Duty of Candour Annual Report

All health and social care services in Scotland have a duty of candour as an organisation. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Health (Tobacco, Nicotine, etc. and Care) (Scotland) Act 2016, 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 provide an annual report about how the duty of candour is implemented in our services. This short report describes how Edge Autism Ltd. has operated the duty of candour during the time between 1 April 2022 and 31 March 2023. We hope you find this report useful.

Name & address of service:	Edge Group Scotland Ltd., Summers House, Eskmills, Musselburgh. EH21 7PE
Date of report:	23/05/2023
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?**	We have a reporting procedure which stipulates that accidents and incidents must be reported by telephone to Management as soon as possible, with a written report to our Responsible Person (our Operations Manager) within 24 hours of the occurrence. The report is reviewed, stored on our internal system, and forwarded to the Care Inspectorate, service users' social worker if necessary, and, if required, the Health and Safety Executive. After receiving and reviewing a report, the senior management team (including our Managing Director and Safeguarding Lead,

	who is a Registered Mental Health Nurse) meets and determines whether Duty of Candour must be triggered. Accidents and incidents may require further investigation, which could then bring evidence to light which leads to the Duty being triggered. The process of investigation includes: ● gaining an understanding of the communication preferences of the affected person/s; ● a written apology to the affected person, and an interview with them which includes an in-person apology; ● interviews with staff; ● and the collation of information from third parties as required. A report is produced, based on the evidence gathered. The report is shared with the affected person, their family, and any third parties as necessary. All parties are given the opportunity to comment upon the report and its findings This works in concert with our Duty of Candour policy, which contains information about how and when to communicate with affected individuals/families in the event of an incident which triggers the Duty. This policy is reviewed annually. Staff are provided with training on Duty of Candour, in the form of an e-learning unit, during their induction with us, as well as with training on when and how to report accidents, incidents and major concerns. The relevant policies and procedures are

	stored on our online information sharing system, and all staff have access. Since accidents and incidents can have a psychological impact upon staff, we carry out incident debriefing sessions in the event of critical incidents, including those which would trigger Duty of Candour, and provide them with regular supervision sessions.

How many times have you/your service implemented the duty of candour procedure this financial year?	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	**No. of occurrences (April 22 - March 23)**
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 as listed above	
Total	1

Did the person responsible for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	Yes.
What lessons did you learn?	The incident occurred in the course of an activity provided by a third party provider. Our investigation found that while the accident may not have been avoidable, a visual demonstration or opportunity to observe the aspect of the activity in question, may have been beneficial for the affected person.
What learning & improvements have been put in place as a result?	We already collect risk assessments from our third-party activity providers, which we review prior to taking up their services. Future reviews of risk assessments will include determining whether or not visual demonstrations are provided for key aspects of activities, and encouraging them to do this as a reasonable adjustment if this is practicable.
Did this result in a change / update to your duty of candour policy / procedure?	No.

How did you share lessons learned and with whom?	An investigation was carried out and a report written. This was shared with the affected person, their family, and the third party provider.
Could any further improvements be made?	No. The affected person stated that Edge Group could not have done anything differently or better when the accident happened.
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?	The person responsible is a senior member of staff and our Deputy Safeguarding Lead, who has a qualification in person-centred counselling skills. He takes account of the communication needs of any affected person and will provide an apology in a form which best suits the needs of the person. He leads on investigation of incidents and accidents, debriefing of staff, and handling our complaints process. He is also our staff supervisor. He is supported by our Safeguarding Lead, for whom he deputises.
What support do you have available for people involved in invoking the procedure and those who might be affected?	We keep in regular contact with the affected individual and their family, in addition to meeting with them to discuss the incident in question. This ensures that they feel supported by the organisation, and gives us the opportunity to monitor their progress to recovery, while the Duty of Candour process is underway and until its conclusion. Staff involved in invoking the procedure are senior managers in the organisation. The person responsible is our staff supervisor and would be the point of contact for the affected individual and their family, and for any staff involved. He is supervised and supported by our Safeguarding Lead.

Please note anything else that you feel may be applicable to report.	The production of this report was delayed in order that we could ascertain whether there would be long-term effects from the injury sustained by the affected person, as this would have determined the incident category in the table above.

If you would like more information about this report, please contact us by email at: enquiries@edgeautism.com

David Myers (Operations Manager), 06/07/2023