

Item: 5

Orkney Health and Care Committee: 7 June 2018.

Duty of Candour.

Report by Chief Executive.

1. Purpose of Report

To advise of the new Organisational Duty of Candour.

2. Recommendations

The Committee is invited to note:

2.1.

That the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 sets out new legislative provisions for organisations providing health services, care services and social work services, known as the organisational duty of candour.

2.2.

That the Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services are required 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.

2.3.

The Organisational Duty of Candour guidance, attached as Appendix 1 to this report, issued in March 2018 by the Scottish Government, the aim of which is to establish whether integration authorities are making sufficient progress on implementation of the legal duty of candour procedure for all organisations that provide health services, care services or social work services.

3. Background

3.1.

Openness and honesty 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.

3.2.

The new 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.

3.3.

The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018 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).

4. Key Messages

4.1.

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.

4.2.

Personalised discussion and communication, review processes that take account of what matters 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 organisational 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.

4.3.

Truly personalised organisational responses when things go wrong require a commitment to the provision of support and training for everyone involved in meetings, reviews and actions arising from the organisational duty of candour.

4.4.

The focus of duty of candour legislation is to ensure that organisations tell those affected that an unintended or unexpected incident has occurred; apologise; involve them in meetings about the incident; review what happened with a view to identifying areas for improvement; and learn (taking into account of the views of relevant persons). Organisations must ensure that support is in place for their employees and for others who may also be affected by unintended or unexpected incidents.

4.5.

Organisations must set out in an annual report the way that the duty of candour procedure has been followed for all the cases that they have identified.

4.6.

There are a number of professional duties of candour such as those required by the Scottish Social Services Council, the Nursing and Midwifery Council, the General Medical Council, the General Dental Council and the General Optical Council. This statutory organisational duty has been developed to be in close alignment with the requirements of these professional duties and will be mutually supportive.

4.7.

The procedure start date is the date that the organisation 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 that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

4.8.

Attached as Appendix 1 to this report is guidance issued by the Scottish Government in March 2018 in respect of the organisational duty of candour.

5. Links to Council Plan

The proposals in this report support and contribute to improved outcomes for communities as outlined in the Council Plan strategic priorities of Caring Communities and Quality of Life.

6. Links to Local Outcomes Improvement Plan

The proposals in this report support and contribute to improved outcomes for communities as outlined in the Local Outcomes Improvement Plan priorities of Strong Communities and Living Well.

7. Financial Implications

There are no financial implications directly arising from this report

8. Legal Aspects

There are no legal implications directly arising from this report.

9. Contact Officers

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10. Appendix

Appendix 1: Organisational Duty of Candour guidance.