monitoring lines can be established for these groups.

3.8 The Scottish Government should clarify whether it intends for the duty to apply to independent medical agencies, and independent ambulance firms. If the duty does apply, it is important to note that these services are not regulated and alternative reporting and monitoring processes will be required.

3.9 Regulated independent health and social care services should publish the annual duty of candour report on their website where they have one, or make other suitable arrangements to communicate the duty of candour report to people who use their services, carers, and people who may wish to use their services. They should then notify the Care Inspectorate / Healthcare Improvement Scotland using the relevant electronic notification systems already provided by these bodies, and supply a copy of the annual report to them using these systems.

3.10 The Care Inspectorate and Healthcare Improvement Scotland should modify their electronic reporting systems so duty of candour events reported during the year using the notification system can be pre-populated into annual reports – this will assist with recording the information and making the notification. Both bodies should consider whether the reporting could be aligned to the existing ‘annual returns’ process. If this is to occur, the Scottish Government should consider whether there is any flexibility to alter, by regulation or otherwise, the date of 6 April specified as being the date by which reports for the preceding year should be submitted.

Monitoring the duty of candour

3.11 The Care Inspectorate and Healthcare Improvement Scotland should use information from the duty of candour reports in analysing intelligence about

the provision of care, and follow up any specific issues at inspections where they deem this necessary.

3.12 The Care Inspectorate, Healthcare Improvement Scotland and the Scottish Government should publish a report on the implementation of the duty of candour no earlier than one year after the activation of the duty. This is expected to be done at such a time as to allow a full year of the duty being in operation to have elapsed. The report should be directed at spreading effective practice across the sector.

3.13 The Scottish Government should clarify with Healthcare Improvement Scotland whether they wish HIS to play a more direct role as a monitoring body for health boards, on behalf of Scottish Government.

General

3.14 There should specific engagement and testing with social work colleagues through Social Work Scotland and the Office of the Chief Social Work Advisor to help refine and test guidance and implementation planning in respect of social work departments.

4.0 ALIGNING THE DUTY OF CANDOUR TO EXISTING PROCESSES

4.1 The duty of candour requires to be activated in a wide range of health, social care and social work services when certain outcomes occur in section 21 (4) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. The outcomes can be modified by regulation. This section seeks identifies possible ways the duty of candour reporting could be aligned to other reporting processes.

4.2 It is important to note that there are very many highly specialised reporting processes for certain types of event, including accidents and deaths at work, facilities, suicides of people in contact with mental health services, and adverse drug reactions. These include devolved and reserved arrangements and many extend well beyond health, social care and social work. This section does not seek to address alignment to these processes, but concentrates on the more general adverse event reporting relevant to responsible persons which work with the monitoring bodies set out in s24(5), namely the Care Inspectorate, Healthcare Improvement Scotland and the Scottish Ministers.

4.3 **Within the NHS**, there is an existing national approach around adverse events. A national framework for learning from adverse events was first published in 2013 (updated in 2015) which seeks to promote consistent approaches to identifying, reporting and reviewing adverse events in Scotland. The scope of the national framework is intended to cover all care provided throughout Scotland, however, implementation support has been focussed on NHS boards. All NHS boards have local reporting systems and processes in place to manage adverse events, which includes being open with all those involved in the event.

The framework sets a broad definition of adverse events being those events that could have caused, or did result in, harm: that is, an outcome with a negative effect. The Learning from Adverse Events Programme has established mechanisms to share key learning points from adverse event reviews widely across Scotland through the use of one-page learning summaries which can be shared via appropriate networks and on a community of practice site. Healthcare Improvement Scotland reports on good practice and learning points, with the last learning and improvement report published in May 2016.

The Suicide Reporting and Learning System (SRLS) forms part of the Learning from Adverse Events programme. When a person in contact with mental health services completes suicide the NHS board notifies Healthcare Improvement Scotland and subsequently submits the completed adverse

event review of that person's care and treatment. The SRLS provides feedback to the NHS board on the process of each review and aggregates learning themes for national service improvement. There is guidance for staff on the SRLS website on how to carry out each stage of the adverse event review, including how to appropriately involve and engage with families and carers.

4.4 **Within independent contractors to the NHS**, there are a variety of reporting processes. Ideally adverse events would be reported to the NHS board that the independent contractor is providing services to; however, this is variable across the country with some NHS boards providing web-based access to their adverse event reporting systems while for other contractors it is impossible to access the NHS board reporting system. General Practice, Pharmacy and Dentistry have been encouraged to use the Significant Event Analysis tool to support reflective practice following an adverse event, and until recently this was a condition of the GP contract. These are reported to NHS Education for Scotland in order to support practitioners improve the quality of their analysis. This is helpful to note in planning approaches in respect of fulfilling the new duties, and in planning how learning will be shared and maximised across the health system, but does not negate the need for the duty to be undertaken by these responsible persons.

4.5 **Within independent healthcare services**, registered providers must make notifications to Healthcare Improvement Scotland when certain events occur. These include:

- serious injury or complication to a service user
- a drug error
- controlled drug incident
- the unexpected death of a service user.

Notifications are made electronically using the eForms system within a set number of days and providers are required to provide certain details when making a notification. The statutory basis for these notifications is set out in the Healthcare Improvement Scotland (Applications and Registrations) Regulations 2011. HIS is required to publish guidance to set out the details. Notifications contribute to the risk and intelligence base used to inform regulatory responses.

4.6 **Within registered social care services**, providers must make notifications to the Care Inspectorate when certain events occur. These include:

- accidents, incidents or injuries to a person using a service
- all deaths of a person using a care service
- adverse event involving a controlled drug.

Notifications are made electronically using an eForms system within a set number of days and providers are required to provide certain details when making a notification. The statutory basis for these notifications is set out in The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011. The Care Inspectorate is required to publish guidance to set out the details. Notifications contribute to the risk and intelligence base used to inform regulatory responses. Learning is promulgated using the existing network of care inspectors.

4.7 **Within social work services** (ie, mainly the functions of a local authority social work department, as opposed to a registered care service), there are a variety of reporting processes for specific types of adverse events. The principal ones relating to the delivery of social work functions (as opposed to regulated care services) are recorded here.

4.7.1. The deaths of looked after children and related categories of young people

The Looked After Children (Scotland) Regulations 2009 establish that local authorities have a duty to notify the Care Inspectorate of the death of a looked after child within 24 hours. The Care Inspectorate requires this to be undertaken using secure email. This duty has recently been extended by the Children and Young People (Scotland) Act 2014 to young people in receipt of aftercare and in continuing care. Learning is promulgated by means of national biennial reports published by the Care Inspectorate. It is likely that many of these incidents would trigger the duty of candour, but not all; some deaths may be "unintended or unexpected" but others may be directly related to "the natural course of the person's illness or underlying condition", as per section 21(2).

4.7.2. Social work criminal justice serious incident reviews (SIRs)

SIRs occur when serious (and specified) adverse events occur to or are caused by a person who is on licence and supervised by a local authority social work department. Notification is by formalised agreement between the Scottish Government, Social Work Scotland (representing all chief social work officers), and the Care Inspectorate, and is made by secure email. Learning is promulgated by means of national biennial reports published by the Care Inspectorate. As per the deaths of looked after children, some may or may not meet the criteria set out in section 21(2).

4.7.3. Initial Case Reviews and Significant Case Reviews – children

These are multi-agency processes for establishing the facts of, and learning lessons from, a situation where a child has died or been

significantly harmed, or where there is a near miss. ICRs are conducted by or overseen by the child protection committee with reporting to chief officers. SCRs are commissioned by chief officers and may be conducted by members of the CPC or by an independent person appointed by chief officers. The updated National Guidance for Child Protection Committees Conducting a Significant Case Review (2015), requests that a written record of the decision of the initial case review whether or not to proceed to an SCR, and an SCR itself, is sent to the Care Inspectorate. The first learning report was published in summer 2016. It is important to note that the Child Protection Committee is not a statutory body, and that these arrangements are being considered by the Scottish Government's child protection improvement programme.

4.7.4. Significant Case Reviews – adults

Significant case reviews in respect of adults are conducted by the adult protection committee, which is a statutory body which includes involvement from the local authority. The Scottish Government is currently consulting on matters relating to the adult protection committee.

4.7.5. Significant Case Reviews – MAPPA

Significant case reviews are from time to time conducted in relation to incidents which arise through the multi-agency public protection arrangements. The processes and routes for these are being considered at present.

4.8 Providers of health and care services have expressed a view that the duty of candour, both in terms of Section 22 (the procedure) and Section 24 (reporting and monitoring) should align where possible to existing systems. The table below suggests a possible way.

Types of responsible person	**What would be needed to align the s22 procedure to existing arrangements**	**Possible recording mechanism**	**How could this help s24 annual reporting to be efficiently undertaken**
NHS boards	Adverse events guidance/local processes would need to be aligned so the definitions for an adverse event match the	Existing electronic recording systems and infrastructures within NHS boards which	The report should be published on the NHS Board's website and notification that this has happened should be sent to a named person in the Scottish

Types of responsible person	What would be needed to align the s22 procedure to existing arrangements	Possible recording mechanism	How could this help s24 annual reporting to be efficiently undertaken
	outcomes in s21(4). Alternatively, NHS boards will need to be able to identify which adverse events require the duty of candour to be triggered, and whether any events need to be recorded as duty of candour incidents even if they do not meet the threshold for adverse events.	could be used to record information. The details of this could be described in guidance. NHS boards use their own recording systems – some have already made adjustments to Datix systems but not all boards use this.	Government by an identified person in a NHS board.
Independent contractors to NHS boards	As existing processes for reporting are variable these would need to be strengthened and aligned to the outcomes in s21(4). Significant Event Analysis could be used as a tool for all duty of candour events, or NHS board reporting systems would need to be available to all contractors.	Independent contractors will need to develop their own localised recording system.	Independent contractors could use significant event analysis reports to compile the annual report to send to Scottish Ministers. However, if independent contractors are to report duty of candour events via NHS boards to Scottish Ministers, it would be preferable that they use the NHS board reporting system to support efficient annual reporting.
Regulated services (independent healthcare and care)	Care Inspectorate / HIS notification guidance would need to be aligned to s21(4) so the threshold for making	Regulated services may wish to use their own recording system. However, the	Both organisations' eForms systems are used to report and store notifications at present. They could be configured so providers can

Types of responsible person	What would be needed to align the s22 procedure to existing arrangements	Possible recording mechanism	How could this help s24 annual reporting to be efficiently undertaken
	notifications about harm to people is the same as when the DoC is activated. If regulatory bodies consider it desirable, the notifications could allow space for providers to describe any elements of the DoC undertaken.	Care Inspectorate and Healthcare Improvement Scotland should modify their existing eForms system to allow information to be submitted and stored in the eForms system.	automatically generate a template DoC annual report at a touch of a button which aggregates information from notifications made in the preceding year. This could have additional free entry fields which providers complete at the point report is generated, and be capable of being submitted electronically to the Care Inspectorate / HIS upon completion. Providers would be asked to publish their report in an appropriate manner.
Local authority / social work services	It is likely that some deaths of looked after children, Criminal Justice Serious Incident Reviews and Significant Case Reviews would trigger the duty of candour. Care Inspectorate guidance on both could be updated to remind local authorities of their responsibility to exercise the duty but no further alignment is needed.	No standardised recording mechanisms exist. Local authority social work departments (or any arrangements to which these responsibilities have been delegated) would develop their own recording mechanisms.	Local authorities would require to maintain records of where they have exercised the duty of candour (outwith a regulated service) and complete an annual report using a template provided. This would require to be published on the local authority website and sent to the Care Inspectorate via the named link inspector.

4.9 Further consultative work would be needed with health and care providers, social work departments, and regulators to determine the feasibility and implementation barriers to such an approach. Some costs would be required to adjust the eForms systems in respect of regulated care services but the cost is likely to be low in respect of the scale of its applicability across many thousands of responsible persons.

5.0 GUIDANCE FOR A TEMPLATE REPORT

The Act mentions what should appear in a report but it does not establish a direct mechanism for requiring the report to take a particular form or follow a particular pattern. Section 24(4) clarifies that "the responsible person must publish a report … in such manner as the responsible person thinks appropriate." The Act provides clarity on certain matters which must (or must not) be in the report; these can be augmented by regulations and guidance. The monitoring bodies – Care Inspectorate, Healthcare Improvement Scotland and the Scottish Government – are empowered to obtain further information from responsible persons if necessary. Scottish Government guidance should recommend that the report is produced in a way that is consistent with this section.

5.1. It is envisaged that the primary purposes of the report should be:

- directed at supporting learning, rather than merely collecting quantitative information
- to provide public assurance that the duty of candour is being embedded in the sectors to which it applies
- to encourage responsible persons to self-reflect on how the duty is being embedded and how the quality of operation can be continually improved
- to contribute to the Care Inspectorate's, Healthcare Improvement Scotland's and the Scottish Government's wide evidence base about the provision of social care and health services.

5.2. This does not mean, however, that the report should become the sole repository for recording the learning from duty of candour events; that will need to be shared in different ways across different parts of the sector. Rather, the report should articulate, in broad terms, what the learning is and how the local learning system identified and implemented change as a result of reviews undertaken.

5.3. The Act specifies certain things that should be in the report:

- information about the number and nature of incidents to which the duty has applied[1]
- an assessment of the extent to which the responsible person carried out the elements of the duty

[1] The "nature of incidents" refers to the category of outcomes which trigger the duty of candour, not the health / social care specialism involved in the incident.

- information about the responsible person's policies and procedures including information about
    - procedures for identifying and reporting incidents
    - information about the responsible person's policies and procedures including information about 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 has applied
- such other information as the responsible person thinks fit.

A report must not mention the name of any individual or contain any information which is likely to identify any individual.

5.4. The guidance should recommend to responsible persons that reports should be produced in a manner consistent with this table.

Requirement in Act	**Guidance to support the production of the report**	**Why is this important?**
-	The report should make clear the name of the responsible person (ie, service or provider) and a brief statement of what its organisational aims and objectives are. The report should make clear the financial year to which the report applies. The report should provide a very short description of what the duty is, in a way which people who use the service will be likely to understand. The guidance should provide model text which will be of assistance to responsible persons.	To provide clear information to the public about the report they are reading.
information about the number and nature of incidents to which the duty has applied	The responsible person should provide information about the number of incidents to which the duty applied in the preceding financial year. The nature of the incidents should relate to the outcomes specified in the Act.	The reader will know how often the duty has been activated. It may also show comparable information on previous years.

Requirement in Act	Guidance to support the production of the report	Why is this important?
	The responsible person may wish to make comparison to previous years if they think this is helpful or appropriate. The responsible person should report each incident only once – that is, where an event has happened in which more than one of the outcomes in the act has occurred, this should be reported against the outcome which the responsible person thinks is most relevant.	
an assessment of the extent to which the responsible person carried out the duty under section 21(1)	The responsible person should reflect on the extent to which they believe they carried out the duty to follow the procedure in section 22. They may wish to comment on: • any over- or under-reporting they think is likely • any feedback from staff and people who use care, or their carers, about how embedded the culture of activating the duty of candour is within the service • any examples of where the duty has not been activated, but where the responsible person has subsequently discovered that it should have been • parts of the procedure to be followed in section 22 which they believe have been well-implemented and those parts of the procedure they have found more challenging The responsible person may wish to report on the number of times a person's carer / relative has been informed, as well as or instead of the person affected.	This will provide public assurance that candour is taken seriously in an organisation. To support self-improvement in the creation of an open and transparent culture

Requirement in Act	Guidance to support the production of the report	Why is this important?
	The responsible person is not expected to report on the percentage of times that each step within the duty has or has not been activated, but on the overall extent to which the duty has been carried out but presenting information about the number of incidents. It is expected that responsible persons will be able to extract more detailed information if this is needed to support improvement, or for a connected purpose.	
information about the responsible person's policies and procedures including information about procedures for identifying and reporting incidents	The responsible person should indicate how their duty of candour policy operates, and whether relevant staff have been trained in this. The responsible person should indicate very briefly which categories of people are responsible for identifying and reporting incidents. In a large organisation, the responsible person may wish to describe how information is aggregated for the purposes of reporting, for example whether proforma reporting tools are returned to central person, etc.	To verify that responsible persons have clear processes in place to follow the procedure and have considered staff training.
information about the responsible person's policies and procedures including information about support available to staff and to persons affected	The responsible person should provide a short summary about how support is provided to people and staff affected by incidents. This might include information about: • the role of managers and senior staff • accessible leaflets and materials for people affected emotional and health support for staff,	To encourage responsible persons to think about what support is and could be available to people and staff.

Requirement in Act	Guidance to support the production of the report	Why is this important?
by incidents	including occupational welfare support • discussions and arrangements with trade unions, works councils, or other employee representatives about the duty The responsible person should also indicate if there is further support they are considering.	To allow people and staff to see what support is available if they have been affected.
information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty has applied	The responsible person should explain what changes have been made to policies, procedures and practices as result of the duty being activated. Responsible persons should focus particularly on describing changes which may support improved practice in other organisations and amongst other responsible practices. The amount of information required to be submitted should be proportionate to the changes to policies and procedures. It is expected that such changes should be described in 1-3 sentences at most. The responsible person may also wish to consider whether any post-event development needs have been identified and addressed. The responsible person may wish to signpost to any learning that has happened and been recorded or shared elsewhere. Responsible persons should include the views from people who have been affected where this is appropriate and illustrates the extent	To help spread learning from adverse events in order to help improve outcomes for people more widely.

Requirement in Act	Guidance to support the production of the report	Why is this important?
	to which the duty has made a difference to people's experiences, either positively or negatively. Responsible people should select an appropriate number of views to be included in the report, commensurate with the number of times the duty of candour has been triggered and the number of people who use their services.	
Any such other information as the responsible person thinks fit.	Responsible persons are free to provide information which they think would be helpful for readers or other services providers.	
A report must not— (a)mention the name of any individual, or (b)contain any information which, in the responsible person's opinion, is likely to identify any individual.	Responsible persons are reminded that in completing a report, they should not mention the name of any individual or provide information which is likely to identify any information. Where information involving a very small of people is being reported, responsible persons may need to exercise caution in how these numbers are presented.	

6.0 TEMPLATE REPORT A – A CARE HOME

A template report is provided below. It is a template written with the perspective of an individual regulated care service in mind.

Sample Duty of Candour Report

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, 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 the duty of candour in our services. This short report describes how Anytown Care Home has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

1. About Anytown Care Home

Anytown Care Home is a care home in Glasgow for up to 54 residents. We provide residential care for older people who find it very hard to live at home. We aim to ensure these people receive an excellent quality of care and live happy, fulfilled lives.

2. How many incidents happened to which the duty of candour applies?

In the last year, there have been seven incidents to which the duty of candour applied. These are where types of incident have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition.

Type of unexpected or unintended incident	**Number of times this happened**
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	0
Someone's treatment has increased because of harm	3
The structure of someone's body changes because of harm	1
Someone's life expectancy becomes shorter because of harm	0

Type of unexpected or unintended incident	Number of times this happened
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries	2

3. To what extent did Anytown Care Home follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure in 6 out of the 7 occasions. This means we informed the people affected, apologised to them, and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future.

In one case we did not offer a meeting to the affected people and we will seek to improve for next year.

We received positive feedback from one person who had experienced additional pain as the result of a fall. She was, of course, upset by the fall but she and her relatives said they were grateful that the manager had met with them to apologise and discuss how to improve things for the future.

4. Information about our policies and procedures

Where something has happened that triggers the duty of candour, our staff report this to the care home manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incidents and reports them as necessary to the Care Inspectorate. When an incident has happened, the manager and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as people who use care and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident. In one case, we identified that the incident arose because of staff misconduct. This is extremely rare and we dealt with this issue through our disciplinary policy.

Where residents in the home and their relatives are affected by the duty of candour, we have arranged for them to have access to this welfare support too.

5. What has changed as a result?

We have made a number of changes to our policies and procedures as a result of the duty of candour. There are three significant changes that we wish to highlight:

- In response to a medication error, we have changed the way medicines are dispensed to ensure that there are photographs of residents on their medication sheets. This means that new staff can ensure the right people receive the right medicine.
- In response to a fall, a resident explained that it would be really helpful to ensure there are two care staff to help her access the step down into the garden. We have ensured that residents who need additional support to go outside receive that support, and are looking at how we can remove the step altogether.
- We have identified that there is a need to review our mealtimes to ensure that people are able to drink enough fresh water after their lunch. We have shared our new practices on this with other care homes locally.

6. Other information

This is the first year of the duty of candour being in operation and it has been a learning experience for our care home. It has helped us to remember that people who use care services have the right to know when things go badly, as well as when they go well.

As required, we have submitted this report to the Care Inspectorate but in the spirit of openness we have placed in on our website and shared it with our residents and their relatives too.

If you would like more information about our care home, please contact us using these details: XXX.

7.0 TEMPLATE REPORT B – A NHS BOARD

Sample Duty of Candour Report

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 short report describes how NHS X has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

1. About NHS X

NHS X serves a population of 845,000 people across mid Scotland. We cover a diverse geographical area, including large and small towns as well as rural areas. Our aim is to provide high quality care for every person who uses our services, and where possible help people to receive care at home or in a homely setting.

2. How many incidents happened to which the duty of candour applies?

Between 1 April 2018 and 31 March 2019, there were 95 incidents where the 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 directory to the natural course of someone's illness or underlying condition.

NHS X identified these incidents through our adverse event management process. Over the time period for this report we carried out 178 significant adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	Number of times this happened (between 1 April 2018 and 31 March 2019)
A person died	7
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
A person's treatment increased	62
The structure of a person's body changed	1
A person's life expectancy shortened	4
A person's sensory, motor or intellectual functions was impaired for 28 days or more	4
A person experienced pain or psychological harm for 28 days or more	2
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries as listed above	12
TOTAL	**95**

3. To what extent did NHS X follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure in 77 out of the 95 occasions (81% of the time). This means we informed the people affected, apologised to them, and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future.

We have reviewed the 18 occasions where we did not follow the duty of candour procedure. For three of these, we were unable to contact the people affected. Of the remaining 15, we provided an apology to the people affected but did not have a follow-up meeting. We are working to improve the reliability of inviting people to follow-up meetings to discuss the event.

4. Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy. Through our adverse event management process we can identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on implementing the duty of candour.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review, and local management teams develop improvement plans to meet these recommendations.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction, so that they understand when it applies and how to trigger the duty. Additional training is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational welfare. This means that staff can contact a confidential telephone line to speak to trained counsellors.

5. What has changed as a result?

We have made a number of changes following review of the duty of candour events. There are three significant changes that we wish to highlight:

- We invited a family to talk about their experience of the review process to an event which a number of our staff attended. Following the family's feedback, we reviewed and updated our adverse event management policy to include a template for a holding letter so that families could be kept updated when there are delays in the process.
  Following an incident where a person had the wrong scar removed, examination mirrors were purchased to allow people to view surgical sites on their back, and the use of these mirrors is now embedded across our surgical departments.
- Following an incident where a person developed an air embolus directly associated with the removal of a Central Venous Cannula (CVC), we rapidly disseminated a risk awareness notice to make all staff aware that only a fully air occlusive dressing should be applied to a CVC site, and the safest dressing to use is a hydrocolloid dressing.

6. Other information

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

As required, we have submitted this report to Scottish Ministers and we have also placed it on our website.

If you would like more information about this report, please contact us using these details: XXX.

8.0 TEMPLATE REPORT C – A CARE AT HOME SERVICE

Sample Duty of Candour Report

Duty of Candour

Duty of Candour is a legal requirement to ensure that if something goes wrong in health or social care services the people affected are offered an explanation, an apology and an assurance that staff will learn from the error. The learning is shared with the people affected and throughout Scotland.

About our organisation

This report describes how a medium sized supported living provider has implemented Duty of Candour throughout the period of April 2018 to March 2019.

"Working for you" supports 70 people to live in their own individual homes with a small team of supporters who are matched to work for the person and provide bespoke, flexible and tailored support that meets their individual needs.

"Working for you" has a Duty of Candour policy and staff guidance. All staff undertake training to help them understand the Organisation's policy and the process of the Duty of Candour which could affect them.

The people we work for have a variety of support needs; the majority have severe and challenging difficulties having spent years in institutionalised hospital care and come to us sharing considerable historical abuse.

Incident Reporting

All health and social care services in Scotland must provide an annual duty of candour report for their service. As a supported living provider this information is sent to our regulator the Care Inspectorate.

During the reporting period, 2 incidents triggered the Duty of Candour.

Type of unexpected or unintended incident	**Number of times this happened**
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0

Type of unexpected or unintended incident	Number of times this happened
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries	1

Procedure

In both incidents the correct procedure was followed:

- We informed the people affected, apologised to them and arranged to meet with them.
- Internally senior staff reflected on the events, identified where systems went wrong and what could we do better.
- This information was shared with all our staff through our "All staff meetings" at team meetings and in support and development.

One person, deemed to lack capacity, had no family or advocate to formally apologise to. We utilised alternative forms of communication including the use of pictures to help this person understand the incident and ensuing procedure.

The family of the other person met with our named person and appreciated the sharing of information and made some positive suggestions for staff learning which we have incorporated.

Our Policy and Process

When an incident occurs that necessitates the implementation of Duty of Candour, our staff reports this to their line manager and to the Senior Manager who oversees the service we provide. The incident is recorded and the named staff member completes the Care Inspectorate reporting e-form.

The internal reporting form highlights the learning needed as a result of the incident and any specific staff team learning necessary.

Our external confidential, employee counselling service is available to all staff at any time but if Duty of Candour is triggered it is emphasised to staff that this is available. Senior management meet with staff to provide support and emphasise this is about learning and improving not blame.

Duty of Candour is part of our Core training which all staff have to undertake, in addition to the legislation a series of scenarios form part of the training to emphasise to staff that while it is distressing when things go wrong, we can and

do learn from our mistakes and adapt our processes to try to minimise the events recurring. This is also included in our whistleblowing policy and values training.

Where the incident arises from staff wrong doing our disciplinary process is immediately put in place.

What have we learned?

In this first year of implementing Duty of Candour:

- We have supported staff in understanding the process as many find it confusing. The guidance has been very helpful.
- Understanding the importance of dysphagic diets and textures must be emphasised to new staff from the start and form part of an extended shadowing process.
- Bath temperature gauges should be checked for accuracy on a regular basis to ensure in proper working order.
- Alongside reporting these events to the Care Inspectorate we shared our learning experiences with CCPS to enable other provider colleagues to benefit from our learning.
- Our annual reporting has become an item for our Trustees to discuss at their Board meeting and is included in our Risk register monitoring.

If you would like more information about this report, please contact us using these details: XXX.

9.0 TEMPLATE REPORT D – A DAYCARE OF CHILDREN SERVICE

Sample Duty of Candour Report

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, 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 the duty of candour in our services. This short report describes how Anytown Nursery has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

1. About Anytown Nursery

Anytown Nursery is a children's daycare service in Stirling for up to 32 children aged 0-5 at any one time. We provide day care to children from before school to early evening. We are in partnership with the local authority which means that although we are an independent nursery, we are funded to provide some hours of early learning and childcare. We aim to ensure that we care for children in a way which supports them to grow and develop.

2. How many incidents happened to which the duty of candour applies?

In the last year, there has been one incident to which the duty of candour applied. These are where types of incident have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition.

Type of unexpected or unintended incident	**Number of times this happened**
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0

Type of unexpected or unintended incident	Number of times this happened
Someone 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	1

3. To what extent did Anytown Nursery follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure. This means we informed the parents affected, apologised to them, and offered to meet with them. We reviewed what happened and what went wrong to try and learn for the future.

4. Information about our policies and procedures

Where something has happened that triggers the duty of candour, our staff report this to the nursery manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the manager and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as people who use care and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident.

Where parents or children are affected by the duty of candour, we have arrangements in place to provide welfare support as necessary.

5. What has changed as a result?

We made a change to our policies and procedures as a result of the duty of candour. We have reviewed the way in which we provide meals and snacks to children to ensure that allergies are known to all staff and that staff are confident about how they can avoid harm arising from them.

6. Other information

This is the first year of the duty of candour being in operation and it has been a learning experience for our nursery. It has helped us to remember that people who use care have the right to know when things go badly, as well as when they go well.

As required, we have submitted this report to the Care Inspectorate but in the spirit of openness we have placed in on our website and shared it with our parents too.

If you would like more information about our nursery, please contact us using these details: XXX.

10. TEMPLATE REPORT E – A NUL REPORT

Where no events triggering the duty of candour have occurred in the preceding year, a report like this should be used.

Sample Duty of Candour Report

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, 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 the duty of candour in our services. This short report describes how our care service has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

1. How many incidents happened to which the duty of candour applies?

In the last year, there have been no incidents to which the duty of candour applied.

2. Information about our policies and procedures

Where something has happened that triggers the duty of candour, our staff report this to the nursery manager who has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the manager and staff set up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as people who use care and their families. We have occupational welfare support in place for our staff if they have been affected by a duty of candour incident.

Where parents or children are affected by the duty of candour, we have arrangements in place to provide welfare support as necessary.

If you would like more information about our nursery, please contact us using these details: XXX.