North Lanarkshire Health and Social Care Partnership

Duty of Candour Report: 2023-2024

Introduction

North Lanarkshire Council (NLC) recognises that when adverse events occur during the provision of treatment or care, openness and transparency is fundamental.

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 was implemented on 1st April 2018 placing an organisational duty (Duty of Candour) on health, care, and social work services to be open and honest with people in their care.

The Duty of Candour arrangements which we have implemented reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. When harm occurs the focus must be on personal contact with those affected; support, and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement.

The overall purpose of this duty is to ensure organisations are open, honest, and supportive when there is an unexpected or unintended incident resulting in death or harm as defined in the Act. All health and social care services in Scotland have a Duty of Candour, 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.

A part of this duty is that Health and Social Care services publish an annual report about the Duty of Candour in our services. This report describes how our services have met Duty of Candour requirements between 1 April 2023 and 31 March 2024.

When must the Duty of Candour procedure be activated?

Organisations must activate the Duty of Candour procedure 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.
- in the reasonable opinion of a registered health professional not involved in the incident:

(a) that incident appears to have resulted in or could result in any of the outcomes mentioned below.
(b) that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

It is important to note that where the Duty of Candour procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for this has to be provided to the relevant person.

The relevant outcomes are as follows:

(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 criteria:

- 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.

Or where:

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 above

Information about policies and procedures

All staff who are employed in the sector should be aware that all instances that necessitate implementation of Duty of Candour must immediately be reported. In such instances, organisations must then take the appropriate action, ensuring relevant bodies [depending on the sector] such as Social Work and \ or Care Inspectorate are notified of the event. Where an incident occurs that triggers the Duty of Candour, organisations have responsibility for ensuring that the Duty of Candour procedure is followed.

Training sessions on Duty of Candour were delivered to 60 home support managers and staff throughout 2023-2034. We will continue to provide support and training when necessary to minimise the impact on the organisation and the vulnerable people that we strive to support.

Information on Duty of Candour and reportable incidents is described in detail within Appendix 1.

All North Lanarkshire Council Social Work In-house services are required to adhere to Duty of Candour reporting requirements. Initial notifications are made when reporting accidents and incidents in accordance with North Lanarkshire Council internal CIRUS system.

How many incidents happened to which the Duty of Candour applies?

Over this reporting period, there were no Duty of Candour related incidents reported by North Lanarkshire Council care and support services.

Conclusions

The requirements for Duty of Candour are such that the number of relatable incidents are generally low nationally. Duty of Candour related knowledge and reporting requirements will continue to be a statutory reporting requirement if or when, they do occur.

The actions described below are intended to ensure that there is an ongoing focus on Duty of Candour.

Actions

If in the future, should any incidents occur that invoke Duty of Candour proceedings, there will be a review process to identify any lessons learned and the result of any such review will be shared with the relevant person/persons.

Awareness raising sessions regarding Duty of Candour will be undertaken with commissioned services over the year.

Grading of Harm	**Definition of Harm**	**Level of Response**
No harm, incident prevented	Any service user safety incident that had the potential to cause harm but was prevented.	These incidents are **outside** of the scope of the Duty of Candour. Social work professionals may however feel it is appropriate to inform the person involved if it is in their best interest.
No harm, incident not prevented	Any service user safety incident that occurred but no harm was caused to the person involved.	These incidents are **outside** of the scope of the Duty of Candour policy. Being open in a discussion between staff involved and the service user and their family is usually undertaken locally.
Low Harm	Any service user safety incident that led to the extra observation or minor treatment such as first aid or additional medication for the person involved.	These incidents are **outside** of the scope of the Duty of Candour policy. Being open in a discussion between staff involved and the service user and their family is usually undertaken locally.
Moderate Harm	A level of harm that is not permanent but has led to a moderate increase in treatment or prolonged psychological harm of more than 28 days. For example, a return to theatre, an unplan readmission to hospital, unexpected admission to critical care, a prolon hospital stay or additional out service user visits.	Duty of Candour is a statutory requirement. Notification should be given to the person affected or their representative in person including an explanation of the incident, the process for investigation and an apology. This will be followed up in writing and on conclusion of the investigation the findings and outcome will be available to the service user of their representative.
Serious Harm	Any service user safety incident that has resulted in permanent harm that is directly related to the incident and not the natural course of an illness or the underlying condition of the person affected. Examples of severe harm are permanent lessening of bodily functions, sensory, motor, physiological or intellectual function, removal of the wrong organ or limb or brain damage.	Duty of Candour is a statutory requirement – see above.
Death	Any service user safety incident that directly resulted in the death of a person and is not related to their illness or underlying condition.	Duty of Candour is a statutory requirement – see above.