**ANNUAL DUTY OF CANDOUR REPORT FOR THE PERIOD 1ST APRIL 2023 TO 31ST MARCH 2024**

**Duty of Candour**

The requirements of legislation relating to the duty of candour apply to all health and social care services in Scotland meaning that it is a legal requirement when things go wrong and mistakes happen, that 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 publish an annual report which describes how Gateway has implemented and operated the duty of candour procedures since the last reporting period. This report describes how our care service has operated our duty of candour during the time between 1 April 2023 and 31 March 2024.

**Gateway**

Gateway provides a range of services and activities to vulnerable adults across the Highland region, including Housing Support, Supported Accommodation, Community Support and Outreach, Self-Directed Support and Care at Home. Our vision is that ‘every person will be empowered to achieve their full potential’.

Gateway is committed to providing a truly personalised organisational response when things go wrong, we commit to the provision of support and training for everyone involved in meetings, reviews and actions arising from a duty of candour incident.

**Gateway’s Process for Duty of Candour**

Where something has happened that may trigger the duty of candour, our support staff ensure that the incident is reported immediately. The Service Manager ensures that all incidents (whether Duty of Candour applies or not) are passed to the Named Person, our General Manager, within 24 hours.

For the duty of candour to apply, the service user needs to have suffered significant harm (not related to the natural course of someone’s illness or underlying condition) AND for the care or service issues of Gateway to have contributed to this event where -

* A different plan and/or a different delivery of care and support may have resulted in a different outcome.
* A different plan and/or delivery of care, on the balance of probability, would have been expected to result in a more favourable outcome.

Should the duty of candour apply then the service user, or their family, will be informed of the incident as soon as possible and within 24 hours. An offer of written notification, including an apology is submitted within a maximum period of five working days.

The General Manager will also report to the Care Inspectorate and the Board of Directors.

An investigation process is then implemented which must be completed within 28 days. Thereafter the investigation report, including Action Plans, is shared across the organisation within 5 working days of completion of the investigation. This allows everyone involved to review what happened and identify changes and improvements for the future.

Gateway’s Duty of Candour Policy was last reviewed in February 2024. All new staff learn about the duty of candour at induction. We know that serious mistakes can be distressing for staff as well as people who use care and their families. Gateway have support mechanisms ordinarily have in place access to external counselling and supervision for staff to access in the course of their daily work, and where duty of candour applies, we actively encourage access to this.

Gateway identifies and manages adverse events, incidents, accidents, near misses and complaints through our Incident Reporting System, where all such reports are reviewed by the Senior Management Team and the General Manager. The incident is recorded, and the Named Staff member completes the Care Inspectorate reporting e-form.

Each of the Gateway Operational Service Managers will have a check-in discussion meeting with the General Manager to identify cases which may trigger the duty of candour process to establish what further investigation is required. The level of review depends on the severity of the event as well as the learning potential.

At the monthly Senior Management Team Meeting consideration is given to investigation outcomes, action points and recommendations, and the ratification of any new processes, training, or policy requirements.

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

|  |  |
| --- | --- |
| **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 | 1 |
| 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 |
| Someone experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment to prevent them from dying | 0 |
| A person needing health treatment to prevent other injuries | 0 |

**To what extent did Gateway follow the duty of candour procedure?**

In managing the incident, the correct procedure was followed:

Gateway informed the people affected, apologised to them, and arranged to meet with them.

Internally senior staff reflected on the events and identified where systems went wrong and what could we do better.

We convened a multi-disciplinary team meeting, including with the person affected, the guardian and a family member as the person concerned is deemed to lack capacity. We shared information about our internal investigation, including the Gateway policies and procedures which were reviewed because of the incident.

The family of the person met with our Named Person and another Senior Manager, and they appreciated the sharing of information and made some positive suggestions for staff learning which we have incorporated.

We have informed all parties as required to meet the legislative requirements of a care provider.

**What has changed as a result?**

Several Gateway Policies have been changed, updated, and shared with staff.

Several new policies have been put in place.

There has been a review of our Risk Assessment processes.

We have placed this report on our website. For further information please contact [info@homelesstrust.org.uk](mailto:info@homelesstrust.org.uk)