

# **NHS FORTH VALLEY**

## **Duty of Candour Annual Report**

**1<sup>st</sup> April 2024 to 31<sup>st</sup> March 2025**

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## **DUTY OF CANDOUR REPORT**

All health and social care services in Scotland have an organisational duty of candour. 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 and receive an apology, and that organisations learn how to improve for the future.

The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and revised The Duty of Candour Procedure (Scotland) Regulations 2025 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This report describes how NHS Forth Valley has operated the Duty of Candour during the time between 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025.

### **1. About NHS Forth Valley**

NHS Forth Valley is one of the fourteen regions of NHS Scotland and serves a population of around 306,000. NHS Forth Valley has one acute hospital and Community Hospitals in the Clackmannanshire, Falkirk, and Stirling area. NHS Forth Valley is headquartered in Castle Business Park, Stirling.

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

The Duty of Candour annual report provides detail of all incidents activating organisational Duty of Candour across NHS Forth Valley.

### **2. Information about our policies and procedures**

Every adverse event is reported through our local reporting system as set out in our adverse event policy and associated documents. This may be retrospective if an adverse event is identified through other means. Through our adverse events procedure we can identify adverse events that have activated organisational duty of candour.

Currently NHS FV have a section on the implementation of duty of candour contained within our adverse event policy. To further strengthen our position on the activation and compliance with duty of candour regulations, NHS FV are developing a stand-alone duty of candour policy and associated procedure. This will be finalised within 2025 along with a comprehensive training and awareness package to support implementation.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide 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.

We have developed a Clinical Governance webpage which includes a section on Duty of Candour. This supports our education and offers access to the NHS Education Scotland, TURAS, Duty of Candour module as well as Scottish Government guidance.

All staff are encouraged to complete the NHS Education Scotland Duty of Candour e-learning module as well as training on adverse event management as part of their induction. Additional education and training sessions in the management of adverse events and identification of Duty of Candour will be offered to support our updated duty of candour policy and guidance processes. Education and training sessions to support clinical staff will also be undertaken.

NHS Forth Valley understands that adverse events can be distressing for staff as well as those affected by the event. Support is available for all staff through the line management structure as well as through Occupational Health.

Patients and/or families are allocated a named contact (who is a member of the review team) who provide regular contact with the patient/family to share information and updates on the progress of any adverse event that has been escalated to the SAER level. The contact person has the require skills to respectively disclose sensitive information and answer questions or concerns the patient/family may have.

We are further undertaking delivery of compassionate communication training to support staff to fulfil this important role. This training is to be delivered by CG Staff and will run throughout 2025/2026. Further to this, the NHS Education for Scotland (NES) DoC training module is available to all NHS FV staff via TURAS.

### **3. How many incidents happened to which the Duty of Candour applies?**

The following section of the report describes how many incidents occurred in NHS Forth Valley that activated the duty of candour procedure. Only complete records with a final decision on duty of candour are taken into account in preparing this report. This will include adverse events escalated through the adverse event management process that were both commissioned for SAER and those that did not meet the threshold for commissioning at level 1 and remained a level 2 or level 3 adverse event review.

As adverse event recording and management is a continuous process there will always be a number of records still undergoing management or review where the final duty of candour decision has not yet been made. Therefore, due to the nature and timing of the review process, some events reported during financial year 2024/25 will not receive a final duty of candour decision until financial year 2025/26 and will therefore be included in next year's report.

During the reporting period 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025, there were 15,251 adverse events reported on NHS FV local reporting system. There were 235 adverse events escalated to NHS FV commissioning group as part of the management of adverse events process that were not commissioned for a level 1 SAER review.

There were an additional 18 adverse events escalated that were commissioned, giving a total of 253. Of the 18 commissioned SAERs within NHS FV for the reporting period, we are unable to report confirmed organisational duty of candour status at the time of this years report production on 17. In line with reporting processes these will be captured in next year's annual report. The one concluded SAER for 2024/25 was confirmed organisational duty of candour and is included in Table 1.

For the previous reporting period 2023/24 we had identified 24 reviews that had been commissioned but were not able to be reported on in that year's annual report. Of those 24 reviews, 13 have been completed with a further 11 ongoing. Of the 13 completed SAERs that we were previously unable to report on, 6 (46%) had confirmed organisational Duty of Candour.

These reviews were undertaken when unintended or unexpected incidents, which resulted in harm or death as defined by the Act and they did not relate directly to the natural course of someone's illness or underlying condition(s).

NHS Forth Valley identified these incidents through our adverse event management process.

All reviews were undertaken robustly in accordance with the Scottish Government framework, ensuring communication and engagement with the patient and or relatives to ensure they remained the focus of the review.

We identified, through the adverse and significant adverse events process, if there were factors that may have caused or contributed to the event, which helps to identify Duty of Candour incidents (see Table 1 below).

**Table1: Number of Times Unexpected or Unintended Incidents occurred between 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025 that have confirmed organisational duty of candour from SAERs.**

<b>Type of unexpected or unintended incident (not related to the natural course of someone's illness. or underlying condition(s))</b>	<b>Number of times this has happened (between 1<sup>st</sup> April 2024 and 31<sup>st</sup> March 2025)</b>
A person died	4
A person incurred permanent lessening of bodily, sensory, motor, psychological or intellectual functions	
A person's treatment increased	2
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor, or intellectual functions was impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent.	

Type of unexpected or unintended incident (not related to the natural course of someone's illness. or underlying condition(s))	Number of times this has happened (between 1 <sup>st</sup> April 2024 and 31 <sup>st</sup> March 2025)
them dying	
A person needed health treatment in order to prevent other injuries as above	
<b>TOTAL</b>	<b>7</b>

It should be noted that, for the families of those who died, there is significant associated pain and psychological harm which is not captured in the table above. Our process in NHS Forth Valley ensures families are offered appropriate support if required.

#### **4. To what extent did NHS Forth Valley follow the Duty of Candour procedure?**

NHS Forth Valley followed the Duty of Candour procedure, this means that we informed the people affected, apologised to them, and offered to meet with them. We always offer to share the final report from SAERs with the patient and/or family. In each case, we reviewed what happened, what went wrong and what we could have done better. Individual and organisational learning has been undertaken, and subsequent action and improvement plans have been developed and completed.

#### **5. What has changed as a result?**

NHS Forth Valley has made a number of changes following review of the Duty of Candour events. There are significant changes that we wish to highlight:

- Development of a stand-alone duty of candour policy for NHS FV with associated operational procedure.
- Planned delivery of comprehensive training in relation to the application of duty of candour guidance.
- Improvements within NHS FV adverse event management system (Ulysses Safeguard) to further support activation and confirmation of organisational duty of candour.

#### **6. Other information**

As required, NHS Forth Valley has submitted this report to the Scottish Ministers and has also placed it on our website.

## Appendix 1

The following Forth Valley GP Practices completed Duty of Candour (DoC) annual reports were received by the Medical Director:

Doune Health Centre	0 DoC
Wallace Medical Centre	0 DoC
Tryst Medical Centre	0 DoC
Bo'ness Road Medical Practice	0 DoC
Polmont Park Medical Group	0 DoC
The Practice, Bo'ness	0 DoC
Tor Medical Group	0 DoC