THE STATE HOSPITALS BOARD FOR SCOTLAND

DUTY OF CANDOUR ANNUAL REPORT

1 April 2024 – 31 March 2025

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Approval Group	Clinical Governance Committee
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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).

Relevant incidents are reviewed by the Duty of Candour Group. If an incident meets the criteria the Duty of Candour Process begins with an apology to the patient or carers from a relevant person. Following this an investigation is commissioned and a meeting scheduled with the patient to discuss the review. A final meeting takes place to share the findings and the changes that will be implemented as a result. Full details of the process are described in RR06 Duty of Candour Policy.

All health and social care services in Scotland have an organisational duty of candour. This is a legal requirement which means that when certain types of incidents happen, the people affected understand what has happened, receive an apology, and the organisation(s) learns how to improve for the future.

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 2024 to 31 March 2025.

If you have any questions or would like more information about the State Hospital, please feel free to contact us at: tsh.info@nhs.scot or 01555 840293.

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 the 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

All new staff are required to complete the NES: Duty of Candour Learn Pro Module once they start in the role. Included within this training is information on the process and links to further resources. We are clear to our staff that serious mistakes can be distressing for them, as well as for the people receiving care and treatment and their families. We have occupational welfare support in place for our staff if they have been affected by an organisational duty of candour incident through the wellbeing centre which can signpost staff to resources for further support and wellbeing.

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 ensure figures are maintained. This is highlighted in Table 1.

Table 1 - Duty of Candour learnPro e-Learning Training

Group	Total Within Target Group 2023/24	Total Within Target Group 2024/25	Number Completed Module 2023/24	Number Completed Module 2024/25	% Uptake 2023/24	% Uptake 2024/25
Registered Practitioners	262	268	257	262	98.1%	97.8%
Non-Registered Practitioners	192	184	189	183	98.4%	99.5%
Total	454	452	446	445	98.2%	98.4%

The proposed Training Plan for 2024-25 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.
- Risk Management Team Leader.
- Consultant Clinical Psychologist.

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:

- Serious Adverse Event (Category 1 & 2) Reviews.
- Complaints.
- Patient incidents reported to the Health & Safety Executive as RIDDOR.
- 24-hour Security Report.
- Whistleblowing.
- Adult Support & Protection Referrals.
- 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 2024 to 31 March 2025 the Duty of Candour Group met on 11 occasions.

6 DUTY OF CANDOUR - INCIDENTS

Between 1 April 2024 and 31 March 2025 the Risk and Resilience Department forwarded 170 incidents for consideration by the Duty of Candour Group, up from 54 in the previous year. Four 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.

(a) A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm").

(b) 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.

Table 2 highlights the number of cases that were referred to the Duty of Candour Group in the last 36 months.

Table 2

Duty of Candour Incidents	2022/23	2023/24	2024/25
Considered	115	54	170
Investigated	0	2	4

There was an increase in incidents considered in 2024/25, rising to 170 from 54 the previous year. Despite the increase in cases considered, the number of incidents formally investigated remained low across all years, peaking at four in 2024/25. This trend may reflect improved identification and reporting processes, while maintaining a high threshold for formal investigation.

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

Table 3

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	0
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.	4

The person required treatment by a registered health professional in order to prevent	Number
The person dying	0
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

Four Incidents met the Duty of Candour Criteria in 2024/25.

All four incidents involved injuries sustained by patients during the course of their care. Each case was thoroughly investigated through the appropriate internal review processes, in line with statutory Duty of Candour requirements.

The Duty of Candour Process was followed for each incident with appropriate action taken for the relevant incident and patient.

1 Review has been delayed due to the availability of staff, an interim report was produced and shared with the patient. A final report will be shared with the patient should the staff member become available.

6.2 What changes are being taken forward following investigation?

At the time of writing the 2024/25 one investigation is still underway and one report was completed as an interim report. From the completed reports, the following learning was recommended:

- Ensure staff are properly trained in the Debrief process and have access to the required materials.
- Ensure staff are supported and encouraged to complete the debrief process and given protected time to do so.
- Engage with staff who require further support when completing and investigating Datix Incidents.
- Develop a process to engage with other services to have a comprehensive understanding of a patients physical health upon arrival at the State Hospital.
- Upskill staff inputting Datix reports with a focus on ensuring all staff involved in the investigation are noted in the Datix.
- When a RIDDOR is recorded, CCTV should be viewed as part of the review process without exception, if available.
- Training need regarding professional boundaries in patient interactions. An investigation has revealed a culture in which staff and patients engage in relationship-building behaviours that, while well-intended, may inadvertently put both parties at risk. The action owner should determine the most effective approach to communicate the importance of maintaining professional boundaries to staff.

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.
- 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.
- Counselling and support services are available via the Occupational Health Service.

8 ADDENDUM

Although national reporting on Duty of Candour does not formally require this step, it has been agreed locally that (as of this reporting year), following completion of the relevant review process for each Duty of Candour incident, the Duty of Candour Group will review the associated investigation report. This is to reflect on whether the Duty of Candour criteria continue to apply. At the time of writing, the redacted investigation reports for the four Duty of Candour incidents have not yet been reviewed by the Group. These findings will be included in the next Duty of Candour Annual Report.

9 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 is report is available on the State Hospital website – www.tsh.scot.nhs.uk/

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

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