



THE STATE HOSPITALS BOARD FOR SCOTLAND

DUTY OF CANDOUR

ANNUAL REPORT

1 April 2023 – 31 March 2024

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Table of Contents	Page
1 Introduction	3
2 State Hospital	3
3 Policies & Procedures	3-4
4 Training	4
5 Duty of Candour – Governance & Monitoring	4
6 Duty of Candour – Incidents	5
7 Duty of Candour – Provision of Support	6
8 Further Information	8

1 INTRODUCTION

The [Health \(Tobacco, Nicotine etc. and Care\) Scotland Act 2016](#) (“The Act”) introduced an organisational Duty of Candour on health, care and social work services. The Act is supplemented by the [Duty of Candour Procedure \(Scotland\) Regulations 2018](#), which highlight the procedure to be followed whenever a Duty of Candour incident has been identified.

The State Hospitals Board for Scotland (“The Board”) is fully committed to the provision of high quality health care in all aspects of its service provision to patients. As part of this objective, we have a duty to limit the potential impact of a wide variety of clinical and non-clinical risks. We do this by developing and implementing robust and transparent systems to ensure that all incidents, which may cause potential or actual harm, are identified, investigated and where appropriate action taken to prevent a recurrence.

Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients and the quality of our healthcare systems and provision.

However, when things go wrong (i.e. where there has been an unexpected incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care) the focus of the Duty of Candour involves notifying the person (and/or relevant person) affected, apologising and offering a meeting to provide an account of what happened, reviewing the incident and offering support to those affected (e.g. those delivering and receiving care).

An important aspect of the Duty of Candour process is the provision of an Annual Report describing how the State Hospital has operated the “Duty of Candour” during the period 1 April 2022 to 31 March 2023.

2 STATE HOSPITAL

The State Hospital is one of four high secure hospitals in the UK. Located in South Lanarkshire in central Scotland, it is a national service for Scotland and Northern Ireland and one part of the pathway of care available for those with secure care needs. The principal aim is to rehabilitate patients, ensuring safe transfer to appropriate lower levels of security.

There are 140 high-secure beds (plus four beds for emergency use) for male patients requiring maximum secure care. A range of therapeutic, educational, diversional and recreational services including a Health Centre is provided.

3 POLICIES & PROCEDURES

All adverse events and near misses are reported through the State Hospital’s risk management system (Datix), as set out within the Incident Reporting & Review Policy – RR01. This system includes a section whereby staff can record if an adverse event has the potential to trigger a Duty of Candour incident. Consequently, through the Incident Reporting and Review process, together with the Duty of Candour Policy incidents that would trigger the Duty of Candour procedure will be identified.

Furthermore, all adverse events and near misses reported within the incident reporting system (Datix) are reviewed in accordance with Incident Reporting & Review Policy – RR01 to understand what happened and to establish if there is action that can be taken to prevent/ minimise a recurrence and/or improve patient care.

Within the State Hospital there are two levels of review:

- Local (standard) Review - undertaken for all incidents reported on Datix by the line manager, person responsible for the area where the incident occurred or by a nominated expert relevant to the issue in question; and
- Enhanced Review – following local review and grading of an incident further review may be necessary to establish the root cause of the incident, known as a Category 1 or 2 Review.

4 TRAINING

Members of staff responsible for inputting incidents onto Datix and for reviewing incidents receive training on the use of the Datix reporting system. During the previous year registered non –registered clinicians have been targeted with regard to undertaking Duty of Candour Learnpro e-learning training to increase numbers.

Duty of Candour Learnpro e-Learning Training

Group / Year	Total Within Target Group 2022/23	Total Within Target Group 2023/24	Number Completed Module 2022/23	Number Completed Module 2023/24	% Uptake 2022/23	% Uptake 2023/24
Registered Practitioners	244	262	236	257	96.7%	98.1%
Non-Registered Practitioners	192	192	188	189	97.9%	98.4%
Total	436	454	424	446	97.2%	98.2%

The proposed Training Plan for 2023-24 targeted all front-line clinical staff with regard to completion of the Duty of Candour e-learning module. The table shows over 98% of staff required to complete this module have completed it overall, increasing on previous year target which has been consistently high.

5 DUTY OF CANDOUR – GOVERNANCE & MONITORING

The Duty of Candour Group, which reports to the Corporate Management Team monitors activity relevant to the Duty of Candour process and comprises of the following members:

- Associate Medical Director (Chair)
- Lead Nurse
- Head of Psychology
- Lead AHP
- Head of Social Work
- Head of HR
- Risk Management Facilitator

The Risk and Resilience Department, on behalf of the Group monitor the incident reporting system on a weekly basis and report all potential incidents to the Group for consideration and action, where required. Furthermore, the following information sources are also utilised in order to identify potential Duty of Candour incidents:

- Enhanced (Level 1 & 2) Incident Reviews;
- Complaints;
- Patient incidents reported to the Health & Safety Executive as RIDDOR;
- 24-hour Security Report;
- Whistleblowing;
- Adult Support & Protection Referrals; and
- Child Protection/Contact Issues

The Duty of Candour Group ensure all incidents meeting the Duty of Candour criteria are investigated in line with Scottish Government guidance and timescales and action taken, where required to prevent/minimise a recurrence. The Group meet on a monthly basis (or more frequently, if required) to discuss potential Duty of Candour incidents. During the period 1 April 2023 to 31 March 2024 the Duty of Candour Group met on 12 occasions.

6 DUTY OF CANDOUR - INCIDENTS

Between 1 April 2023 and 31 March 2024 the Risk and Resilience Department forwarded 54 incidents for consideration by the Duty of Candour Group, down from 115 in the previous year. Two incidents met the criteria, i.e. an unintended or unexpected act incident that resulted in death or harm, as defined within the [Act](#) and did not relate directly to the natural course of a person's illness or underlying condition.

The outcomes are:

- (a) the death of the person,
- (b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm"),
- (c) harm which is not severe harm but which results in—
 - (i) an increase in the person's treatment,
 - (ii) changes to the structure of the person's body,
 - (iii) the shortening of the life expectancy of the person,
 - (iv) an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days,
 - (v) the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.

Duty of Candour Incidents	2021/22	2022/23	2023/24
Considered	103	115	54
Confirmed	1	0	2

In the last year, how many incidents did the duty of candour procedure apply?

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	0
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0

Harm which is not severe harm but results or could have resulted in:	Number
An increase in the person's treatment	0
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	0
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	0

The person required treatment by a registered health professional in order to prevent:	Number
The person dying	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0

6.1 Duty of Candour Procedure

2 Incidents met the Duty of Candour Criteria in 2023/24.

1 incident that was identified is still under review as part of a Category 1 Investigation, the report was due on 24 February 2024 but due to unavailability of key staff involved in the investigation it has been delayed. The incident related to a medication error, further learning will be shared and action as soon as it is available. Reference Cat 1 23-01

1 incident related to a self harm incident. The incident was investigated as a Category 2 Report and learning shared within the organisation, reference Cat 2 23-01.

6.2 What has changed as a result?

At the time of writing the 2023/24 one investigation is still underway, learning will be shared in the 2024/25 Annual Report.

The following recommendations were made following the approval of the Cat 2 23-01 Report:]

1. It is recommended that if a patient is discovered to have been in possession of a sharp object unsupervised (unless approved by Care Team), or if an object has been broken (deliberate or accidental). There is a process in place which ensures the patient is checked for any potential injuries, whether self-inflicted or accidental. This would include any sharp objects that could be used to harm themselves or broken objects such as CDs or razors.

2. It is recommended that consideration is given to whether more robust disposable razors are available. These were described as “flimsy” items and as such there may be ongoing risk of them being broken and used to cause harm. Staff will also be reminded to record all instances of razors breaking to consider whether this happens with any regularity.

3. Although an informal debrief took place in this case, it may be helpful to consider a more formal process around this when instances of harm occur. (Note: Reviewers are aware that a debrief process is currently being tested in some wards within TSH)

4. Liaise with local hospitals and confirm a process that will minimise the resources required when patients are required to attend A&E.

Recommendations 1, 2 and 3 have both been closed. 4 have been allocated to owners and are being considered at the time of writing.

7 Duty of Candour – Provision of Support

In line with the expectations of all staff regardless of the cause or outcome of any Incident, patients and/or relevant persons will be provided with all reasonably practical support necessary to help overcome the physical, psychological and emotional impact of such an incident. This includes:

- Treating the patient and/or relevant person with respect, consideration and empathy;
- Offering the patient the option of direct emotional support during any notification of an “Incident (e.g. from a family member, a friend, a care professional or a trained advocate;
- Offering access to assistance with understanding what is being said, e.g. through interpreting services, non-verbal communication aids, written information, etc;
- Providing access to any necessary treatment or care to recover from or minimise the harm caused by the adverse event, where appropriate; and
- Providing information about available impartial advocacy and support Services

When an Incident occurs, members of staff involved in the patient’s clinical care may also require emotional support and advice. Any members of staff who have been directly involved in the incident and those with the responsibility for undertaking the Review process and communicating with the patient and/or relevant person should be given access to assistance, support and necessary information, where required.

To support staff involved in Incidents, the following arrangements are in place within the State Hospital:

- A 'fair blame and open' culture that discourages the apportion of blame and, following adverse incidents, focuses on "what went wrong" and what can be done to prevent a recurrence;
- De-briefing arrangements are in place for members of staff involved in patient safety incidents; and
- Counselling and support services are available via the Occupational Health Service

8 FURTHER INFORMATION

The Duty of Candour Policy highlights the responsibilities of staff and the procedure to be followed when undertaking the Duty of Candour process can be found on the intranet.

As required, this report is available on The State Hospital website.

If you would like further information about this report please contact us using the following contact details:

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