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Duty of Candour

Annual Report

2023/24

1. **About Community Integrated Care**

Community Integrated Care was founded in 1988 by Dr David Robertson, with the vision of supporting people with care needs to move from institutional hospitals to living with independence in the community. David established our charity with the clear belief in social inclusion and the power of communities.

We are one of the UK’s largest health and social care charities. We work in the community, enriching the lives of people with many different care and support needs.

Since the early days we have grown to provide many innovative and bespoke services to thousands of people across England and Scotland.

We are one of Scotland’s largest and most successful social care charities. We have the local knowledge to really understand the communities we work in. Our teams across Scotland are proud to provide support to enable people to live their best lives possible.

Our vision is to enable people to lead the **Best Lives Possible**. We work to provide support based on the principles of choice, dignity and respect in the community. And that resonates in our vision of “**Your Life, Your Choice**”.

We know what we want to achieve, and our values drive us forward every day. We are clear and focused on what makes up the DNA of our charity: **Include, Deliver, Aspire, Respect** & **Enable**

On 1st August 2023 Community Integrated Care merged with Inspire an Organisation which since 1988 Inspire has provided support to people with learning disabilities and additional support needs, including autism, across the North-east of Scotland.

Inspire was a registered charity, operating 39 services providing support to more than 350 people.

Inspires vision was to empower people’s life choices. This was achieved through a wide range of services across communities including on site and visiting staff support to people in their homes, respite care, innovative day services and added value activities including Supper Clubs and events. These services and activities have continued to operate post-merger.

1. **Duty of Candour**

This is a legal requirement as set out in the Health, (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018, to ensure that if something goes wrong in health or social care services that the people affected are offered an explanation, an apology, and an assurance that staff will learn from this error. Learning is shared with the people affected, within the organisation, and across the sector as required.

The purpose of the 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.

We 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 not involved in the incident:   
  a) that incident appears to have resulted in or could result in any of the outcomes outlined in the table below; and

b) That the outcome relates directly to the incident rather than the natural course of the person’s illness or underlying condition.

An important part of this duty is that we provide an annual report on any Duty of Candour incidents in our services.

1. **Our Procedure and Processes**

Where an unexpected or unintended incident occurs, our procedure requires us to:

* Notify the person affected (or representative where appropriate)
* Provide an apology
* Carry out a review into the circumstances leading to the incident
* Offer and arrange a meeting with the person affected and/or their representative
* Provide the person affected with an account of the incident
* Provide information about any further steps taken
* Make available, or provide information about support to persons affected by the incident
* Prepare and publish an annual report on the duty of candour

1. **Duty of Candour Incidents**

During the period, there was one incident that triggered the Duty of Candour. This incident occurred in a former Inspire service prior to the merger with Community Integrated Care and resulted in the person being treated and subsequently dying in hospital. This incident was identified by the person’s GP as triggering Duty of Candour both for the GP practice and for Inspire. These parties liaised and worked together as they would for any other incident whilst maintaining their own responsibilities under duty of candour.

Inspires procedure was followed with a full investigation carried out by our H&S Manager with relevant internal and external reporting. Regular contact was made with the person’s family appraising them of the detail of the incident and all associated developments and actions.

The incident was an unintended event which occurred in the provision of Inspires care. In respect of the triggering of the GP’s Duty of Candour they issued an apology both to the person’s family and to Inspire identifying key clinician learning points.

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| |  | | --- | | **Type of unexpected or unintended incident** | | **Number of times this happened** |
| Someone has died | 1 |
| Someone has permanently less bodily, sensory, motor, physiological or intellectual function | 0 |
| Someone’s treatment has increased because of harm | 0 |
| 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 dying | 0 |
| A person needing health treatment to prevent other injuries | 0 |

1. **Procedure Followed**

Where an unexpected or unintended incident occurs, our procedure requires us to:

* Inform relevant Senior Managers that the incident has occurred
* Notify the person affected (and/or family/relative where appropriate)
* Provide an apology
* Carry out a review into the circumstances leading to the incident
* Offer and arrange a meeting with the person affected and/or their family, where appropriate
* Where possible provide the person affected with an account of the incident
* Provide information about further steps taken
* Make available, or provide access to, support to those affected by the incident
* Our Health and Safety system has an integrated checklist regarding notifications in respect of incidents. This includes stakeholders such as families, the Care Inspectorate, HSE and H&SCP’s.
* Staff have access to an external confidential counselling service and Community Integrated Care are committed to maintaining contact and providing assistance to affected staff.

1. **Learning Outcomes**

N/A

1. **Other Information**

If you would like further information regarding this report, please contact

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