

NHS Greater Glasgow and Clyde	Paper No. 26/145
Meeting:	NHSGGC Board Meeting
Meeting Date:	29 October 2026
Title:	NHSGGC Duty of Candour Annual Report 2025-26
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1. Purpose

The attached NHSGGC Duty of Candour Annual Report for 2025-26 is presented to the Board for approval, publication on the NHSGGC website, and notification to the Scottish Government.

2. Executive Summary

This report explains how NHSGGC implemented its statutory Duty of Candour between 1 April 2025 and 31 March 2026, ensuring people affected by unintended harm are informed, apologised to and involved in reviews. It identified 213 qualifying reviews with good procedural compliance.

The report also provides an update on associated policies and procedures, staff training and support, learning, and actions to strengthen reporting, oversight, patient and family engagement, and continuous improvement.

3. Recommendations

The NHSGGC Board are asked to approve the report for publication on the NHSGGC website, and notification to the Scottish Government.

4. Response Required

This paper is presented for **Approval**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- | | |
|------------------------------------|------------------------|
| • Improve Outcomes for People | <u>Positive</u> impact |
| • Health Quality Care & Experience | <u>Positive</u> impact |
| • Digital First Approach | <u>Positive</u> impact |
| • Sustainability and Value | <u>Neutral</u> impact |
| • Supported Workforce | <u>Positive</u> impact |

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity

- Boardwide Clinical Governance Forum
- Corporate Management Team
- Clinical and Care Governance Committee

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

- Boardwide Clinical Governance Forum
- Corporate Management Team
- Clinical and Care Governance Committee

8. Date Prepared & Issued

Paper prepared on: 12 October 2026

Paper issued on: 21 October 2026



NHSGGC

Duty of Candour Annual Report 2025-26

Contents

Contents

Contents	2
1. Introduction	3
2. What is Duty of Candour	4
3. About NHS Greater Glasgow and Clyde	4
4. Our Policies and procedures	5
4.1 NHSGGC Duty of Candour Policy	5
4.2 How we identify and report Duty of Candour events	6
4.3 Staff Support	6
4.4 Training	7
4.5 Learning	7
5. How many incidents happened to which Duty of Candour applies	8
6. The nature of incidents to which Duty of Candour applies	8
7. To what extent did NHSGGC follow DoC procedures?	9
8. Examples of Improvements	10
8.1 Paracetamol Prescribing and Administration	10
8.2 Repeated Contacts in Mental Health Services	10
8.3 A Complex Care Protocol, ...	11
9. How are we embedding the Duty	11
9.1 Prospective tracking system	11
9.2 Updates to our StaffNet pages	12
9.3 Engagement with patients and families	12
9.4 Oversight of action completion and learning	12
9.5 Learning System	12
Appendix 1: Summary of Duty of Candour Incidents and Type	14

1. Introduction

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 unintended or unexpected incidents occur that result in (or could result in) death or harm, the people affected are informed, receive an apology, and the organisation reviews what happened and learns how to improve for the future.

An important part of this duty is that we provide an annual report about how the organisational duty of candour has been implemented in our services.

This report describes how NHS Greater Glasgow and Clyde (NHSGGC) has operated the organisational duty of candour requirements during the period 1 April 2025 and 31 March 2026.

As this report continues to evolve, we aim to:

- demonstrate learning which has taken place
- provide assurance that the duty of candour is being embedded
- to self-reflect on how the duty is being embedded and how we can continually improve the operation of the duty.



2. What is Duty of Candour

The organisational duty of candour is set out in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and associated Duty of Candour Procedure Regulations. It applies to organisations providing health services, care services and social work services in Scotland.

Within NHSGGC, the organisational duty of candour is embedded within our clinical governance and adverse event management arrangements. It operates alongside the professional duty of candour applicable to individual healthcare professionals.

3. About NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde is the largest territorial NHS Board in Scotland, providing a wide range of acute and community health services to a diverse population across Glasgow and surrounding areas. We work with partners across Health and Social Care Partnerships to deliver safe, effective, person-centred care.

Our approach to quality and safety is underpinned by a culture of openness, learning and continuous improvement. Duty of candour is an important component of this, supporting compassionate communication with people affected by adverse events and strengthening our systems for learning and improvement.



4. Our Policies and procedures

4.1 NHSGGC Duty of Candour Policy

The aim of the NHS Greater Glasgow & Clyde (NHSGGC) Duty of Candour Policy is to ensure that people affected by any unintended or unexpected incident are treated with openness, honesty and compassion.

The policy applies to all staff in NHSGGC, in all services and in all settings. All staff can become aware of harm and have a responsibility to be aware of the legal duty in relation to Duty of Candour.

The purpose of our Duty of Candour policy is to:

- Improve the support, timeliness, quality and consistency of communication with relevant persons when an unexpected or unintended incident occurs so that they:
 - receive prompt information to enable them to understand what happened
 - receive a meaningful apology (defined as a sincere expression of sorrow or regret)
 - are informed of the action the Health Board or Health and Social Care Partnerships (HSCPs) will take to try and ensure that a similar incident does not recur
- Create the environment where staff are open about what happened and discuss incidents promptly, fully and compassionately with relevant persons to:
 - help maintain trust and confidence necessary for an effective therapeutic relationship
 - help relevant persons cope better with the after-effects
 - promote a thorough review into the incident including the relevant person's perspective
 - provide relevant persons with assurance that lessons learned will be implemented to help prevent a similar type of incident
 - provide an environment where relevant persons, healthcare professionals and managers feel supported when things go wrong
- Provide clear information to staff on what they should do when they are involved in an incident and the support available to them, as well as how to communicate effectively

Our Duty of Candour policy was updated in 2025 in line with updated Scottish Government Guidance, and our updated Policy for Managing Significant Adverse Events.

This year, we created a separate operational procedure to compliment the policy. It provides further detail on the methodology and specific processes which should be followed.

We also reviewed the Duty of Candour Toolkit. This contains templates, guidance and further information, which we review, evaluate and update on an ongoing basis. We also created a quick guide to Duty of Candour to add to the toolkit.

4.2 How we identify and report Duty of Candour events

The Duty of Candour regulations outline that organisations must carry out a review of the circumstances which they consider led, or contributed to, the unintended or unexpected incident.

Within NHSGGC, Duty of Candour events are classed as Significant Adverse Events (SAE). In 2025 we updated our Policy for Managing Significant Adverse Events to align with the updated Healthcare Improvement Scotland (HIS) national framework. Our updated policy formalised 3 levels of adverse event review within NHSGGC, and well as the formation of Adverse Event Oversight Groups (AEOGs) to provide enhanced evaluation and monitoring.

The Duty of Candour legislation does not specify the manner in which the review is undertaken, but in NHSGGC it is likely that this will be a Level 1 Significant Adverse Event review (SAER) or a Level 2 Local Adverse Event Review (LAER).

Regardless of the type of review undertaken, we aim to ensure that the procedure is followed and recorded, and is triggered as soon as we become aware of the event - within our Significant Adverse Event Briefing Note we ask questions about Duty of Candour to help identify events that trigger the requirements as soon as possible in the review process.

4.3 Staff Support

NHSGGC aims to create an environment in which all staff feel encouraged to report incidents and are supported throughout the review process.

The NHSGGC Policy, Procedure and Toolkit for managing significant adverse events includes:

- a leaflet for staff explaining the SAE process
- a leaflet for managers on how to support staff
- a reflective exercise template to help learning from the incident

Staff are encouraged to seek support from Occupational Health, and Local Management Teams are asked to consider incident debriefs, clinical supervision and peer support.

Staff are also encouraged to seek help from their relevant professional bodies. Counselling services are available to all NHSGGC employees.

4.4 Training

It is very important that staff are fully aware of the regulations and the NHSGGC Duty of Candour Policy.

It is acknowledged that clinical staff currently have a responsibility to ensure a professional duty of candour (generally being open and honest with patients regarding their care) and will already have a level of competence and understanding which will facilitate implementation of this legislative Duty of Candour Policy.

For those staff who require additional training and support, particularly with the interpersonal aspects of Duty of Candour Policy implementation, there are a range of programmes in place.

Clinical leads/managers assess training requirements for particular roles. These can be added to the relevant programme / module for Role Specific Induction, or refresher training as deemed appropriate. As a minimum it is expected that the Duty of candour Turas LearnPro module is added to mandatory training every 3 years for role specific staff.

In addition, the requirements of the Duty of Candour regulations are embedded in existing relevant policy based programmes, for example SAER Reviewer training and People Management programmes.

To support staff to understand the Duty of Candour legislation, we direct staff to the NHS Education Scotland online course which is available through LearnPro.

15 staff completed this course between April 2025 and March 2026.

4.5 Learning

In line with our SAER process, NHSGGC expect that where there are system of care issues that contributed to an event a learning summary is developed (investigation outcome 3 and 4). NHSGGC uses the Healthcare Improvement Scotland (HIS) template for sharing learning nationally.

We will enhance information on learning from Duty of Candour events in future reports.

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

At the time of writing this report in June 2026, **213** incidents were identified that activated the organisational duty of candour between 1st April 2025 and 31st March 2026

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.

Of the 213 events :

- 1 was reviewed through the complaints process*
- 98 were reviewed as a local adverse event review
- 114 were reviewed as a significant adverse event review

** The family raised a number of concerns regarding the care provided through the complaints process of which 2 issues should have been logged on Datix as incidents – one relating to a medication incident, the other relating to a delay accessing a clinic. An apology was provided within the complaint response. the family were informed that a review would take place and received a formal response addressing their questions, meeting the basic requirements of the process.*

6. The nature of incidents to which Duty of Candour applies

Appendix 1 provides detail on the nature of the 213 incidents to which Duty of Candour applies.

The top 3 incident categories are:

- Treatment problem (38)
- Slips, trips and Falls (50)
- Medication Incident (30)

The top duty of candour type is an increase in treatment (90 events) followed by death (40 events).

7. To what extent did NHSGGC follow DoC procedures?

At the time of writing this report in June 2026, 164 reviews have concluded. These show good compliance with the procedure. Where the procedure has not been followed valid reasons have been provided.



***Legal proceeding:** This event concerns a patient who was taken into custody after an assault. The *Central Legal Office* advised that due to ongoing legal proceedings at the time of the review it was not appropriate to contact family or patient as any information obtained may prejudice the ongoing legal case.

We will produce and publish an Addendum report later in the year, to include details of any additional organisational duty of candour procedures, as well as those not yet concluded at the time of the initial annual report.

8. Examples of Improvements

In line with our SAER Policy and approach, actions generated from closed reviews are tracked until completion. 602 actions were generated from the closed Duty of Candour event reviews.

221(37%) have been completed by the time of writing this report.

Significant Adverse Event Reviews have directly informed revisions to policies and standard operating procedures across NHSGGC. Key improvements have included strengthened medication safety processes, particularly in relation to weight-based prescribing, enhanced complex care protocols, clearer escalation pathways, and improved documentation standards. These changes are formally tracked through governance structures, with ongoing audit and monitoring to ensure effective implementation and sustained improvement.

A small selection of improvements are provided below.

8.1 Paracetamol Prescribing and Administration

A number of significant adverse events have highlighted that patient weight was not taken into account when prescribing and administering paracetamol.

In response, mitigation measures have been introduced within the electronic prescribing system. The default dose for paracetamol and paracetamol-containing products has been removed. Prescribers are now required to actively enter a dose rather than relying on a pre-populated standard. In addition, a “Pause for Paracetamol” initiative has been introduced, supported by a poster to reinforce safe practice.



8.2 Repeated Contacts in Mental Health Services

A process has been implemented to ensure that repeated contacts or escalating concerns trigger timely clinical review, supporting patient safety and service quality. Individuals who contact the service more than once within a 24-hour period, or present with significant changes in risk or mental state, are promptly acknowledged and their current care plan reviewed against presenting concerns. Where required,

cases are escalated for multidisciplinary discussion, including senior clinical input for complex or high-risk situations. All reviews are clearly documented, including the rationale for decisions, whether the care plan remains appropriate or requires amendment, with agreed actions, responsibilities, and timescales recorded. Outcomes are communicated to the individual and, where appropriate, their carers, alongside clear guidance on next steps. Ongoing monitoring arrangements include agreed review timeframes and regular audit to ensure compliance with documentation and review standards.

8.3 A Complex Care Protocol

A Complex Care Protocol has been implemented across all health visitor and school nursing services. All Health Visitors and school nurses have received training and LearnPro module available. Child with Complex Care is captured as part of Caseload management discussions. This has been a theme although small CP numbers if that makes sense, basically it's about having a lead to coordinate care, thanks

9. How are we embedding the Duty

We continue to review and enhance our systems and processes for Duty of Candour

9.1 Prospective tracking system

We recognised that the current data collection and reporting approach could lead to delays in identifying incidents that trigger Duty of Candour (we currently use the briefing note and SAER/LAER report template to check compliance) There can also be significant changes in the number of incidents that trigger Duty of Candour throughout the year, and we found occasions where it was identified at the end of the SAER/LAER that the requirements of the act have not been met, causing delays in completing the review.

We have developed a prospective data collection process which went live on 1st April 2026 which will support services to monitor the requirements of the act in real time, reduce data lags, and improve efficiency of reporting. Questions will be added to Datix (our Incident Management System) to record compliance with the act in real time, which will be monitored by the Local Adverse Event Oversight Groups.

As this process embeds, Clinical Risk will maintain their current monitoring and reporting process to ensure quality and completeness of data.

9.2 Updates to our StaffNet pages

The SAER policy section of the Clinical Governance Support Unit (CGSU) Staffnet pages has been redesigned to enhance access to key documents and guidance, including a specific section on staff support.

9.3 Engagement with patients and families

Information leaflets outlining the review process and incorporating QR codes enable feedback from patients, families and staff to inform service improvement.

Work is planned for 2026/27 to further strengthen feedback mechanisms, ensuring insights are systematically captured, analyzed, and used to enhance the quality and transparency of the review process.

9.4 Oversight of action completion and learning

The recently formed Local Adverse Event Oversight Groups have a key role to agree actions required, ensuring actions are appropriate and proportionate; and monitor completion of actions and sharing of learning.

We have also enhanced oversight of open actions through the SAER Dashboard to support oversight, which includes live data on the status of open actions, and visibility of overdue actions.

9.5 Learning System

NHSGGGC aspires to be a learning organisation—one that intentionally learns from when things go wrong and uses those insights to drive improvement.

A central objective of the Year 2 Quality Strategy plan is to develop a NHSGGGC Learning System, which aims to accelerate and strengthen organisational learning, improve safety, and enhance the sharing of insights across services.

We will use this system to enhance our learning about Duty of Candour events.

Appendix 1: Summary of Duty of Candour Incidents and Type

Incident Category	Duty of Candour Type										Grand Total
	A person died	A person experienced pain or psychological harm for 28 days or more	A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	A person needed health treatment in order to prevent them dying	A person needing health treatment in order to prevent other harm as listed	A person's life expectancy shortened	A person's sensory, motor or intellectual functions was impaired for 28 days or more	A person's treatment increased	The structure of a person's body changed	Not Recorded at Time of Report	
2222 Crash Call/Cardiac Arrest	5	0	0	0	3	0	0	4	0	0	12
Abscondment/Missing	0	0	0	0	0	0	0	0	2	0	2
Communication	0	1	0	0	0	1	0	3	0	0	5
Diet Inappropriate	0	0	0	0	0	0	0	1	0	0	1
Discharge or Transfer Problem	1	0	0	0	0	0	0	1	0	0	2
Health Records - General	0	0	0	0	0	0	0	1	0	0	1
Health Records - Scanning Issues	0	1	0	0	0	0	0	0	0	0	1
Infection Control	1	0	0	0	0	0	0	5	0	1	7
Laboratory/Specimen	0	1	0	0	1	0	0	0	0	1	3
Medical Devices/Equipment	1	0	0	0	4	0	0	0	0	0	5
Medication Incident (All Categories)	1	0	0	1	9	0	1	15	0	3	30
Moving and Handling	0	0	0	0	0	0	1	0	0	0	1
Neonatology	0	0	0	0	1	0	0	0	0	0	1
Other Incidents	12	1	0	0	3	0	1	3	0	0	20
Patient Observations	0	0	0	0	0	0	0	2	0	1	3
Pressure Ulcer Care	2	0	0	0	0	0	0	10	0	0	12
Radiation/Imaging Incident	1	0	0	0	0	0	0	1	0	0	2

Incident Category	Duty of Candour Type										Grand Total
	A person died	A person experienced pain or psychological harm for 28 days or more	A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	A person needed health treatment in order to prevent them dying	A person needing health treatment in order to prevent other harm as listed	A person's life expectancy shortened	A person's sensory, motor or intellectual functions was impaired for 28 days or more	A person's treatment increased	The structure of a person's body changed	Not Recorded at Time of Report	
Slips, Trips and Falls	4	6	1	0	6	0	3	28	2	0	50
Suicide	6	0	0	0	0	0	0	0	0	0	6
Theatre Processes	0	0	0	0	1	0	0	3	0	1	5
Transfusion Incidents	0	0	0	0	1	0	0	0	0	0	1
Treatment Problem	5	4	2	0	6	0	2	12	2	5	38
Venous Thrombosis (Health Care Associated)	0	0	0	0	0	0	0	1	0	0	1
Violence and Aggression	1	1	0	0	0	0	0	0	1	0	3
Total	40	15	3	1	35	1	8	90	7	12	212

This table summarises the 212 incidents reviewed through the Local Adverse Event Review or Significant Adverse Event Review processes. It does not include the additional event reviewed through the complaints process, which is included in the overall total of 213 Duty of Candour events reported above.