CHILDREN'S HOSPICE ASSOCIATION SCOTLAND
CLINICAL CARE & GOVERNANCE COMMITTEE
15 JULY 2019
CCG (2019) 012

Paper No.	CCG (2019) 012
Title	Duty of Candour Report
Author of Paper	Libby Gold
Brief Description of the Content	CHAS has a statutory duty to publish an annual report on how we meet duty of candour in our services. The statutory requirement is that we publish a report in the manner we choose as soon as possible after 6 April each year, and then notify Healthcare Improvement Scotland that we have done so. We have attached the proposed report which describes how CHAS has operated the duty of candour during the time between 1 April 2018 and 31 March 2019.
Recommendations	The committee is asked to agree the report and note that it is our intention to publish this report on the CHAS website and inform Healthcare Improvement Scotland. Gillian Phillips will coordinate this.
Financial Implications from this Paper	None
Relationship to the Strategic Plan and Risk	Good governance Statutory Requirement.

CHILDREN'S HOSPICE ASSOCIATION SCOTLAND
CLINICAL CARE & GOVERNANCE COMMITTEE
DUTY OF CANDOUR ANNUAL REPORT

About CHAS

1. CHAS runs two independent healthcare services (Rachel House in Kinross and Robin House in Balloch) and a registered care service (CHAS at Home, operating across Scotland). These services are registered with Healthcare Improvement Scotland and the Care Inspectorate respectively. Through these services, CHAS provides medical, nursing and social work support to babies, children and young people with life-shortening conditions, and their siblings and families. These conditions often result in extremely complex needs.

2. All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that if 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.

3. An important part of this duty is that we provide an annual report about the duty of candour in our services. This short report describes how CHAS has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

4. In line with the legislative requirements, we have taken care not to enclose information which may identify any individual.

How many incidents happened to which the duty of candour applied?

5. During 2018/19, one incident happened to which the duty of candour applied. This table shows all the possible causes of unintended incidents which trigger the duty of candour, and the number of times these triggered the duty of candour in CHAS.

Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (April 2018 - March 2019)
A person died	-
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	-
A person's treatment increased	1
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	-
Total	1

To what extent did CHAS follow the duty of candour procedure?

6. When we realised the event listed above had happened, we followed the duty of candour procedure. This means we informed the people affected, apologised to them, and offered to meet with them. We reviewed what happened and what went wrong to try and learn for the future.

Information about our policies and procedures

7. Prior to the duty of candour coming into effect, CHAS nurse managers attended the duty of candour workshops that were held across Scotland. The purpose of these was to raise awareness of the new duty and ensure our staff are confident in understanding why it is important and how to apply it in CHAS.

8. In addition, all staff have completed an online duty of candour e-learning module, which has been developed by regulators and NHS Education for Scotland. We have built this into our induction for new staff and monitor the completion rate centrally.

9. We have also carried out face-to-face sessions with staff to help them understand duty of candour. We have a duty of candour policy and procedure in place to guide staff. Our training includes important elements on providing an apology if something goes wrong and doing so in a person-centred way

What changed as a result of the duty of candour?

10. Triggering the duty of candour meant we learnt important lessons about the duty of candour procedure, as well as how we handled the event itself.

11. From the event itself, we identified the need to further improve our skills and knowledge to provide care for a child with a rare condition, including the management of the child's diet and nutrition. We learned we required mechanisms to support staff to communicate more effectively with each other about the child.

12. In terms of the duty of candour policy and procedure itself, we learned that it was important to ensure a senior manager contacted the affected family within twenty four hours. We also learned that the template letter, which we had previously developed, could be improved.

13. We have put in place additional training and reflective discussions about the rare condition involved in the duty of candour event, and the management of diet and nutrition. The training and reflective discussions highlighted there was a need to liaise with families more frequently particularly when the child's needs or their condition had changed.

14. Evaluations of the training were carried out, and staff reported that the training will help them to support each child's needs better. The impact of the training is already having a positive result as staff continue to meet with parents/carers to discuss appropriate programmes of care on their child's visit.

15. We have developed tools to support the prevention and acute management of the rare condition, including management of diet and nutrition. This includes a standard operating procedure and model care plan specifically for the rare condition, and guidelines have been produced for staff on nutrition.

16. We changed our template letters to make the apology clearer. In addition, we shared learning across all CHAS services. We used an SBAR report and discussed this at practice development meetings. New policies and procedures were rolled out in our standard ways, and we put in place an immediate safety briefing.

17. We would welcome discussions and mechanisms to share lessons learned outside of CHAS and ensure other care providers benefit from the learning in this case. We are also considering further training on the power of the apology.

Support available for affected people

18. Immediately after the event, we held daily briefings for staff and allocated members of staff to support the staff directly involved. We also allocated staff members to support the family directly involved.

19. We also have a wide range of support available for staff, including:

- support from our Senior Leadership Team
- an independent and confidential employee support programme provided by an external organisation, including with face-to-face support where required
- clinical supervision and reflective practice (4-6 times per year) for our nursing staff
- line management support (4-6 weekly and as required)
- external peer support for managers
- daily huddles and shift briefings for all care staff.

Other information

20. We remain committed to supporting the duty of candour and providing the highest quality service. For further information, please contact support@chas.org.uk

Recommendation

21. The committee is asked to **approve** the report and note that the report will be published on the CHAS website once approved.

Libby Gold
Associate Nurse Director
July 2019