Penumbra
Mental Health

Duty of Candour

Section 2.1: Rights & Safeguards/Policy No: 2.1.16

Your journey. Your way.

Policy Statement

Penumbra is committed to providing high quality care and support and to ensure the best possible outcomes for people using our services and activities.

Penumbra is equally committed to being open and honest with people who use our services and activities, or their families or representative, when serious harm (physical or psychological) has happened as a result of the care and support received. The harm may be the result of an intended or unintended incident by either someone employed in Penumbra or by the way we function as an organisation. Penumbra is committed to learning from these events.

About this Policy

DEFINITION

The overall purpose of Duty of Candour is to ensure organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined by **Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016**.

For the purpose of this policy the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 will be referred to as 'The Act'

For the purpose of this policy "staff" includes full-time, part-time, relief staff, agency staff, students and volunteers.

AIM

The purpose of this policy is to:

- Penumbra staff are aware of and abide by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018
- Penumbra staff are made aware of their legal responsibilities
- Penumbra staff follow organisational procedures

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Policy into Practice

1) LEGISLATION

The organisational duty of candour provisions are outlined in two pieces of legislation:

- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016
- The Duty of Candour Procedure (Scotland) Regulations 2018

These set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow 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).

Openness and honesty should be central to the actions of those providing care to others. It should be at the heart of every relationship between those providing, receiving and/or experiencing treatment and care. Trust and effective communication can be difficult to maintain and easy to lose when things have gone wrong.

The organisational 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.

2) THE NEED FOR CANDOUR

Enabling and managing risk is a central part of delivering high quality health, care and social work services. Candour promotes responsibility for developing safer systems, better engages staff in improving services, and creates greater trust in people who use these services, either first hand or on behalf of someone else.

Personalised discussions and communication, review processes that take account of what matters most to those affected, and supportive responses following unintended or unexpected incidents all help to support and promote a culture of learning. Putting people at the centre of our responses to unintended or unexpected incidents resulting in death or harm also helps create the conditions where people feel psychologically safe to contribute to such discussions.

The focus of the duty of candour legislation is to ensure that organisations tell those affected that an unintended or unexpected incident has occurred, apologise to them, involve them in meetings about the incident, review what happened with a view to identifying areas for improvement, and learn (taking account of the views of relevant persons).

3) PROVISIONS OF THE ACT

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3.1. Provisions in the Act include the following measures:

- **Duty of Candour** – The Act includes a Duty of Candour on health and social care organisations. This creates a legal requirement for health and social care organisations to inform people (or their families/carers) when they have been harmed as a result of the care or treatment they have received.
- **Ill-treatment and wilful neglect** – The Act establishes a new criminal offence of ill-treatment or wilful neglect which would apply to individual health and social care workers, managers and supervisors. The offence also applies to organisations.

3.2. What the provisions mean for Penumbra

Penumbra is required to follow a Duty of Candour procedure which includes notifying the person affected, apologising and offering a meeting to give an account of what happened.

Penumbra is required to review each incident and consider the support to those affected (people we support, their family or representative and/or Penumbra staff).

Penumbra will publish an Annual Report for each financial year highlighting when the Duty of Candour has been applied. This will include the number of incidents, how we have implemented the duty and what learning and improvements have been put in place.

4) KEY PRINCIPLES OF DUTY OF CANDOUR

Providing health and social care services is associated with risk and there are unintended or unexpected events resulting in death or harm from time to time. When this happens, people want to be told honestly what happened, what will be done in response, and to know how actions will be taken to stop this happening again to someone else in the future.

Penumbra are committed to a focus on support, training and transparent disclosure of learning to influence improvement and support the development of a learning culture across services. Candour is one of a series of actions that should form part of organisational focus.

Transparency, especially following unexpected harm incidents is vital to improving the quality of health and social care.

Being candid promotes accountability for safer systems, better engages staff in improvement efforts, and engenders greater trust in patients and service users.

5) WHO DOES THE DUTY OF CANDOUR PROCEDURE APPLY TO?

Organisations that provide a health service, care service, or social work service to which the duty of candour applies is referred to in the relevant legislation as a ***responsible person.*** This is set out at section 25 of the Act:

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- A Health Board
- 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
- A person (other than an individual) providing an independent health care service
- 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
- A person (other than an individual) who provides a social work service.

This means that the new Duty applies to organisations and not individuals. It is placed upon health, care and social work organisations.

Penumbra as a whole is therefore the *responsible person* in terms of the Act. The organisational lead for Duty of Candour within Penumbra is the Director of Programmes.

The *responsible person* has responsibility for:

- Carrying out the procedure
- Undertaking any training required by regulations
- Providing training, supervision and support to any person carrying out any part of the procedure as required by regulations
- Reporting annually on the duty.

A ***relevant person*** is the person who has been harmed during the incident, 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.

6) INCIDENTS WHICH ACTIVATE THE DUTY OF CANDOUR PROCEDURE

Organisations (as responsible persons) 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 (means a member of a profession to which section 60(2) of the Health Act 1999 applies) not involved in the incident:
  (a) that incident appears to have resulted in or could result in any of the outcomes mentioned below; and
  (b) the outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

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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:

- **death of the person**
- **a permanent lessening of bodily, sensory, motor, physiological or intellectual functions**
- **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**
- **the person requiring treatment by a registered health professional in order to prevent –**
  - **(i) the death of the person, or**
  - **(ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.**

6.1. The view of the registered health professional

A registered health professional must give their view on the incident and its relationship to the occurrence of death or harm, alongside pre-existing illnesses or underlying conditions. Penumbra services must ensure that the registered health professional who gives the opinion mentioned above is not someone who was involved in the incident.

This means that the final decision by Penumbra about whether to activate the duty of candour procedure for a particular incident will be informed by the views of a health professional that has not been personally involved but could work for the organisation.

The requirement is for someone not involved in the incident to provide a view to inform a decision about activating the duty of candour procedure. A detailed and comprehensive analysis of the incident to form an opinion about contributory factors is not required.

Although it will be for Penumbra to determine the most appropriate way of obtaining the views of the registered health professional not involved in the incident, it is likely that health professionals will require services 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?

Penumbra staff will refer to Policy 2.2.1 Accident & Incident Monitoring and liaise with the Director of Programmes when activating the duty of candour procedure. Please refer to **Section 7 Organisational Procedure** below.

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6.2. What is the procedure start date?

The procedure start date is the date Penumbra 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 in, an outcome listed above and that relates directly to the incident. It does not the natural course of the relevant person's illness or underlying condition.

7) ORGANISATIONAL PROCEDURE

7.1. *Relevant Person* in the procedure refers to:

(a) the person who has received the health service, the care service or the social work service, or
(b) where that person -
(i) has died, or
(ii) 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.

7.2. Notifying the *relevant person*

As soon as reasonably practicable after becoming aware that a safety incident has occurred that falls into the moderate harm or more serious categories Penumbra must:

1. Notify the 'relevant person' that the incident has occurred and;
2. Provide reasonable support to the relevant person in relation to the incident

The notification must:

a) Be given in person by one or more members of staff
b) Provide an account of all the facts known about the incident to date
c) Advise the person what further enquiries into the incident will be undertaken
d) Include an apology and/or a sincere expression of regret, and;
e) Be recorded in writing

The member of staff should be clear in the first meeting that the facts may not yet have been established, tell the relevant person only what is known and believe to be true, and answer and questions honestly and as fully as they can.

7.3. Therefore, Penumbra will follow these key stages of the Duty of Candour procedure:

a) To notify the relevant person (i.e. the affected person or their family/carer/representative) as detailed above
b) To provide an apology

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c) To carry out a review into the circumstances leading to the incident
d) To offer and arrange a meeting with the relevant person
e) To provide the relevant person with an account of the incident
f) To provide information about further steps taken
g) To offer support, or provide information about support to those affected (e.g. the relevant person and staff)
h) To prepare and publish an annual report on the Duty of Candour

The aim of the Duty is to ensure that people are told when harm occurs as a result of the support they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be notified.

- It is **not** necessary to inform a person where a '**near miss**' has occurred, so long as the incident has resulted in no harm to the person.

- Arrangements must be in place to notify a person affected by an incident who lacks capacity to make a decision about their care, including ensuring that a person acting lawfully on their behalf is notified as the ***relevant person.***

- Other than in the exceptions outlined above, information should only be disclosed to family members or carers where the supported person has given express or implied consent. Express consent is permission for something that is given specifically, either verbally or in writing; implied consent is inferred from signs, actions, or facts, or by inaction or silence.

- Information provided should be given in person and include a step-by-step account of all relevant facts known about the incident at the time. The information should be as detailed, or as simple, as the ***relevant person*** wants. The information must be given in a manner that the ***relevant person*** can understand.

- Penumbra will also ensure that a meaningful **apology** (see below) is given, in person, by the most appropriate representative of the organisation.

- Penumbra will also ensure that all reasonable support is provided to the ***relevant person*** to help them overcome the physical, psychological and emotional impact of the incident, including:
    - Treating the person with respect, consideration and empathy
    - Offering direct emotional support during the process of notification, perhaps from a family member, friend, care professional or advocate
    - Offering help to understand what is being said, perhaps through an interpreter, advocate, non-verbal communication aids, Braille etc.
    - Providing access to treatment and care to recover from or minimize the harm caused if appropriate
    - Providing details of specialist independent sources of practical advice and support, or emotional support / counselling
    - Providing information about available impartial advocacy and support services, and other relevant support groups

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- Providing support to access Penumbra's Complaints Handling Procedure.

- Following the notification in person, written notification will also be provided, even though enquiries may not yet be complete. The written notification must contain all the information that was given in person, including an apology, as well as the results of any enquiries that have been made since the face-to-face meeting.

- The outcomes or results of any further enquiries and investigations must also be recorded and provided in writing to the ***relevant person*** if they wish to receive them.

- If the ***relevant person*** cannot be contacted in person or declines to speak to representatives of Penumbra, a documented record must be kept of all attempts to make contact.

- In this situation, the wishes of the ***relevant person*** not to communicate with Penumbra must be respected and a record kept. Also, if the ***relevant person*** has died and there is nobody who can lawfully act on their behalf, a record should be kept.

- All correspondence from the ***relevant person*** relating to the incident must be responded to in an appropriate manner and a record of communications should be kept.

8) APOLOGY

For the purposes of the Act, an "apology" means a statement of sorrow or regret in respect of the unintended or unexpected incident that caused harm or death.

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.

It is important that an open and honest apology is provided from the outset as this can reassure the relevant person and/or their family. It will also set the tone for moving things forward.

The SSSC has provided guidance on Duty of Candour including how to make an apology. Resources can be found on the Company Drive: Duty of Candour

The Act states that the responsibility for the apology rests with the ***responsible person*** – i.e. Penumbra.

Within Penumbra, the Director of Programmes will ensure a formal apology on behalf of the organisation is delivered, whilst recognising that there are likely to have been individuals who have provided individual apologies.

It is important to apologise immediately the event comes to light. When making your apology you should not worry about who is to blame or what has gone wrong but merely apologise for the event occurring. **It is everyone's responsibility to make an apology**.

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9) MONITORING & REPORTING

The purpose of the Duty of Candour procedure is to support the implementation of consistent responses across health, social work and social care providers when there has been an incident that has resulted in unintended or unexpected harm that is not related to the course of the condition for which the person is receiving care.

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

Using Policy 2.2.1 Accident & Incident Monitoring and associated recording forms, Penumbra monitors accidents, incidents and near misses across the organisation. In conjunction with information obtained through our complaints and whistleblowing procedures Penumbra will produce an Annual Report at the end of each Financial Year demonstrating how we have met the various steps within the Duty of Candour procedure, what we have learned and how this learning has been shared.

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

The monitoring bodies – Care Inspectorate, Healthcare Improvement Scotland and the Scottish Government – are empowered to obtain further information from responsible persons if necessary.

10) OFFENCES OF WILFUL NEGLECT OR ILL-TREATMENT

Part 3 of the Act establishes offences relating to the wilful neglect or ill-treatment of adults receiving health care or social care. There are two main offences in this part: an offence that applies to care workers (e.g. Recovery Practitioners & Workers), and an offence that applies to care providers (e.g. Penumbra).

The offence is committed where a care worker is providing care for another person and ill-treats or wilfully neglects that person.

Wilful neglect or ill-treatment to children is not covered by the Act.

11) STAFF DEVELOPMENT

All Penumbra staff are required to complete the Duty of Candour e-learning Module as provided by NHS Education for Scotland and found on the TURAS Learn site: https://learn.nes.nhs.scot/Scorm/Launch/2654

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This e-learning module takes approximately one hour to complete and should ideally be done on your desktop internet browser and not through RDS. You can copy and paste the above link onto your browser to complete the course.

A certificate is available upon completion and can be used toward SSSC PRTL Registration requirements.

TURAS also includes further information on Duty of Candour and has resources such as FAQ'S, guidance and factsheets:
https://learn.nes.nhs.scot/24970/person-centred-care-zone/openness-and-learning/duty-of-candour

Links & References

RELATED POLICIES

This policy should also be viewed in context with the following Penumbra policies:

- Penumbra's Complaints Handling Procedure
- Policy 2.1.3 Complaints
- Policy 2.1.2 Rights
- Policy 2.1.13 Our Commitment
- Policy 2.2.1 Accident & Incident Monitoring
- Policy 3.1.4 Whistleblowing

Penumbra's Safeguarding Framework:

- 2.1.11 Safeguarding – Adult Support & Protection
- 2.1.12 Safeguarding – Child Protection

REFERENCES

The Duty of Candour Procedure (Scotland) Regulations 2018

Organisational Duty of Candour Guidance March 2018

Scottish Government Duty of Candour Policy

Appendices

Appendix One - Reporting and monitoring as defined by the Act

Appendix Two - Duty of Candour Report Template

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Appendix Three - Brief Summary of the Stages in the Duty of Candour Process

MONITORING AND EVALUATION

This policy will be reviewed as part of Penumbra's policy review schedule and at least every three years.

POLICY 2.1.16 DUTY OF CANDOUR

Date of last review	17.03.23
Date of next review	17.03.26

Policy lead	Jane Cumming	*Director of Services & Innovation*
Last reviewed by	Katie Smith	*Quality & Improvement Manager*
Consultation	Anne-Marie Allen	*Unite*
	Stephen Finlayson	*Head of Innovation & Improvement*
	Joanne Mayne	*Director of Corporate Services*

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Appendix One – Reporting and Monitoring as defined by the Act

1.1.1.1 Reporting and monitoring

(1)A responsible person who provides a health service, a care service or a social work service during a financial year must prepare an annual report on the Duty of Candour as soon as reasonably practicable after the end of that financial year.

(2)The report must set out in relation to the financial year—

(a)information about the number and nature of incidents to which the duty under section 21(1) has applied in relation to a health service, a care service or a social work service provided by the responsible person,

(b) an assessment of the extent to which the responsible person carried out the duty under section 21(1),

(c) information about the responsible person's policies and procedures in relation to the duty under section 21(1), including information about—

(i) procedures for identifying and reporting incidents, and

(ii) support available to staff and to persons affected by incidents,

(d) information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty under section 21(1) has applied, and

(e) such other information as the responsible person thinks fit.

(3)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.

(4)The responsible person must publish a report prepared under subsection (1) in such manner as the responsible person thinks appropriate.

(5)On publishing a report, the responsible person must notify—

(a)Healthcare Improvement Scotland, in the case of a report published by a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),

(b)the Scottish Ministers, in the case of a report published by any other responsible person which provides a health service,

(c)Social Care and Social Work Improvement Scotland, in the case of a report published by a responsible person which provides a care service or a social work service.

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(6)A person mentioned in subsection (7) may, for the purpose of monitoring compliance with the provisions of this Part, serve a notice on a responsible person requiring—

(a)the responsible person to provide the person serving the notice with information about any matter mentioned in subsection (2) as specified in the notice, and

(b)that information to be provided within the time specified in the notice.

(7)The persons are—

(a)Healthcare Improvement Scotland, in relation to a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),

(b)the Scottish Ministers, in relation to any other responsible person which provides a health service,

(c)Social Care and Social Work Improvement Scotland, in relation to a responsible person which provides a care service or a social work service.

(8)The Scottish Ministers, Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland may publish a report on compliance with the provisions of this Part by responsible persons.

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Appendix Two – Duty of Candour Report Template

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 Penumbra

This report describes how Penumbra has implemented Duty of Candour throughout the period of April 2018 to March 2019.

As one of Scotland's largest mental health charities Penumbra supports around 1600 adults and young people every week and employ 400 staff across Scotland

Penumbra has an extensive Policy Handbook covering three sections:

- Organisational
- Services & Supported People
- Human Resources

As such Penumbra has a Duty of Candour policy and procedure in place to all staff through the Company Drive.

Incident Reporting

All health and social care services in Scotland must provide an annual Duty of Candour report for their service. As one such provider this information is sent to our regulator the Care Inspectorate.

During the period [ ] [ ] idents triggered the Duty of Candour:

Type of unexpected or unintended incident	Number of times this happened
Someone has died	
Someone has permanently less bodily, sensory, motor, physiological or intellectual functions	
Someone's treatment has increased because of harm	
The structure of someone's body changes because of harm	
Someone's life expectancy becomes shorter because of harm	
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	
Someone experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	

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A person needing health treatment in order to prevent other injuries	

Procedure

Describe procedure followed for Duty of Candour Incidents including notification, apology and learning.

Our Policy & Process

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

Penumbra's Accident & Incident Monitoring Form and Practice Reflection Tool from our Supervision Toolkit highlights the learning needed as a result of the incident and any specific staff team learning necessary.

Our external confidential, Employee Assistance Programme 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.

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

What have we learned?

Describe any changes made, locally and organisationally e.g. changes to training, policies, reporting, meeting agendas etc.

If you would like more information about this report, please contact our Director of Programmes: jane.cumming@penumbra.org.uk

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Appendix Three – Brief Summary of the Stages in the Duty of Candour Process

Requirement under Duty of Candour	Responsible Person/Department	Timeframe
For incidents where moderate harm, serious harm or death has occurred, the relevant person must be informed.	Registered Manager for episode of support during which the incident occurred. The Director of Programmes should be made aware and if appropriate, involved	As soon as possible after the incident has been detected and reported but always within 10 working days of the incident
Initial notification of incident must be verbal (face-to-face, where possible) unless the relevant person declines notification or cannot be contacted in person. Sincere expression of regret or sorrow must be provided verbally. This must be recorded in the notes.	Registered Manager for episode of support during which the incident occurred. The Director of Programmes should be made aware and if appropriate, involved	As above
Step-by-step explanation of the known facts must be offered to the relevant person.	As above	As above
Written notification to the relevant person. The written notification should outline the facts discussed at the notification meeting and include a sincere expression of regret or sorrow.	As above. All letters must be approved by the Director of Programmes	As above
Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded	As above. All follow-up letters to relevant person to be approved for release by the Director of Programmes	As above
Share incident investigation report (including action plans) with an accompanying letter.	Investigating Officer or other nominated person. Letter to be approved and signed off by the Director of Programmes	As soon as reasonably practicable but always within 25 working days of report being signed off as complete and incident closed by the Director of Programmes

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