DUTY OF CANDOUR ANNUAL REPORT 2025-2026

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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 2025 to 31 March 2026.

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 and Application Guidance has been developed and will be launched during Q3, 2026/2027.

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
- 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; and
- 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 (this may also involve an interpreter).

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, NHS 24 Breathing Space, National Wellbeing Hub, Workforce Wellbeing; Beyond the Pandemic, Frontline Workers Self Leadership, NHS National Education for Scotland (NES): National Trauma Transformation Programme 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. The NES DoC training module is available to all staff via the NHSAA Learn Pro System. The module includes ways of ensuring that staff and organisations are open, honest and supportive when there is an unintended or unexpected incident resulting in death or harm, with guidance and supportive tools around providing a person centred apology and planning and preparing for subsequent discussions. In addition, the NES Compassionate Communication Skills Training Programme is available to all staff via application process and focuses on the use of compassionate communication skills to support involvement of patients and families in adverse event reviews.

As part of the implementation of the standalone Duty of Candour Policy, Duty of Candour awareness sessions will be delivered to staff involved in adverse event management and review processes. These sessions will provide an overview of Duty of Candour principles and responsibilities, ensuring a consistent understanding of requirements across the organisation. In addition, NHS staff who review and approve adverse events will continue to receive initial and refresher training on adverse event management, including the identification, activation, and application of Duty of Candour requirements.

5. Number and nature of DoC adverse events

At the time of writing this report on 2 October 2026, of the 9908 reported adverse events from 1 April 2025 until 31 March 2026, 450 patient / service user adverse events were escalated for consideration of DoC through the adverse event management process (as detailed in section 2). 87 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 87 patients have been affected (unless the same patient has been affected more than once).

62 events resulted in the commissioning of a LMTR and 25 events resulted in the commissioning of a SAER.

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

Table 1 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	11
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	23
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	1
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	2
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.	49
The person required treatment by a registered health professional in order to prevent:	
The death of the person	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Total	**87**

Table 1: Number and nature of DoC adverse events 1 April 2025 – 31 March 2026

An appropriate category is selected and confirmed by the Final Approver for each adverse event. Chart 1 demonstrates the categories for the 87 DoC adverse events and highlights 36% are related to pressure ulcers and 25% to slip, trip or falls.

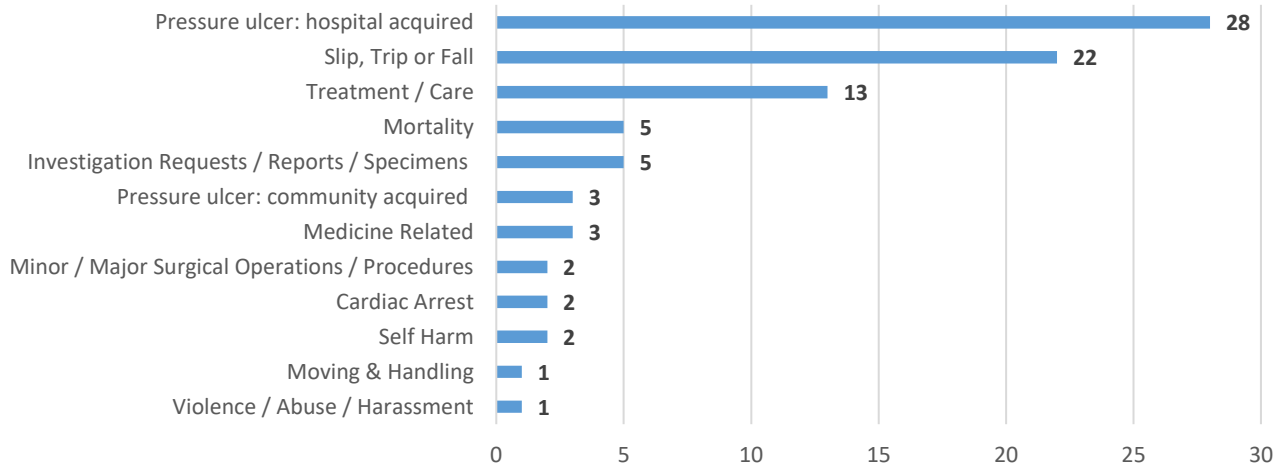

Chart 1 - categories of DoC adverse events

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

Where Duty of Candour (DoC) was determined to be applicable, NHSAA commenced the required DoC process in accordance with legislative requirements. Compliance with the individual stages of the DoC procedure was recorded within the local reporting system following approval of the SAER or LMTR report.

At the time of writing, 28 of the 87 adverse event reports (32%) remain pending approval and, therefore, a complete assessment of DoC compliance is not yet available. The analysis presented in table 2 relates to the 59 events for which the review process has been completed and approval has been granted. These cases were assessed against the key requirements of the Duty of Candour legislation.

DoC Procedure Steps	Number of events compliant	Reasons given for events not compliant
We informed the patients and / families and provided a verbal apology	55	One event noted unsuccessful telephone contact attempts and no response to voicemail– letter forwarded. One event noted numerous unsuccessful telephone contact attempts and no address available. One event noted the patient had passed away with no family contact or official next of kin. One event noted no contact details for NOK – letter forwarded to deceased patient's address.

DoC Procedure Steps	Number of events compliant	Reasons given for events not compliant
We followed the verbal apology up in writing with details of the review process	52	Five events noted further contact was declined. One event noted numerous unsuccessful telephone contact attempts and no address available. One event noted the patient had passed away with no family contact or official next of kin.
We took on board their views, listened to their concerns and addressed questions they had within the review	53	Two events noted they had no questions and declined any further contact. One event noted numerous unsuccessful telephone contact attempts and no address available. One event noted the patient had passed away with no family contact or official next of kin. One event noted no contact details for NOK – letter forwarded to deceased patient's address with no response. One event noted the NOK advised they had not been given the opportunity; a verbal apology and follow up letter were issued previous to this.
We informed them of the outcome of the review and provided a copy of the final review report	39	Seven events noted they did not wish a copy of the final report. Six events noted report was offered and to contact us if they wish a copy. Five events noted further contact was declined. One event noted numerous unsuccessful telephone contact attempts and no address available. One event noted the patient had passed away with no family contact or official next of kin.

Table 2 – Compliance with DoC stages

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

An elderly patient was admitted to hospital following a collapse at home, presenting with confusion, epigastric pain, and a productive cough. Initial assessment and management of the presenting condition were timely and appropriate. During the admission, the patient required multiple peripheral venous catheters (PVC) for intravenous therapy. The patient subsequently developed a hospital-acquired Staphylococcus Aureus Bacteraemia, with the likely source identified as a skin and soft tissue entry point related to peripheral venous catheter insertion. The patient's clinical condition deteriorated despite ongoing management, and they died during the hospital admission.

In response, an Improvement Plan has been developed as follows:-

- All staff carrying out PVC insertion (medical, nursing and clinical support staff) must complete a recognised cannulation and venepuncture training course and complete a competency framework.
- All staff must complete the PVC insertion and maintenance documentation bundle as per Guideline G084 – Insertion & Maintenance of PVC in Adults (16 years and over).
- Peripheral vascular catheter insertion and maintenance bundle audits must be completed weekly and compliance maintained at 95%.

Example Two

A patient was admitted for planned day-case bilateral third and fourth flexor toe tenotomy surgery. Admission through the day surgery unit followed the correct process, with checklist completion, informed consent, and surgical site marking undertaken as required. Surgery was completed on the third and fourth toes of the right foot as intended. During the procedure on the left foot, it was identified that the incorrect toe had been operated on. On review, the second, third, and fourth toes of the left foot were operated on, rather than the third and fourth toes as documented in the consent.

In response, an Improvement Plan has been developed as follows:-

- Surgical marking for those undergoing surgery should be improved and guidance on this should follow a formalised process such as that within a Standard Operating Procedure (SOP). This SOP should define:
    i) The marking of surgical sites, including that of digits associated with hand and foot surgery, for use across NHSAA.
- A full review of theatre safety documentation should be undertaken to ensure surgical marking and side laterally is embedded as standard practice and incorporated into theatre safety checklists.
- Consideration should be given where bilateral surgery is indicated, to conduct a second surgical pause as aide memoire to the correct operation on the second site.

8. Additional information

This is the eighth 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 2025-2026 will have an addendum published during Q4, 2026/2027, 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.