DUTY OF CANDOUR ANNUAL REPORT 2024-2025

Table of contents

1. Introduction

This annual report is in relation to the organisational Duty of Candour (DoC) and is a separate duty from the professional, moral and ethical DoC which exists for a range of regulated health and social care professionals. The organisational DoC provisions from the Health (Tobacco, Nicotine etc. and Care)(Scotland) Act 2016 and the DoC Procedure (Scotland) Regulations 2018, sets out the obligations on the procedure for those providing health and social care services in Scotland.

This is a legal requirement when unintended or unexpected events happen that result in (or could result in) death / harm or intervention is required to prevent death / harm and does not relate directly to the natural course of someone's illness or underlying conditions. The people affected receive an apology, they understand what has happened and the organisation conducts learning focused reviews to identify areas for improvement. This underpins the Scottish Government's commitment to openness and learning which are vital to the provision of safe, effective and person-centred health care. The DoC legislation became active on 1 April 2018.

A requirement of this duty is the provision of an annual report detailing the number of events which have activated DoC and how NHS Ayrshire & Arran (NHSAA) has fulfilled its' responsibilities for events reported from 1 April 2024 to 31 March 2025.

NHSAA serves a population of around 376,000 people and employs in the region of 10,500 staff. The Board provides a full range of primary and secondary clinical services covering the mainland of Ayrshire, the islands of Arran and Cumbrae and three Local Authority areas of North, South and East Ayrshire. The Board currently operates over two Acute Hospital sites, University Hospitals Ayr and Crosshouse and 70 community based healthcare settings including GP practices. Our aim is to provide high quality care for every person who uses our services and where possible, help people to receive care at home or in a homely setting.

2. Information about our policies and procedures

NHSAA has a robust process for the identification and management of adverse events where DoC is activated and this process is integrated within the NHSAA Adverse Event Policy. A stand-alone Duty of Candour Policy is being developed and launched during 2025.

A defined guidance for application of DoC in relation to unavoidable Grade 3, Grade 4, Suspected Deeper Tissue Injury and ungradable pressure ulcers, acquired under our care, was implemented in alignment with Healthcare Improvement Scotland's Pressure Ulcer Standards.

Adverse events are reported onto the local reporting system as set out in the NHSAA Adverse Event Policy. Each event is reviewed to understand what happened and how we might improve the care we provide in the future. The Reviewers and Final Approvers initially identify potential DoC events. When identified, an escalation is generated to the relevant Directorate Adverse Event Review Group (AERG) and an Adverse Event Review

Level Decision Making SBAR is submitted to the AERG to determine applicability of DoC and the type of review to be undertaken. This decision is based on: -

- the adverse event;
- the content of the Adverse Event Decision Making SBAR;
- NHSAA agreed 'Never Events' list;
- NHSAA Adverse Event Policy, and
- the specialist knowledge of the subject experts of the AERG.

The type of review depends on the severity of the event as well as the potential for learning. There are three types of review with general approach of;

- ward / departmental review for severity consequence 1-3,
- Local Management Team Review (LMTR) led by the service where the event occurred for severity consequence 4,
- Significant Adverse Event Review (SAER) led by a different service to where the event occurred for severity consequence 5.

NHSAA has committed to commissioning a minimum of a LMTR where DoC has been activated. In addition, we have robust governance arrangements to monitor all reported adverse events to provide further assurance that any events which may be DoC applicable are identified.

Where DoC is confirmed by the AERG, all necessary actions are taken in accordance with the DoC requirements. The key stages are as follows: -

- notify the patient affected (and / or family where appropriate);
- provide a verbal apology with follow up in writing;
- carry out a review into the circumstances leading to the adverse event;
- offer and arrange a meeting to take on board their views and listen to their concerns;
- provide them with an account of the adverse event and with detail of the review findings;
- provide information about improvement actions;
- make available and / or provide information about support, and
- prepare and publish a DoC annual report.

Both the SAER and LMTR processes include the stages detailed above and a formal report is produced to identify learning which is shared with the patient / family / staff involved as requested. Organisational Learning Summaries are developed and shared accordingly throughout NHSAA. Recommendations are made where Local Management Teams develop Improvement Plans to meet the recommendations.

3. Support for our patients / families

We understand how distressing it can be for our patients and their families when they are affected by an adverse event, particularly when this is a significant event which activates DoC. As such, following a verbal apology, a single point of contact (SPOC) from the Review Team is assigned to the patient / family. They have the required skills to respectfully disclose sensitive information and answer any questions or concerns. The SPOC endeavours to arrange meetings with the patient / family as required, takes on

board their views, listens to their concerns, advises on the review process and provides regular updates. Upon conclusion of the review, the patient / family are offered a copy of the final review report and an opportunity to discuss the findings. In addition, a review process information leaflet is provided.

4. Support and training for our staff

We appreciate adverse events can be distressing for our staff as well as our patients and that it's vital to help them to understand what happened, to make sure they do not feel isolated and to emphasise the purpose of the review is for learning and improving and not about apportioning blame. This is critical to reduce the impact of trauma and help with their health, wellbeing and recovery. As such, they are assigned a SPOC from the Review Team who has the required skills to support them throughout the review process. Upon conclusion of the review, they are offered a copy of the final review report and an opportunity to discuss the findings. In addition, an information leaflet is provided to explain what to expect when involved with a review and signposting to the many internal support services available e.g. Occupational Health, Staff Care, Better Health Hub and Psychology Services.

NHSAA strive to ensure that staff who are part of a Review Team have the relevant training, guidance and support on the process. NHS National Education for Scotland: DoC training module is available to all staff via NHSAA Learn Pro System with guidance and supportive tools around providing a person centred apology and planning and preparing for subsequent discussions. In addition, all staff who review and finally approve adverse events receive initial / refresher training on adverse event management and the activation of DoC.

5. Number and nature of DoC adverse events

At the time of writing this report on 27 June 2025, of the 9633 reported adverse events from 1 April 2024 until 31 March 2025, 425 patient / service user adverse events were escalated for consideration of DoC through the adverse event management process (as detailed in section 2). 93 events (1% of total number of reported adverse events) were reviewed by the relevant Directorate AERG and DoC activated. Within NHSAA, a separate adverse event is reported for each patient event therefore 93 patients have been affected (unless the same patient has been affected more than once).

76 events resulted in the commissioning of a LMTR and 17 events resulted in the commissioning of a SAER.

There have been no large-scale adverse events (one event which resulted in multiple patient's being affected) reported during this time frame.

Table 1 below provides a breakdown of the number and nature of DoC adverse events:-

Nature of unexpected or unintended adverse event where DoC was applicable	**Number**
Death of the person	8
A 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	11

Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	2
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	1
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.	69
The person required treatment by a registered health professional in order to prevent:	
The death of the person	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	**93**

Table 1: Number and nature of DoC adverse events 1 April 2024 – 31 March 2025

An appropriate category is selected and confirmed by the Final Approver for each adverse event. **Chart 1** below demonstrates the categories for the 93 DoC adverse events and highlights 58% are related to pressure ulcers:-

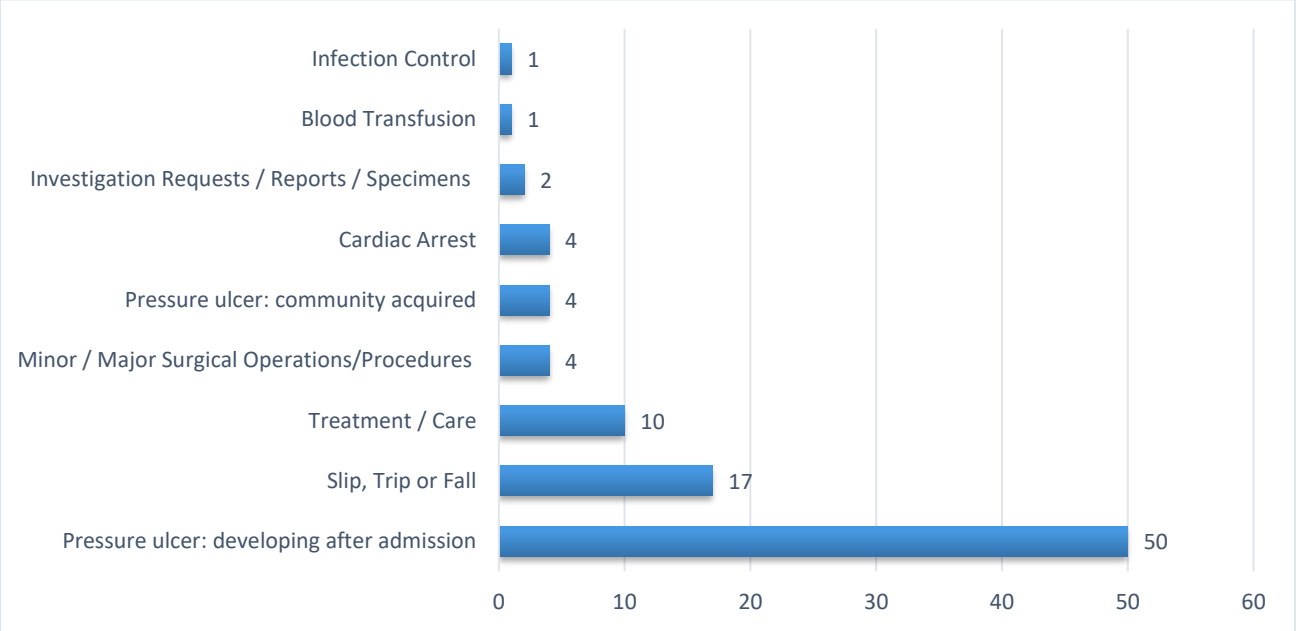

Chart 1 demonstrates the categories for the 93 DoC adverse events

6. To what extent did NHSAA follow the DOC Procedure?

When DoC was triggered for the events listed above, NHSAA commenced the full DoC procedure steps as detailed below. The local reporting system is updated to reflect the steps completed following approval of the SAER / LMTR Report. As such, at the time of writing this report, there are 51 of the 93 event reports not yet approved (55% of events) therefore full DoC data is not available at present. The 42 events that have concluded were assessed for compliance with **Table 2** providing the elements of the DoC legislation:-

Table 2: Compliance

DoC Procedure Steps	Number of events compliant	Reasons given for events not compliant
We informed the patients and / families and provided a verbal apology.	40	One event had no contact number available – a letter was forwarded to the family with no response. One family were not contactable following numerous attempts.
We followed the verbal apology up in writing with details of the review process.	40	One event noted that a verbal apology was provided however the Review Team were unaware that written follow up was required; the final report was shared. One family were not contactable following numerous attempts.
We offered an opportunity to address questions they had within the review.	41	One family were not contactable following numerous attempts.
We informed them of the outcome of the review and provided a copy of the final review report.	35	One event had no contact number available – a letter was forwarded to the family with no response. Two families were unable to be contacted following numerous attempts. Three patients/families declined a copy of the report. One report has not been shared however no reason has been identified by the review team.

7. What has improved as a result?

A number of changes to local policies and procedures have been made as a result of events that triggered DoC; examples are as follows:

Example One

A patient attended to have two procedures performed. The patient had the procedures performed as per the Surgical Booking Form however, the Surgical Booking Form did not reflect the procedures required in relation to what was documented within the clinical notes. The review identified there was several missed opportunities to identify the discrepancy. In response, an Improvement Plan has been developed as follows:-

- Develop a single document to follow the patient through assessment to surgical booking and completion of procedure, linked to the development of the safe delivery of Nurse Led Minor Surgery in (relevant specialty) Guideline.

- Introduction of a surgical pause/timeout for all surgical procedures.
- A need for adequate induction to practice and policies for all staff who are new to a specialty.

Example Two

Resuscitation attempts were carried out on a patient who had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place from a previous admission. The review identified the lack of awareness of the pre-existing DNACPR led to resuscitation efforts being made which were not appropriate. In response, an Improvement Plan has been developed as follows:-

- Staff who are responsible for the taking and recording of patient observations must have robust knowledge regarding appropriate escalation and the timely repeat observations that are required. All staff who are responsible for the recording of National Early Warning Score (NEWS) to complete NHS Education for Scotland NEWS mandatory education e learning module.
- Patients who have DNACPR documents in place should be identified. These documents are located at the front of the patient's medical notes and should be checked by staff on patient's admission to hospital. Where existing documents are in place, they should be flagged timely to relevant clinical staff.

8. Additional information

This is the seventh year of the organisational DoC being in operation and it has been another year of learning and refining our existing adverse event management process to include the required outcomes.

As required by the legislation, Scottish Ministers and Healthcare Improvement Scotland will be advised when this report has been published on the NHS Ayrshire and Arran public website.

This DoC Annual Report 2024-2025 will have an addendum produced later in the year (2025) to address additional adverse event reviews which activate DoC and the DoC process requirements which are not yet concluded at the time of publishing this report.

The organisational duty of candour lead in NHS Ayrshire and Arran is the Executive Nurse Director, Jennifer Wilson.

9. Addendum update 8 January 2026

It was agreed that the DoC Annual Report 2024/25 would have an addendum update produced later in the year (2025) to address additional adverse event reviews which activated DoC and the DoC procedural requirements which were not yet concluded at the time of publishing the report.

The number of adverse events reported between 1 April 2024 and 31 March 2025, reviewed by the relevant Directorate AERG and confirmed with DoC activation, increased from 93 to 124.

This has resulted in the commissioning of a further 25 LMTRs and 6 SAERs.

Table 3 update - provides an update on the number and nature of DoC adverse events from 1 April 2024 to 31 March 2025:-

Nature of unexpected or unintended adverse event where DoC was applicable	**Number**
Death of the person	15
A 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	22
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	2
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	1
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.	82
The person required treatment by a registered health professional in order to prevent:	
The death of the person	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	**124**

Chart 2 update - demonstrates the updated categories for the 124 DoC adverse events and highlights 53% are related to pressure ulcers:-

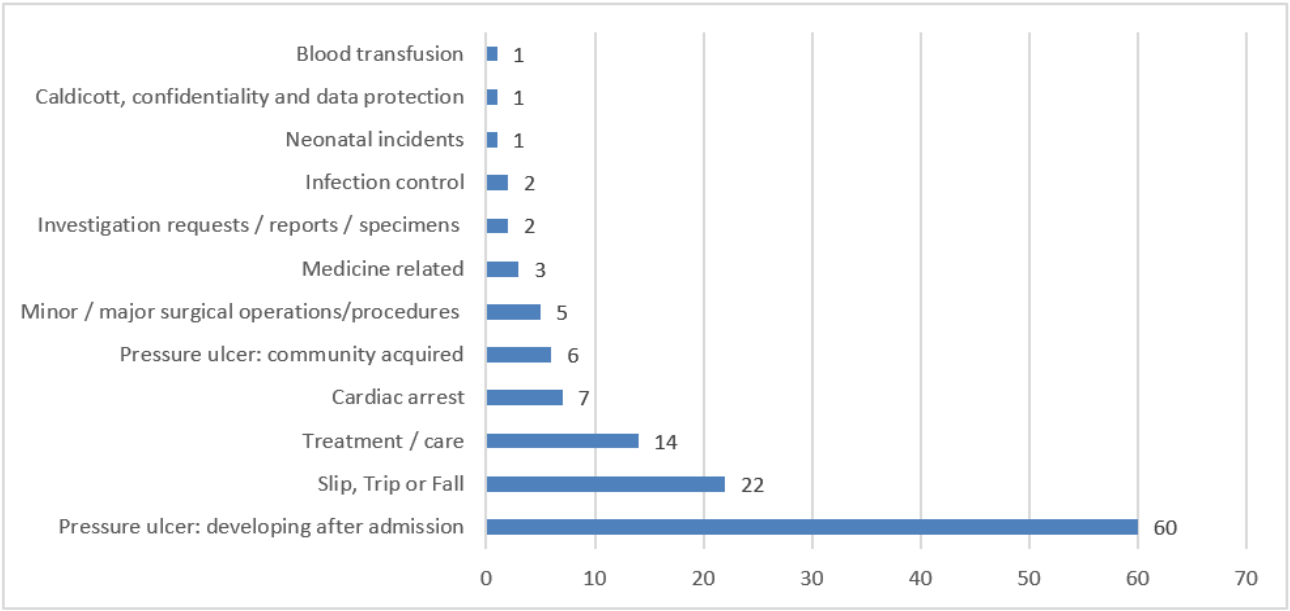

Table 4 update – of the 124 adverse events with DoC activated, 56 LMTR/SAER reports (45%) have not yet been approved, and therefore full DoC procedural step data is not available for these events. The remaining 68 reports have concluded and were assessed for compliance of the following procedural steps:-

DoC Procedure Steps	Number of events compliant	Reasons given for events not compliant
We informed the patients / families and provided a verbal apology.	65	Three patients/families could not be contacted by telephone despite numerous attempts.
We followed the verbal apology up in writing with details of the review process.	64	Two patients/families did not wish a follow up letter. One patient/family received a verbal apology however the Review Team was unaware that this was to be followed up in writing. Despite this, an opportunity was provided for questions to be addressed during the review and the final report was shared with the patient/family. One patient/family could not be contacted by telephone despite numerous attempts and no forwarding address was obtained.
We offered an opportunity to address questions they had within the review.	67	One patient/family could not be contacted by telephone despite numerous attempts and no forwarding address was obtained to provide an opportunity to address questions during the review.
We informed them of the outcome of the review and provided a copy of the final review report.	50	Eleven patients/families declined a copy of the report. Five patients/families were offered a copy of the report however no response received. One report has not been shared and no reason was identified nor indication that they wished a copy. However, the patient/family did receive a verbal apology with follow up letter and they confirmed they had no questions to be addressed. One patient/family could not be contacted by telephone despite numerous attempts and no forwarding address was obtained to provide them with a copy of the report.

When AERGs are unable to determine from the Adverse Event Review Level Decision Making SBAR whether DoC activation is required, the DoC decision is paused until the LMTR / SAER is concluded. Currently, 23 events remain under review and await DoC consideration, which may impact the figures reported in this addendum.

A Duty of Candour Policy is being developed and will now be published 2026.