Duty of Candour Annual Report

1st April 2024 - 31st March 2025

Duty of Candour 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 Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

In accordance with this duty, NHS Lothian is required to produce an annual report outlining how the Duty of Candour has been applied within its services. This report summarises the operation of the Duty of Candour by NHS Lothian between 1 April 2024 and 31 March 2025.

1. About NHS Lothian

NHS Lothian serves a population of more than 850,000 people living in Edinburgh, East, Mid and West Lothian. The organisation covers a diverse geographical area, including large and small towns as well as some rural areas. NHS Lothian also provides some services for patients in the Borders and in Fife and is a national centre of expertise for certain specialties provided to people across Scotland.

Our aim is to provide high quality care for every person who uses our services, and where possible, help people to receive care at home or in a homely setting.

2. Number and nature of Duty of Candour incidents

Since the last annual report, there have been 33 incidents identified where the duty of candour applied. These are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

NHS Lothian identified these incidents principally through our adverse event management process although these can be highlighted through other routes such as a complaint and would then be reviewed through the adverse event management process.

NHS Lothian review and consider all adverse events where the patient outcome was either moderate or major harm or death for application of Duty of Candour. The inclusion in our review of events where there was moderate harm is used to capture instances which did not result in severe harm, but harm which resulted in one or more of the criteria as set out in the legislation.

Duty of candour incidents are identified through the adverse event review process, which examines factors that may have caused or contributed to the event.

Nature of unexpected or unintended incident where Duty of Candour applies	Number of events identified between 1 April 2024 and 31 March 2025
A person died	10
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	≤5
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	16
Changes to the structure of the person's body	≤5
The shortening of the life expectancy of the person	≤5
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:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	≤5
Total	33

3. To what extent did NHS Lothian follow the duty of candour procedure?

When the events listed above were identified, NHS Lothian correctly followed all steps of the procedure in 27 cases. This included informing the people affected, issuing an organisational apology, inviting participation in the review, and offering to provide feedback on the review outcome. In cases where the full process was not followed, the reasons included: provision of information on the review process without an offer to meet; no evidence of an initial apology; and instances where the matter was addressed through the complaints process, and it was considered inappropriate to re-engage with the patient or family.

Reviews have been commissioned for all of these events, 32 of which have been completed. In all cases, there was a review of what happened, what went wrong and what could have been better and offered to feedback the outcome and learning from the events to the people affected.

In each case, both individual and organisational learning have been considered, with improvement plans developed and either completed or in progress.

Improvement work is ongoing to enhance the reliability of communication processes with patients and families where a significant adverse event has occurred, thereby strengthening compliance with the Duty of Candour process.

4. Information about our policies and procedures

Every adverse event is reported through the local reporting system as set out in the adverse event management policy and associated procedures. Reporting may be retrospective if an adverse event is identified through a claim, complaint, or other means. The adverse event management process enables the identification of incidents that trigger the Duty of Candour procedure. The adverse event management policy includes a section on communicating with patients and families about adverse events, including the implementation of the Duty of Candour where relevant.

Each adverse event is reviewed to understand what happened and how we might improve the care provided in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the adverse event review, and relevant management teams develop improvement plans to meet these recommendations.

Staff have access to information on the intranet via our dedicated duty of candour page and are encouraged to complete the NES Education Scotland Duty of Candour e-learning module, also sign posted through the intranet pages.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction. Additional training and advice are also readily available for those members of staff who frequently review adverse events, and for those who act as key points of contact with people who have been affected by an adverse event.

Adverse events can be distressing for staff as well as people who receive care. Support for staff is available through our line management structure as well as through the following support services:

- Occupational Health Services
- Staff Support & Confidential Counselling Services
- Staff Peer Support Service
- Here 4 U helpline
- Staff Listening Service offered by the Spiritual Care Team

5. What has changed as a result?

Consideration is always given to actions that can be taken to prevent a recurrence of adverse events.

The NHS Lothian Quality Strategy aims to apply a Quality Management System (QMS) across the organisation. This system focuses on four key areas: Quality Planning, Quality Improvement, Quality Control, and Quality Assurance. The aim is to improve processes and systems while learning from past events. A key part of the approach is comprehensive quality planning focussed on improving patient safety and reducing avoidable harm, informed by capturing lessons from adverse events, identifying themes, and implementing improvements through planned programmes of work.

In addition, examples of specific changes following Duty of Candour events are highlighted below:

- A patient received a significant overdose of treatment due to a breakdown in checking patient identification prior to the procedure. Following this, a number of changes have been implemented.

    - Health records now manage the arriving of patients at reception rather than the nurse delivering care
    - The pre-procedure checklist has been updated to include a prompt to ensure identity is checked.
    - A clear escalation process with key contacts for advice is now also displayed within the treatment area.

- As a result of administration of an incorrect drug, causing temporary high blood pressure and tachyarrhythmia in a patient, it has been agreed that pre-diluted syringes of the correct drug be trialled for use over the next 12 months in the relevant theatres.

- As a result of a failure to suspect a possible overdose and failure to act on adverse physiology consistent with suspected toxidrome, the need to consult Toxbase (The UK National Poisons Information Service) was highlighted to all staff; access is available via the ED App, and the Intranet site. The ED observation Ward Standard Operating Procedure (SOP) has also been revised to confirm that patients remain the responsibility of the ED Care Provider when they move to the Observation Ward.

- Following a patient being discharged from hospital with medication that was not prescribed for them and was subsequently readmitted with severe hypercalcaemia the review process for discharging patients from unit has been reviewed and a new check list is in place.

- Due to an incorrect drug calculation which resulted in an overdose to a patient a poster has been designed and displayed in all ward areas which explains availability of alternative, age appropriate, strength morphine and this has been highlighted to all staff.

- Due to the delay in a surveillance appointment which resulted in a patient presenting with cancer which required significant surgery, the process for clinical validation of high-risk patients has been clarified including review of documentation, staffing resource allocated to this pathway and embedding use of functionality on Trak to evidence clinical validation and decision making. Due to known limitation of return slots and demand on service, slots for high-risk patients have been ring fenced to enable review within the appropriate time frame

- As a result of a patient receiving two treatments for several years which contributed to a condition which may have caused a fracture, a SOP for Day Unit prescribing is now in place and text added to GP letters after receiving the IV infusions of the drug to include specific action to GP to stop prescription of the drug orally

6. Other information

Learning continues both locally and nationally to improve the implementation of processes that fulfil the statutory organisational Duty of Candour. For NHS Lothian, priorities continue to be:

- Development of planned programmes of work informed by identified themes from adverse event review to improve patient safety and reduce avoidable harm
- Improving reliability of communication with patients and families at all stages of the review process, including clarity of roles and responsibilities all those involved

As required, Scottish Ministers have been notified that this report has been published on the NHS Lothian website. If you would like more information about this report, please contact us.

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