

NHS Greater Glasgow and Clyde	Paper No. 26/47
Meeting:	NHSGGC Board
Meeting Date:	30 April 2026
Title:	NHSGGC Duty of Candour Annual Report Addendums: 2023-24 and 2024-25
Sponsoring Director:	Dr Scott Davidson, Executive Medical Director
Report Author:	Ms Paula Spaven, Director of Clinical and Care Governance Professor Colin McKay, Deputy Medical Director, Corporate

1. Purpose

The NHSGGC Duty of Candour Annual Report Addendums for 2023-24 and 2024-25 are presented to the Board for approval.

2. Executive Summary

Each year NHSGGC provides an annual report about how the Board has operated the Duty of Candour (DoC) during the year. The annual report is approved at the Board in October and published on the NHSGGC Website.

It is outlined in the annual report that an Addendum will be produced and published 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.

The Addendum reports provide updated figures and information.

There will be further work to review the content and presentation of the Duty of Candour Annual Report and Addendum for 2025-26, in line with the recently updated Scottish Governance Guidance and feedback. This will enhance information on how we have operated the procedure, what we have learnt, training and support to staff, and how we have provided support to relevant persons.

There is also ongoing work to

- allow DoC incidents to be identified and recorded prospectively rather than at the end of the review process.
- reinforce the role of LAEOGs in providing assurance of completion of the DoC requirement.

3. Recommendations

Members are asked to approve the reports for publication.

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:

- | | |
|------------------------|------------------------|
| • Better Health | <u>Neutral</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Neutral</u> impact |
| • Better Workplace | <u>Neutral</u> impact |
| • Equality & Diversity | <u>Neutral</u> impact |
| • Environment | <u>Neutral</u> impact |

6. Engagement & Communications

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

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

7. Governance Route

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

- NHSGGC Boardwide Clinical Governance Forum: 8th December 2025 - endorsed.
- NHSGGC Corporate Management Team: 23rd February 2026 – endorsed.
- NHSGGC Clinical and Care Governance Committee: 5th March 2026 - endorsed.

8. Date Prepared & Issued

Prepared on: 2 April 2026
Issued on: 22 April 2026



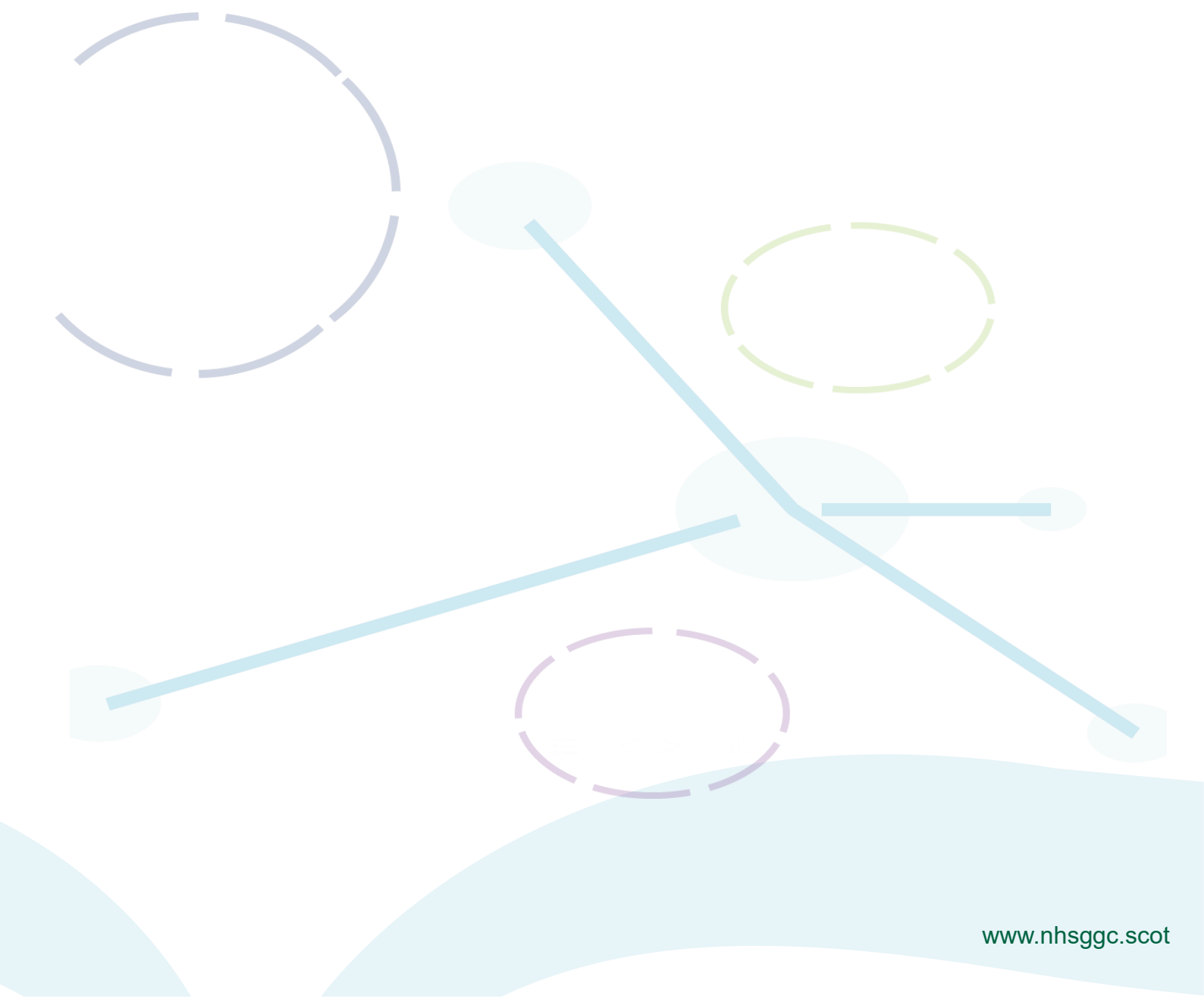
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Organisational Duty of Candour – Addendum Report 2023/2024

April 2026

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1. Introduction

As reported in the Organisational Duty of Candour Annual Report **01 April 2023 and 31 March 2024**, there were some delays in the completion process of some reports, due to delays in commissioning, complex reviews and clinical capacity.

As a result, it was agreed and outlined, in our Organisational Duty of Candour Annual Report **2023/2024**, that this Addendum would be produced and published. It includes details of any additional organisational duty of candour procedures as well as those not yet concluded.

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

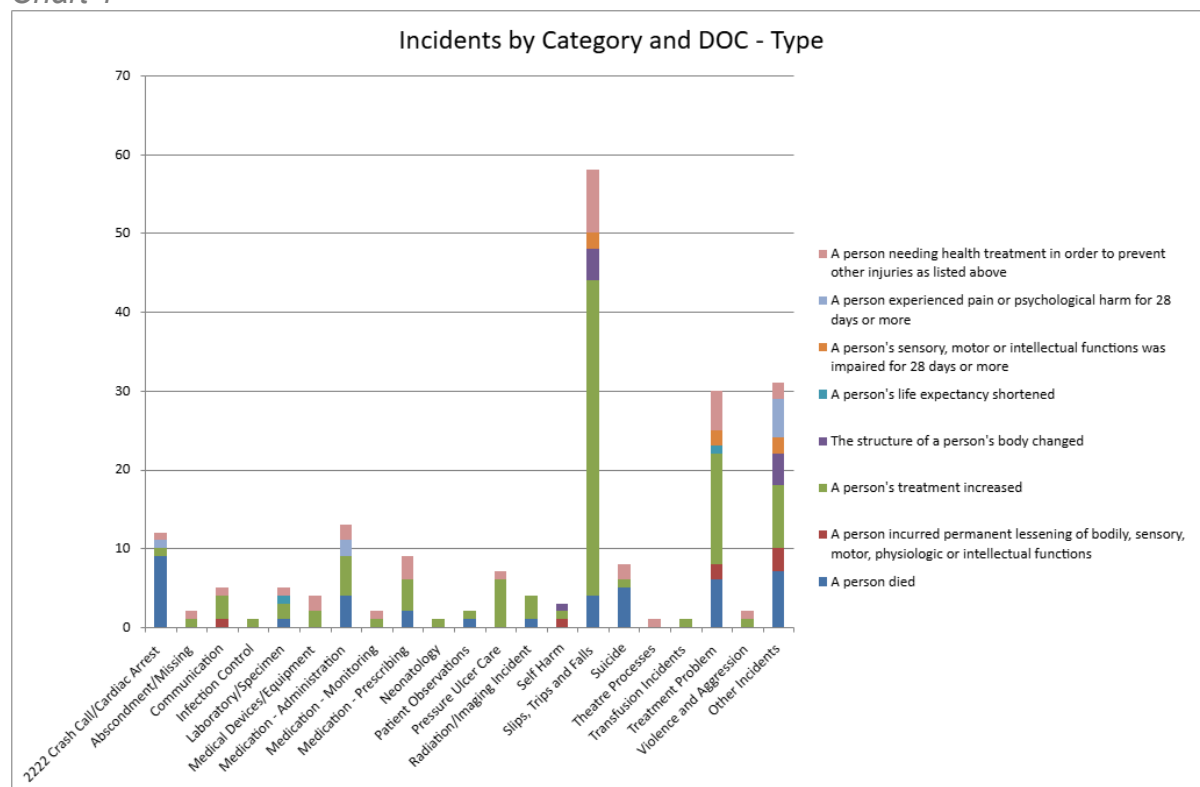
By **November 2025** the figures increased from the **12** reported to a total of **201** incidents between **01 April 2023 and 31 March 2024**. **201** of these procedures are complete and the types of incidents are listed in the table below. Type of unexpected or unintended incident.

Number of instances: 201

Table 1

Incident Type	Number of Incidents
Someone has died	39
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	7
Someone's treatment has increased because of harm	97
The structure of someone's body changes because of harm	9
Someone's life expectancy becomes shorter because of harm	2
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	6
Someone experienced pain or psychological harm for 28 days or more	8
A person needed health treatment to prevent them dying	0
A person needing health treatment to prevent other injuries	32
A healthcare infection incident was acquired during treatment	1

Chart 1



3. To what extent did NHSGGC follow the Duty of Candour procedures?

The 201 completed investigations were assessed to ensure that an apology was provided, patients and/or relatives were informed and invited to participate in the review, and copies of the final report were shared.

In 195 cases, patients or families received an apology. In four cases, the patient or family could not be contacted; one patient had no contact with family, and in one case, disclosure was deemed potentially harmful to the patient.

186 patients or families were involved in the investigation. In two cases, it was considered that involvement would cause further harm; in two cases, a clinical decision was made not to involve the family due to the time elapsed since the event. In one case, there were ongoing legal proceedings, and in eight cases, the team were unable to contact the family. Two patients or relatives requested no contact.

The report was shared with 186 patients or families. In two cases, disclosure was deemed potentially harmful, and three patients had subsequently passed away. Four patients or relatives requested no contact, and in six cases, the team were unable to make contact.

4. Learning from Duty of Candour Events

There were 907 actions generated from the 201 Duty of Candour events. At the time of reporting, 66% (596) of these have been closed.

- A template on Emis has been introduced to assist staff to record decision surrounding observation levels.
- All psychiatric hospitals undertaking environmental risk assessments to reduce ligature risk.
- High strength Alfentanil was removed from routine wards in Acute Service.



This report includes only a small sample of learning from Duty of Candour events. Learning summaries are produced for events where there are system of care issues that contributed to the event (investigation outcome 3 and 4), which are shared through relevant clinical governance structures. The Board Annual Clinical Governance Report also includes consideration of learning.

There is ongoing work to develop a learning system in NHSGGC which will accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.



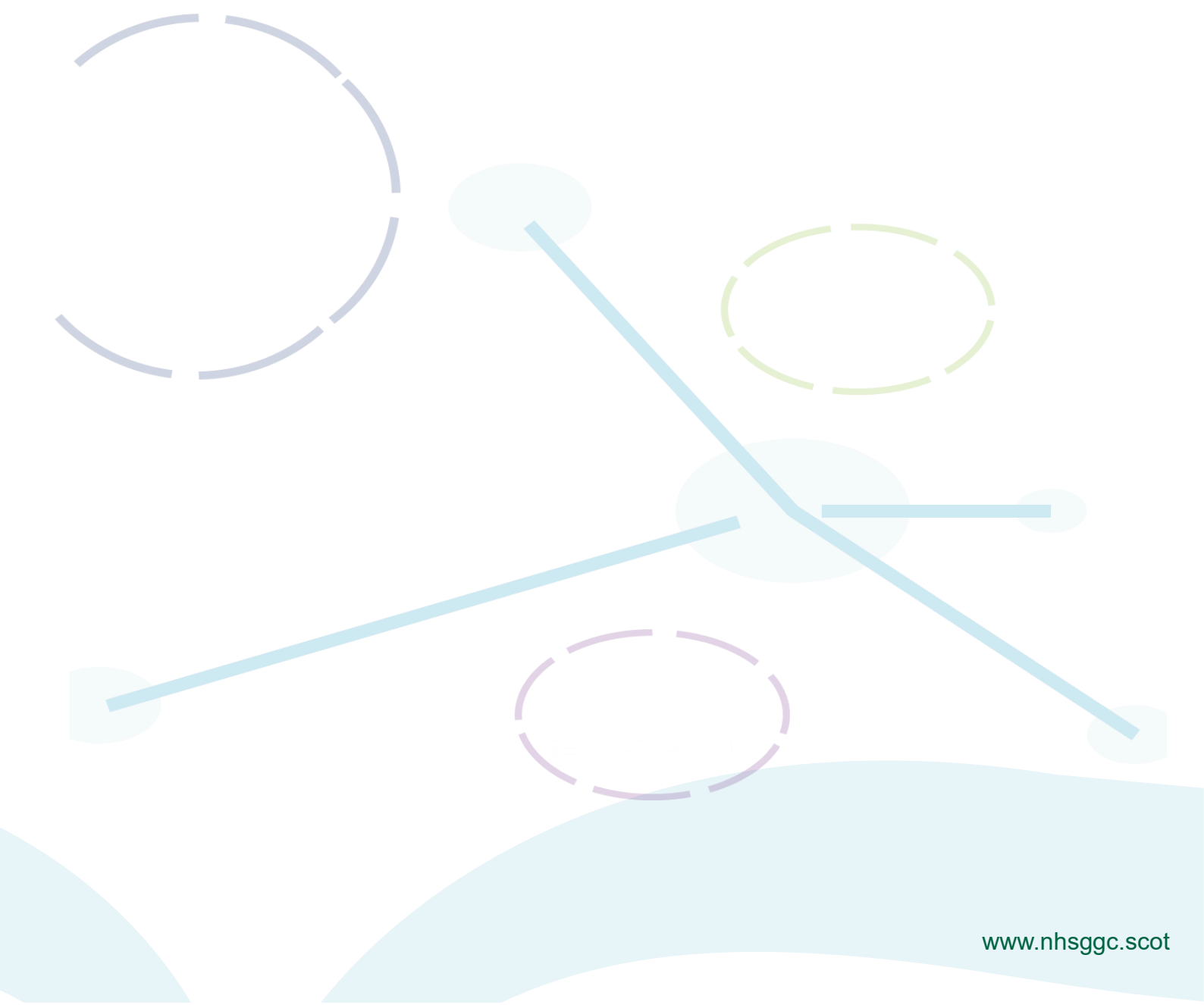
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Organisational Duty of Candour - Addendum 2024/2025

April 2026

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1. Introduction

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As a result, it was agreed and outlined, in our Organisational Duty of Candour Annual Report **2024/2025**, that this Addendum would be produced and published. It includes details of any additional organisational duty of candour procedures as well as those not yet concluded.

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

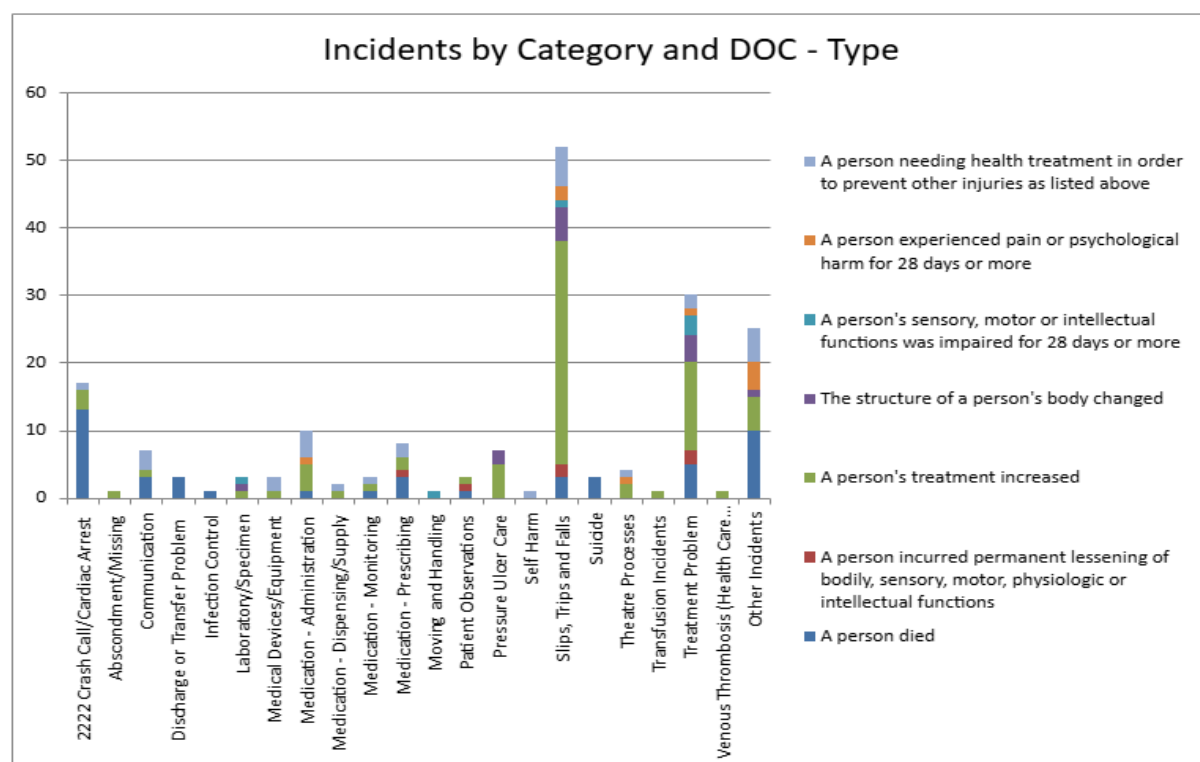
By **November 2025** the figures increased from the **24** reported to a total of **188** incidents between **01 April 2024 and 31 March 2025**. **188** of these procedures are complete and the types of incidents are listed in the table below. Type of unexpected or unintended incident

Number of instances: 188

Table 1

Incident Type	Number of Incidents
Someone has died	46
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	6
Someone's treatment has increased because of harm	78
The structure of someone's body changes because of harm	13
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	6
Someone experienced pain or psychological harm for 28 days or more	9
A person needed health treatment to prevent them dying	0
A person needing health treatment to prevent other injuries	29
A healthcare infection incident was acquired during treatment	1

Chart 1



3. To what extent did NHSGGC follow the Duty of Candour procedures?

The 188 completed investigations were assessed to ensure an apology was provided, patients and/or relatives were informed and invited to participate in the review and copies of the final report were shared.

182 patients/families received an apology. In one case there was a clinical decision made to not involve patients/ families in the investigation, in four the team were unable to contact the family and one patient had no contact with family members.

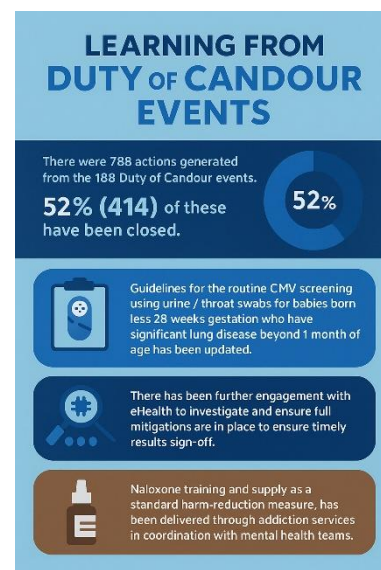
176 patients/families were involved in the investigation. Two patients declined and in three it was considered that involvement was likely to cause further harm. In one case there was a clinical decision made not to involve the family, one patient had no contact with family members and in five cases the team were unable to contact the family.

The report was shared with 174 patients/families. In two cases there was a clinical decision made not to involve the family, in one case disclosure was deemed potentially harmful. One patient had no contact with family, one subsequently passed away three patients requested no further contact and six were unable to be contacted.

4. Learning from Duty of Candour Events

There were 788 actions generated from the 188 Duty of Candour events. 52% (414) of these have been closed.

- Guidelines for the routine CMV (Cytomegalovirus) screening using urine / throat swabs for babies born less 28 weeks gestation who have significant lung disease beyond 1 month of age has been updated.
- There has been further engagement with eHealth to investigate and ensure full mitigations are in place to ensure timely results sign-off.
- Naloxone training and supply as a standard harm-reduction measure, has been delivered through addiction services in coordination with mental health teams.



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