West Lothian Drug and Alcohol Service
WLDAS
Reducing Harm, Supporting Recovery

Duty of Candour Policy and Procedure

Background
The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 introduced a new duty of candour on health, care and social work services and came into effect on 1 April 2018.This duty is to ensure that organisations are open, honest and supportive *when there is an unexpected or unintended incident resulting in death or harm to a service user* and sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. Organisations are required to apologise and to meaningfully involve those affected in a review of what happened.

When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement.

They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

Duty of Candour Annual Report
In Scotland, care services and social work services have a legal obligation, under The Duty of Candour Procedure (Scotland) Regulation 2018, to produce a short annual report showing the learning from their duty of candour incidents in the reported period. Organisations must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where it has applied the duty of candour. The Annual Report should be published on the organisation's website and a copy sent to the Care Inspectorate (if the service is regulated by the Care Inspectorate)

Note: WLDAS is not regulated by the Care Inspectorate

Procedure
The following duty of candour procedure must be followed as soon as possible after identification of an incident whereby something goes wrong with someone's treatment or care and this has resulted, or could result, in harm or death. Types of unexpected or unintended incidents are listed in the Annual Report Template below. This list is not exhaustive.

- WLDAS staff will report to the Deputy Manager (or in their absence the General Manager) as soon as possible any incident whereby a person has experienced an unintended or unexpected incident which appears to have resulted in harm or death.
- The Deputy Manager will determine whether the incident meets the criteria for implementing the Duty of Candour Policy and Procedure.
- The Deputy Manager has responsibility for ensuring that the duty of candour procedure is followed.
- The Deputy Manager will take immediate action to reduce risk of harm to the individual and records the incident.

- The Deputy Manager will notify the person/family/relative with an account of the incident first determining their preferred method of communication. For example, by telephone or e mail
- The Deputy Manager will provide an apology.
- The Deputy Manager will also ensure that those involved in the incident receive appropriate support throughout the process.
- When an incident has occurred, the Deputy Manager and staff will set up a learning review into the circumstances that led to the incident. If the Deputy Manager is involved in the incident, this is led by the General Manager. This allows everyone involved to review what happened and identify changes for the future.
- Following the review the Deputy Manager will offer a meeting with the person affected and/or their family and offer a copy of the review report. They will be told about anything WLDAS is doing to improve the quality of service provided by WLDAS as a result of the review.
- Serious adverse events can be distressing for staff as well as for people who use our services and their families. As well as line management support and supervision, additional employee support will be put in place for our staff if they have been affected by a duty of candour incident. Where carers or other family members are affected by the duty of candour, we have arrangements in place to provide welfare support and will provide advice on other support available as appropriate.
- WLDAS will prepare and present to its Board of Trustees and publish on their website an annual duty of candour report at the end of each financial year. A copy of the Annual Report Template is attached as an Appendix.
- All new staff will learn about the duty of candour at their induction.

Signed by (Member of the Board) .....
Date: August 2023 **Review Date:** August 2025

Appendix

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Duty of Candour Annual Report Template

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

Name & address of service:		
Date of report:		
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?		
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	NO

How many times have you/your service implemented the duty of candour procedure this financial year?	
(not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (April XX - March XX)
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions was impaired	

for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries as listed above	
Total	

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	
What lessons did you learn?	
What learning & improvements have been put in place as a result?	
Did this result is a change / update to your duty of candour policy / procedure?	
How did you share lessons learned and who with?	
Could any further improvements be made?	
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	
What support do you have available for people involved in invoking the procedure and those who might be affected?	
Please note anything else that you feel may be applicable to report.	