

NHS Dumfries and Galloway



Meeting:	Healthcare Governance Committee
Meeting date:	October 2025
Title:	Duty of Candour Annual Report
Responsible Executive/Non-Executive:	Ken Donaldson, Executive Medical Director
Report Author:	Maureen Stevenson, Patient Safety & Improvement Manager

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- quality of clinical care drives decision-making about the provision, organisation and management of services within NHS Dumfries and Galloway
- the planning and delivery of services takes full account of the perspective of patients, carers and families
- care delivered within NHS Dumfries and Galloway meets relevant standards
- the quality and safety of care provided to patients is monitored effectively
- the NHS locally learns, and applies the lessons learned, from patient feedback (including complaints) and adverse incidents
- the lessons learned from investigations in other NHS organisations are examined and applied appropriately

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

Please select the level of assurance you feel this report provides to the board/committee and briefly explain why:

- This paper provides **Significant assurance** that NHS Dumfries & Galloway have appropriately applied Duty of Candour Legislation

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From the list below, please select which Board Priority this paper relates to. If none of the priorities suit, please select other and briefly explain why this paper needs to be reviewed at Board/Committee:

Quality & Safety

Comment:

The Duty of Candour Annual Report provides assurance that NHS Dumfries & Galloway have appropriately and reliably applied Duty of Candour as per the legislation and updated guidance received in April 2025.

2 Report summary

2.1 Situation

The Board is required to produce and publish on our website a Duty of Candour Annual Report.

Duty of Candour is an integral part of our Adverse Event Framework and procedures.

In the last year, there were 3 incidents closed where the Organisational Duty of Candour procedure was confirmed to apply.

2.2 Background

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them 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 duty of candour procedure provisions reflect our commitment to place people at the heart of health and social care services in Scotland.

2.3 Assessment

Significant progress has been made in ensuring that all aspects of Duty of Candour are completed once a decision has been made that it applies.

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All 4 of the Duty of Candour actions were completed in each of the above cases, meaning that we are fully compliant with the act.

3 cases, investigated as Significant Adverse Event Reviews closed in 24/25 were confirmed by Patient Safety Group to have Duty of Candour applied.

2.3.1 Quality/ Patient Care

Duty of Candour applies where the quality of patient care has fallen below that we would expect.

2.3.2 Workforce

Staff wellbeing is an integral component of our approach to Quality, Patient Safety & Risk. Staff involved in SAERs where Duty of Candour has been deemed to apply may be impacted as second victims. Staff are supported to work through these issues

2.3.3 Financial

Not directly assessed in year however should the affected persons or their families seek financial redress claims can be significant.

2.3.4 Risk Assessment/Management

Described in Adverse Event and Duty of Candour Procedure.

2.3.5 Risk Appetite

- Minimal

Comment:

The Board has a low risk appetite for things that might compromise the quality & safety of patient care.

2.3.6 Equality and Diversity, including health inequalities

Not specifically addressed in this paper although overarching Risk Management and Quality Strategies have had an Impact Assessment completed.

2.3.7 Climate Emergency and Sustainability

Not directly considered

2.3.8 Consumer Duty

An impact assessment has not been considered for this paper.

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2.3.9 Other impacts

None

2.3.10 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate and in accordance with the Health and Social Care Communication and Engagement Strategy and process.

2.3.11 Route to the Meeting

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

- Quality & Safety Board October 2025
- Patient Safety Group (PSG) October 2025

2.4 Recommendation

- **Assurance** – To give confidence of compliance with legislation, policy and Board objectives.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Duty of Candour Annual Report

Duty of Candour Annual Report 2024/25

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 incidents happen, the people affected understand what has happened, receive an apology, and the organisation(s) learns how to improve for the future. An important part of this duty is that we provide an annual report about the organisational duty of candour in our services. This report describes how NHS Dumfries & Galloway has operated the organisational duty of candour during the time between 01 April 2024 and 31 March 2025.

We hope you find this report informative. If you have any questions or would like more information about NHS Dumfries & Galloway, please feel free to contact us at: dg.patientservices@nhs.scot

NHS Dumfries & Galloway include Duty of Candour as part of our approach to how we manage adverse events and patient feedback.

3 SAER cases were confirmed to have triggered organisational duty of candour in 2024/5.

Duty of Candour (DOC) is an integral part of our Adverse Event Framework and procedures. Each of the cases cited was commissioned as a Significant Adverse Event Review by Patient Safety Group who confirmed organisational Duty of Candour at the conclusion of the process.

Recommendations are made as part of the Significant Adverse Event Review and local management teams develop improvement plans to meet these recommendations.

Duty of Candour Triggers

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died *	2
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	1
Changes to the structure of a person's body	0
The shortening of the life expectancy of the person	0
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:	
i.) The person dying or ii.) an injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
TOTAL	3

There are four elements to the procedure which are required to be considered and documented in our Risk Management system:

- Patient/Family Informed

- Apology Offered
- Recorded in Patient's notes
- Relevant Manager Informed

All of the above cases complied with these elements in full.

All of the families involved were contacted, offered an apology and asked to contribute their questions to the review process.

We took on board their queries and concerns and offered them the opportunity to meet at the conclusion of the review.

Internally senior staff reflected on the events and identified where systems went wrong and how these might be improved.

The information was shared with staff involved and more broadly through Directorate and Professional review and learning mechanisms.

Learning

Investigation of Duty of Candour incidents follows the same mechanism as other Significant Adverse Event Reviews with contributing and learning themes identified.

All of the cases reviewed identify a number of factors/issues that contributed to the adverse event. These include factors that may be out with the control of the individual or the team on that day, on that shift or with the person concerned.

Factors relating to the environment, the task and the persons involved all interact to create error inducing conditions which most of the time our teams successfully navigate around. Themes found in the Duty of Candour cases this year include:

- The need to invest in automating manual processes
- Intra and inter team communication at the interface of care could have been better
- Staff training, supervision and support in recognising rare presentations
- Engaging and supporting families in safety planning

Involving people and their families and supporting them throughout the process continued this year with family contacts identified for all the cases.

Internal processes to ensure Duty of Candour is appropriately and comprehensively enacted continues to be effective which is demonstrated through sustaining 100% compliance with all duty of candour elements.

What has changed as a result

We have undertaken a review of supervision for clinicians working in remote areas of our region. This has led to changes in our service models, improvements in our policies and training of staff.

We have identified and assessed a risk around manual administrative processes which we are working as a Board to prepare a business case for automation.