DUTY OF CANDOR

ANNUAL RETURN

1 APRIL 2024 -

31 MARCH 2025

Duty of Candour

*This is a legal requirement under the **Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016** and the **Duty of Candour Procedure (Scotland) Regulations 2018**. If something goes wrong in health, care, or social work services, the organisation must offer those affected **an explanation**, **a written apology**, and **meaningful involvement in reviewing the incident**, with learning and improvements shared both within the organisation and, where appropriate, across the sector.*

*In England, an equivalent statutory duty exists under **Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**, which similarly requires an apology, transparency, factual disclosure, and appropriate learning mechanisms following a notifiable safety incident.*

About our Organisation

This report describes that as a care at home provider, we have implemented Duty of Candour throughout the periods indicated.

Professional Carers supports people to live in their own individual homes with teams of carers who are matched to work for the person and provide person centred care that meets their individual needs.

Professional Carers has a Duty of Candour policy and staff guidance. Managers undertake training to help them understand the organisations policy and the process of the Duty of Candour which could affect them. The people we work with have a variety of support needs: some have severe and challenging difficulties while others maintain some independence but require additional support.

Incident Reporting

All health and social care services in Scotland must provide an annual Duty of Candour report for their service, whilst in England, we see this as best practice. As a care at home provider this information is sent to our regulators on an annual basis.

Procedure

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.

Type of unexpected or unintended incident	**Number of times this has happened during this reporting period**
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic, or intellectual functions	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 in order to prevent them from dying	0
A person needing health treatment in order to prevent other injuries	0

What have we learned?

The **Duty of Candour**—in both Scotland and England—teaches us a lot about how health and social care services should approach mistakes and patient safety. Here are the key lessons we can learn when incidents are reported:

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1. Openness and Transparency Are Essential

- Being honest when something goes wrong builds **trust** between staff, patients, families, and communities.
- Covering up mistakes damages confidence in services and can worsen the harm done.

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2. Saying Sorry Matters

- A genuine apology acknowledges the person's experience and starts the process of healing.
- Importantly, in law, an apology is **not an admission of liability**, but it is a recognition of the impact on the individual.

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3. Learning, Not Blaming

- The focus should be on understanding **why** something went wrong, not simply who is at fault.
- This encourages a **"just culture"**, where staff feel safe to report mistakes, knowing that the organisation will learn and improve rather than punish unfairly.

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4. Involving People Affected

- Those harmed (and their families) are not just passive recipients of care—they are active partners in identifying what went wrong and what needs to change.
- This gives them dignity and helps services design safer, more responsive systems.

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5. System-Wide Learning

- Mistakes aren't usually one-off or isolated—they often reveal **wider issues in processes, training, or communication**.
- Duty of Candour ensures lessons are shared **within organisations and across the sector**, preventing the same errors from recurring elsewhere.

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6. Cultural Change in Health and Social Care

- The duty pushes organisations to shift from a defensive mindset ("protect the reputation") to a learning mindset ("protect the people and improve the system").
- This culture change improves **safety, quality, and patient experience** over time.

If you would like more information about this report, please contact us: Professional Carers Wirral Ltd, 221 Seaview Road, Wallasey, Wirral CH45 4PD Tel: 0151 638 4500