NHS
Greater Glasgow and Clyde

NHSGGC

Duty of Candour Annual Report

2025

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1. Introduction

We are pleased to present the Duty of Candour Annual Report for 2024-2025.
An important part of the Duty of Candour Procedure (Scotland) Regulations 2018 is that NHSGGC provide an annual report about how duty of candour is implemented in our services.

This report describes how NHSGGC has operated the duty of candour during the period 1 April 2024 and 31 March 2025.

2. What is Duty of Candour

NHS Greater Glasgow and Clyde (NHSGGC) is one of 14 regional NHS Boards in Scotland. The Board provides strategic leadership and performance management for the entire local NHS system in the Greater Glasgow and Clyde area and ensures that services are delivered effectively and efficiently. Responsible for the provision and management of the whole range of health services in this area including hospitals and General Practice, NHSGGC works alongside partnership organisations including Local Authorities and the voluntary sector. NHSGGC serves a population of 1.3 million and employs around 41,000 staff – it is the largest NHS organisation in Scotland and one of the largest in the UK.

The statutory duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 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). The Duty of Candour (DoC) legislation became active from the 1st April 2018.

Organisations are required to apologise and to meaningfully involve patients and families in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen.

The statutory organisational duty of candour has been developed to be in close alignment with the requirements of the professional duty of candour.
Duty of Candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short- and long-term effects of what has happened.

The organisation records and reviews whenever the patient or family was not informed to ensure NHSGGC fully meet the policy principles.
Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest and not stop someone from raising concerns. The legislation requires that NHSGGC must also publish a Duty of Candour annual report.

NHSGGC identify through several different processes such as significant adverse event reviews or complaints if there were factors that may have caused or contributed to an unintended incident, which helps identify duty of candour incidents. There can be delays however in completing the reviews which means there may be more duty of candour incidents which are not able to be reported at this time.

There have been additional codes added to the electronic incident reporting system (Datix) to allow an annual report to be created for Duty of Candour events. The compliance with Duty of Candour is monitored via the Clinical Risk reports that are submitted to the Acute; Mental Health and Partnership Clinical Governance Forums.

3. How many incidents happened to which Duty of Candour applies

At the time of writing this report, 24 incidents were identified which triggered Duty of Candour which were reported in the period 1st April 2024 and 31st March 2025. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

It is recognised that investigations are still ongoing when this report is produced, and until reviews are concluded, it is not possible to determine if events are duty of candour.

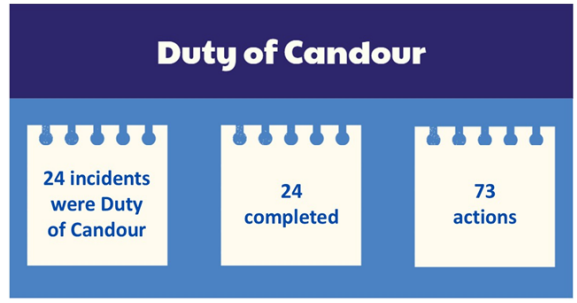
A breakdown of the 24 incidents identified at this stage is provided below.

Type of unexpected or unintended incident	Number of times this happened
A person's treatment increased	14
A person needing health treatment in order to prevent other injuries	5
A person died	3
A permanent Lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A person's sensory, motor or intellectual functions was impaired for 28 days or more	1
Total	**24**

4. To what extent did NHSGGC follow DoC procedures?

A Significant Adverse Event Review (SAER) has been commissioned for 15 Duty of Candour events. A Local Adverse Event Review (LAER) has been commissioned for 7 DoC events and the procedure for 2 events was concluded through the complaints process. At the time of writing, all 24 reviews have been concluded.

The 24 completed reviews have generated 73 actions. The diagram below summarises the progress of SAE investigations for Duty of Candour incidents to date.



The 24 events that have concluded were assessed for compliance with the following elements of the regulations.

- Apology given
- Patient or Relative informed of the review
- Patient or Relative invited to participate in review
- Patient or Relative informed of the results of the review

23	22	20	22
Patients / Families were given an apology	Patients / Families were informed of review	Patients / Families were asked to contribute to the review	Patients / Families were given the results of the review
• 1 unable to contact family	• we complied with Duty of Candour for these 2 events	• 1 patient declined • 1 unable to contact family • 2 patients / families questions reviewed as part of complaints process	• 1 patient / relative requested not to have any contact • 1 unable to contact the family

5. Information about our policies and procedures

The Board maintains a policy on Duty of Candour which is informed by the requirements set out in The Duty of Candour procedure, and regulations in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) implemented in April 2018.

The NHSGGC Duty of Candour Policy was due for review in September 2024. However, due to the imminent release of the updated Healthcare Improvement Scotland (HIS) National Framework for Reviewing and Learning from Adverse Events in NHS Scotland, the ongoing work to review the NHSGGC Policy on the Management of Significant Adverse Events, and the updated Scottish Government Organisational Duty of Candour guidance which was published in March 2025, an extension was applied to allow any changes or recommendations to be included in the review and update of the policy and toolkit.

6. Duty of Candour update 2023/24

Updated figures for 2023/2024

At the time of writing this report, the data for 2023/24 was re-run to close off this period and identified 97 incidents which triggered Duty of Candour. The 97 completed investigations were assessed for compliance with the regulations, which identified:

- 95 patients/families received an apology. In 1 case the patient had no contact with their family and in 1 case there was a process issue
- 95 patients/families were involved in the investigation. In 1 case the patient had no contact with their family and in 1 case there was a process issue
- The report was shared with 91 patients/families and reasons for not sharing were in 2 cases the patient/relative requested not to have any contact and had no contact with family; in 2 cases it was a process issue. In 1 case service were unable to contact family and in 1 case the patient subsequently passed away

A breakdown of the 97 incidents is presented below:

Type of unexpected or unintended incident	Number of times this happened
A person's treatment increased	51
A person died	18
A person needing health treatment in order to prevent other injuries	14
A person experienced pain or psychological harm for 28 days or more	4
The structure of a person's body changed	3
A person's sensory, motor or intellectual functions was impaired for 28 days or more	3
A person's life expectancy shortened	2
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
A person experiences pain or psychological harm for a period of at least 28 days	1
Total	**97**

The 97 incidents generated 450 actions generated, of which 380 were closed at the time of reporting.

7. What has changed as a result?

There have been a number of changes following the reviews of the duty of candour events. The list below highlights a selection of learning being applied to improve care:

- Registered Mental Health Nurse and Healthcare support worker provision is now in place for RAH site wide 24 hours per day, 7 days per week. Requests are made via the Lead Nurse of the Day and Chief Nurse (Out of Hours via on call manager)
- A Mental Health, short life working group was formed to review the current Mental Health proforma/triage tool, identify any areas of improvement such as level of patient observation, need for repeat assessment and develop robust Mental Health triage patient and family communication information
- Audits are being carried out in a number of wards across Clyde Sector to evidence staff understanding of 4AT. 4AT is a quick assessment, four-item test used to screen for delirium and cognitive impairment
- There has been an addition of a verbal handover of any accountable items in-situ and of room swab count, at time of surgical pause in Maternity theatres across NHSGGC

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