Duty of Candour report:
Highland Outreach Services: 1 April 2021 – 31 March 2022

Duty of Candour is a legal requirement, part of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016, to ensure that if something goes wrong in the services all relevant information is shared with the people affected. They are offered an explanation, an apology and assurance that staff will learn from and share this learning if something goes wrong.

1. How many incidents happened to which the duty of candour applies?
In the last year, there have been no incidents to which the duty of candour applied.

2. Information about our policies and procedures

Change Mental Health Outreach in Highands (Fort William, Alness and Golspie) The services offers an outreach service to support people affected by mental illness to live in their own homes and make better links with their local communities. Support is person centred and flexible round the individual's needs and outcomes.

Support in Mind Scotland has a Duty of Candour policy and guidance for staff. The key stages:

- Notifying the person affected/ family/ relative as appropriate
- Providing and apology
- Review of circumstances that led to the incident
- Offer a meeting with person/family/ relative as appropriate
- Provide affected person with account of incident
- Provide information about further steps taken
- Make available or provide information about support to persons affected by the incident

All incidents that trigger the Duty of Candour are monitored, recorded and reported to the relevant organisations. The area manager completes the Care Inspectorate reporting e-form

Staff members affected by the incident are reminded that they can access the Health Assured 24-hour service at any time for personal support.

A meeting is held with staff to provide support, review and share learning and improving the service Duty of Candour is part of induction training. The emphasis is that while things can go wrong that we learn from mistakes and make adaptations to prevent or minimise reoccurrences.

	Time frame for this report: From 01.04.2021 to 31.03.2022	
	Type of unexpected or intended incident	**Number of times this has happened**
1	Someone has died	0
2	Someone has permanently less bodily, sensory, motor, physiologic, or intellectual functions	0
3	Someone's treatment has increased because of harm	0
4	The structure of someone's body changes because of harm	0
5	Someone's life expectancy becomes shorter because of harm	0
6	Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
7	Someone experienced pain or psychological harm for 28 days or more	0
8	A person needing health treatment in order to prevent them dying	0
9	A person needing health treatment in order to prevent other injuries	0
	Total number of incidents	0
	Actions taken for each incident	n/a
	Learning for each incident and how this was shared	n/a
	If no incidents, please state 'Nul report'	**Nul Report**

Lesley Collins

Highland Resource Centre and Outreach Manager Locality Manager

17th March 2023