NHS Golden Jubilee

Meeting:	**NHS GJ Board**
Meeting date:	**28 May 2026**
Title:	**Duty of Candour Annual Report 2025-2026**
Responsible Executive:	**Mark MacGregor, Executive Medical Director**
Report Author:	**Kevin McMahon, Head of Risk & Clinical Governance**

1. Purpose

This is presented to NHS GJ Board for:

- Decision

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

This aligns to the following NHSGJ Corporate Objectives:

- High Performing Organisation – Establishing the conditions for success to enable excellent outcomes and experience for patients and staff.

2. Report summary

2.1 Situation

The Duty of Candour Annual Report for NHS Golden Jubilee details the number of incidents, types or harm and improvements made in 2025-2026 as a requirement of the national Duty of Candour legislation.

2.2 Background

All health and social care services in Scotland have a Duty of Candour (DoC). This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, that the people affected understand

what happened and receive an apology. Organisations should also agree actions (where appropriate) to improve care for the future.

An important part of this duty is that we provide an annual report about how the DoC is implemented in our services. This report describes DoC events and learning during the time between 1 April 2025 and 31 March 2026.

2.3 Assessment

2.3.1 Quality/ Patient Care

The Clinical Governance team work closely with Division Management Teams to constantly review ways of improving the process for reviewing Significant Adverse Events (SAER) to ensure the best possible quality of review and best possible outcome for the patient/family involved.

2.3.2 Workforce

The SAER process and DoC process undoubtedly presents challenges in various forms to the workforce both from a psychological and capacity perspective. The organisation is reinforcing support mechanisms for those involved whilst ensuring that learning is the focus of the outcome of the reviews.

2.3.3 Financial

There is a potential for financial impact to the organisation in relation to claims as a result of adverse events which trigger the DoC.

2.3.4 Risk Assessment/ Management

SAERs are managed on a case by case basis and risk assessment is supported where required, this is further embedded within action plans if appropriate.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed as this paper provides a report following an analysis of data.

2.3.6 Other impacts

Potential for reputational impact due to the nature and content of the report.

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Service Clinical Governance Meetings throughout the year (as SAER's are completed)
- Division Management Team Meetings throughout the year (as SAER's are completed)

- Clinical Governance Risk Management Groups (for final approval of SAER reports)

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Service Clinical Governance Meetings throughout the year (as SAER's are completed)
- Division Management Team Meetings throughout the year (as SAER's are completed)
- Clinical Governance Risk Management Groups (for final approval of SAER reports)
- Paper approved by Clinical Governance Risk Management Group on 28 April 2026.
- Staff Governance and Person Centred Committee 12 May 2026

2.4 Recommendation

- Approval

3 List of appendices

The following appendices are included with this report:

Duty of Candour 2025 – 2026 Annual Report
Appendix No 1, Duty of Candour Criteria

Duty of Candour Annual Report

2025 – 2026

Contents

1. Introduction

All health and social care services in Scotland have a Duty of Candour (DoC). This is a legal requirement, which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the DoC is implemented in our services. This report describes how we have operated the DoC during the time between 1 April 2025 and 31 March 2026.

2. About Golden Jubilee National Hospital

NHS Golden Jubilee (NHSGJ) has always aimed to ensure that we support the delivery of NHS Scotland's national health priorities. Our focus since our establishment has been to meet NHS Board demands and deliver equity of access to high quality healthcare for as many patients as possible so that they benefit from our clinical expertise and excellent facilities.

3. Our Policies and Procedures

Adverse Events are reported, and reviewed on the board's incident management system, Datix. The procedure for reviewing each level of incident is set out in the Adverse Events Management policy. The Adverse Events Management policy and supporting tools/ guidance reflect the DoC requirements.

The decision on an incident being classed as a DoC event is built into the Initial Assessment Tool (IAT) and Significant Adverse Event Review (SAER) process. All severity 4 and 5 adverse events are automatic escalations, as potential SAEs. Legislation requires that a **clinical** person must make the **final decision** on Duty of Candour.

The Clinical Governance Lead and/ or Clinical Nurse Manager, depending on the type of event, will complete the Initial Assessment Tool (IAT) with a decision taken during this process to proceed to SAER or not. If not, a clear rationale is set out.

The review process includes a specific question relating to the Duty of Candour status. The completed assessment and recommendation of Duty of Candour is then agreed/ approved by the Division Management Team (DMT), which includes an Associate Nurse and Associate Medical Director.

Any IATs that do not progress for review, are presented and discussed at the Service's Clinical Governance Forum, with multi-disciplinary representation to ensure learning is captured. This offers further opportunity for any challenge on the level of review and DoC status.
Each adverse event is reviewed, with a focus on learning/ potential learning from what has happened, regardless of the level of harm. On completion of an adverse event review; actions are identified, and these are monitored through Clinical Governance Service Meetings to completion via the Clinical Governance reporting framework.

All staff receive training regarding adverse event reporting and the implementation of DoC via the corporate induction e-learning package. Training is provided to those responsible for reviewing incidents on Datix and a supporting toolkit is available to staff who could potentially take part in a Significant Adverse Event investigation; this will take the form of blended learning, utilising virtual sessions and in-person sessions.

We know that being involved in a significant adverse event can be challenging for staff as well as those affected by the event. Support is available to staff via their line managers, colleagues, Clinical Governance Lead and the Clinical Governance department. Staff can also access support via the Spiritual Care Lead and the Occupational Health team who are available to provide support in different forms following significant adverse events, where required. This support is also available to patients/families where required.

4. Duty of Candour Activity 2025-2026

During the reporting period 1 April 2025 to 31 March 2026, 21 events triggered the organisational Duty of Candour; **table 1** below shows the breakdown of these in relation to the outcome of the event, specific detail regarding the events is documented in **appendix 2**.

Table 1: Duty of Candour Rationale

Duty of Candour Rationale	Total
Changes to the patient's body structure	1
Increase in patients treatment	10
Patient experiencing pain or psychological harm - at least 28 days	1
Permanent injury	1
The patient died	5

Treatment or intervention to prevent injury	1
Treatment or intervention to prevent patient death	2
Grand Total	**21**

Regardless of DoC status, when significant adverse event reviews are commissioned, the appropriate team makes contact with patients and/ or families to advise of an event and the investigation process.

4.1 Events

Of the 21 events that triggered DoC, 6 remain open at the time of reporting (22 April 2026).

In all of the DoC cases, relevant parties were advised a review was taking place. With all closed DoC events, a copy of the final report is provided, with an offer made to meet to discuss the content of the report with the patient/ family.

In February 2025, Healthcare Improvement Scotland (HIS) published an updated national adverse event framework that expanded the timescale for concluding SAERs from 90 days to 120 days.

No SAE events reported during the reporting period have met the DoC process requirements including meeting the 120-day timescale for completion of the review process**.**

Meeting timescales for concluding SAER's remains a challenge, however improvement work is ongoing. The Clinical Governance team work closely with the Divisional Management Teams to improve compliance with timeframes and will monitor and report progress making necessary amendments where indicated.

4.2 Learning

Further to the review of the events that triggered the DoC, several learning points have been identified.

Some of the learning points that have been **completed** includes:

- Regular audit of key records and paperwork implemented to ensure completeness and accuracy.
- Improved communication across all staff groups via safety briefs and ward handovers ensuing key information relating to falls is shared and discussed.
- Process and checks in place to ensure appropriate consent for high-risk patients.

- Staff training and support to feel empowered to respectfully remind and challenge colleagues.
- Development of a policy outlining the optimum pathway for management of urgent orthopaedic revision procedures.

Some of the learning points where implementation is **ongoing** includes:

- Staff education and training to reinforce need for adequate pause is undertaken at time of implant check in theatre.
- Facilitated discussions to further promote a safety culture across theatre teams.

The implementation of learning and actions from SAER's continues to be a challenge; however, there has been a significant effort from Clinical Governance department, Divisional Management Teams and services to progress open actions. There has also been a focus on the quality of actions agreed through the review process.

At its peak in 2025 – 2026, there were 137 open actions, reducing to 91 in January 2026. This has increased towards the end of the financial year, however will continue to be prioritised throughout 2026 – 2027.

5. Conclusion

This is the 8th year of the DoC being in operation. The organisation continues to learn and refine processes to ensure adherence to the DoC process.

This report will be cascaded via the Clinical Governance reporting structure for internal information and published on our public website as per the DoC legislation. The Scottish Government are aware of the publication of this report and we acknowledge that they may, for the purposes of compliance with the DoC provision, request information regarding the content of this report.

Appendix 1 – DoC Criteria

Incident, which activates the duty:

The DoC procedure must be carried out by the responsible person as soon as practicable after becoming aware that an individual who has received a health, social care or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions

- an increase in the person's treatment
- changes to the structure of the person's body
- the shortening of the life expectancy of the person
- 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
- 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
- the person requiring treatment by a registered health professional in order to prevent,
    - the death of the person, or
    - any injury to the person, which, if left untreated, would lead to one or more of the outcomes, mentioned above.