Duty of Candour

Annual Report 2024/25

Safety Quality and Risk Team

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NHS Orkney

Duty of Candour Report 2024/25

1. Introduction

All health and social care services in Scotland have a 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 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 Orkney 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 Orkney, please feel free to contact us at: **ork.clinicalgovernance@nhs.scot** **01856 888283**.

2. Background

The Duty of Candour (DoC) legislation[1] became active from the 1st of April 2018 with revised guidance being released in March 2025. This placed a statutory obligation on organisations who provide health, care or social work to follow these regulations which stipulate that duty of candour processes must be activated as soon as reasonably practicable after becoming aware of the following:

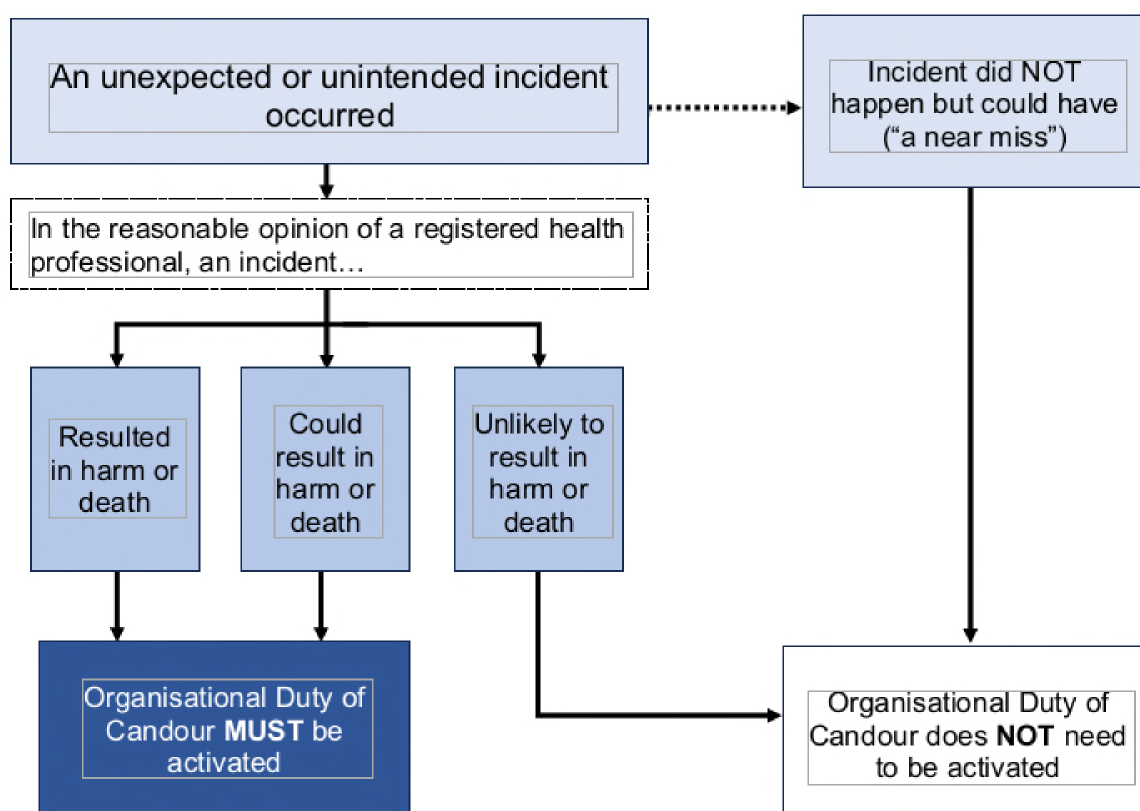
- An unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person
- In the reasonable opinion of a registered health professional not involved in the incident:
  - that incident appears to have resulted in or could result in any of the outcomes mentioned in The Act[2]
  - that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition

[1] Duty of Candour Legislation
[2] Regulation 20

If a patient suffers **death or serious**[3] harm because of an adverse event that the organisation is responsible for, the following should occur:

- An apology is offered to the patient or their relative
- The patient / relative is informed that there will be an investigation
- The patient / relative is given the opportunity to ask questions to be answered as part of the investigation
- The result of the investigation is shared with the patient / relative and a meeting is offered
- The organisation learns from the investigation by implementing the recommendations/ actions

Below is a decision flow chart that demonstrates how Duty of Candour is applied



3. NHS Orkney

NHS Orkney is the smallest health board in Scotland sitting north of the mainland and serves an archipelago of islands with a population of approx. 22,000 people.

[3] Guidance on serious harm and death

NHS Orkney employs 751 staff (597.21 WTE) who provide a range of primary, community-based and hospital services.

In accordance with NHS Orkney's Learning from Incidents Policy, all clinical incidents are reported to the line manager and recorded on the incident reporting system, NHS Orkney currently uses Datix. DoC is considered as part of this process and reporters have an opportunity to consider potential DoC, both professional and organisational, in relation to the Act.

The clinical risk, and the level of review required of each incident, is assessed and where appropriate an initial assessment is undertaken to determine if this meets DoC.

Currently NHS Orkney's local Duty of Candour Procedure sits within the NHS Orkney's Learning from Incidents: and management of Significant Adverse Events policy. The policy and procedural documents undergo regular review to ensure that they are in line with latest legislation. They are currently under review to ensure that they align with the revised framework for reviewing and learning from adverse events in NHS Scotland[4]

We assume that all category one incidents met the DoC threshold and therefore organisational DoC is undertaken as part of the Significant Adverse Event Review (SAER) process.

The organisation ensures that all staff are aware of organisational DoC from their first day in the organisation. As part of the induction process all staff members are given access to the NHS Orkney Colleague Guide. This guide gives them an overview of a number of areas of the organisation, one being Clinical Governance. This section includes an overview of DoC including a video explaining how this relates to them.

4. Training and Support for Staff

As stated above all new staff receive information on DoC, we also highlight the National Education Scotland Turas training on Duty of Candour. For the reviewers who undertake investigations that would meet the DoC standard they are offered the Compassionate Conversations training course, as this supports them talking with patients, their families and staff involved in incidents in a compassionate, empathetic way.

We are clear to our staff that serious mistakes can be distressing for them, as well as for the people receiving care and treatment and their families. We have occupational welfare support in place for our staff if they have been affected by an organisational

[4] A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland

duty of candour incident. This includes an employee assistance programme called Wisdom, this is an app that covers wellbeing to good mental health and offers a support line where people can speak to or video call professionals who can support them in a variety of areas including when they have been involved in distressing events at work.

We recognise that there is more work that we can do to support of team as well as patients and are therefore developing a patient and staff wellbeing programme focusing on this.

As outlined above in the background section once an incident has been submitted this is reviewed and categorised. This helps us recognise where DoC needs to be implemented. The Medical Director is the person who makes this decision overall with support from the Head of Patient Safety, Quality and Risk to enact this. They also ensure that staff are supported in undertaking DoC.

Recommendations are made as part of the Duty of Candour review, and local management teams develop improvement plans to meet these recommendations.

5. Support for the Relevant Person

The relevant person is in most cases the patient, where the patient does not have capacity or has died, this is the next of kin, or the person who has power of attorney.

We understand that incidents are distressing for patients and their loved ones, we offer meetings to talk through concerns with the family and to ensure wherever possible that we answer all their questions. Currently we signpost people to external organisations or to their General Practitioners if they need support. However, as part of the work on the patient and staff wellbeing programmes we are looking at other services that we can provide to ensure that people are supported as much as possible.

6. Incidents where Duty of Candour applied

During the reporting period, there has been **two** incidents where the duty of candour applied. These are incidents that have happened which are unintended or unexpected, and do not relate directly to the natural course of someone’s illness or underlying condition.

DoC incidents are identified through NHSO Significant Adverse Event management process. Over the reporting period, there have been **four** Significant Adverse Event Reviews (SAER) launched. These events include a wider range of outcomes than those defined in the organisational DoC legislation as we also include significant

adverse event reviews and adverse events that did not result in significant harm but had the potential to cause significant harm.

Through the SAER process, it is identified if there were factors that may have caused or contributed to the event, which helps to identify if DoC should be applied.

There are **two** SAER in progress that were reported during this time which may meet the DoC requirements, but due to these investigations still being open, it is not possible to declare this at this time; therefore, these will be reported on in the next DoC annual report.

There were **four** SAER that were outstanding at the time of the last annual report, these have now been completed and of these, **one** met the criteria for DoC.

This report will cover the known DoC events from this reporting period and the one not included in last year's annual report; acknowledging there may be more once the two outstanding reviews have been completed, and these will be included in the next annual report.

Type of unexpected or unintended incident *(not related to the natural course of someone's illness or underlying condition)*	**Number of times this happened** *(between 1 April 2024 and 31 March 2025, including the one outstanding from the 23/24 report)*
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	1
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions were impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them from dying	
A person needing health treatment in order to prevent other injuries as listed above	
Total events Duty of Candour was applied	**2**

7. To what extent did NHS Orkney follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the procedure fully in two out of two instances (100% of instances). This means:

- we informed the people affected, apologised to them and arranged meetings with them, and met them
- we also took on board their views and listened to their concerns
- internally, senior staff reflected on the events and identified where systems went wrong and what how we could do better
- this information was shared with all our staff through our Clinical Quality / Clinical Governance Groups that happen once a month, and in Senior Leadership Team meeting which is also once a month. We also give an overview of learning within our quarterly Safety, Quality and Experience reports which we are hoping will be shared with the public in the near future to support openness and transparency.

In some of these cases the patient involved chose not to meet with us and did not want to be involved in the review.

8. What Has Changed / What Have We Learnt

For all SAER, not just the reviews where DoC is suspected / confirmed, an apology is given, patients and families are invited to be involved in the review and a comprehensive explanation of the incident is provided.

Below we have set out a few of the recommendations from SAER that meet the DoC criterion. These are the recommendations that would not make the case identifiable. The current position of the actions is highlighted in bold. Where there is no current position highlighted, this is because the SAER was closed at the end of the year and therefore the action plans have not been signed off by the governance committees, so there is no update at this time. Due to the small numbers of SAER and this being publicly available, the learning shared is not the full learning as this may lead to identification of individuals involved.

The recommendations and actions from the SAERs where DoC criteria were met include:

- Development of guidance for prioritisation of referrals
  ACTION: This piece of work is being undertaken by one of the surgical Consultants, ensuring that where a priority is changed that there is clear communication with the GP and patient including the reasons for this.
- Improve communication with patients and families throughout care

ACTION: This is being included in a larger piece of work looking at the whole patient journey and how patients (and their families) experience can be improved. This work will include patient engagement to identify what is important to patients

- Improve communication between health boards
  ACTION: Following the incident, we have ensured that there are named people within each board involved in the incident who speak regularly to discuss any concerns that may arise
- Strengthen discharge planning
  ACTION: A programme of work supporting timely discharge is underway. This is looking at ensuring medication is ready as well as any social care aspects are in place and that the patient is discharged earlier in the day as well.
- Strengthen medication and pharmacy support to inpatient areas
  ACTION: Hepma has been implemented within the organisation which supports this function
- Recruitment of substantive endoscopists to effectively manage waiting lists
  ACTION: The organisation has implemented a new procedure called a cytosponge to reduce the numbers of people requiring an endoscopy and therefore freeing up more spaces on the operating lists. It is also out to recruit another endoscopist.

Alongside reporting these events as per guidance and internally to the organisation we also share the learning summaries on our Community of Practice site to enable other health boards to benefit from our learning. Our annual report is also shared with our Board and Board sub – committee with responsibility for clinical governance to promote learning and DoC awareness.

9. NHS Orkney Policies, Procedures and Guidance

All adverse events are reviewed to help to understand the context and cause of the event, allowing for changes to be implemented to improve the services for all patients, as set out in the Learning from Adverse Events Policy. All adverse events are treated as if they meet the criteria for DoC until investigated and found not to. This means that for all adverse events a SAER is undertaken, and the requirements set out within the DoC guidance is undertaken. This includes an apology and an invitation to patients' and if the patient requests, their families, to be involved in the SAER process. From all SAER there are recommendations and an action plan to meet the recommendations. These actions are led by the most suitable staff to be responsible for taking the actions forward and ensuring changes are made, embedded into business as usual, and learning shared. The monitoring process for DoC is carried out by the Safety, Quality and Risk Team. This includes tracking the SAERs to establish which events have met the DoC criteria (in conjunction with

Medical Professionals), monitoring compliance to ensure all aspects of the legislation have been followed and correlation with the causation codes recorded for each incident. This is currently reported at the Clinical Quality Group and Clinical Governance Group, which are led and attended by a range of senior leaders and mangers. The reports and learning summaries will continue to be reviewed at these groups with the collated action plans being reviewed until completion to ensure a 'closing of the loop' process.

As the latest edition of the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland was released in February 2025, we are currently reviewing our policy and processes to ensure that they align with the changes within the framework.

10. Conclusion

It is recognised that there are a small number of SAER annually and that due to this being able to look at themes and trends from these is difficult. We do however aim to look at these in conjunction with incidents and complaints in the coming year, so that we can look for themes and trends and be able to provide greater understanding of where we need to focus in more detail. Over the coming year this work will continue and be evidenced in the way we report on DoC next year.

We always contact patients' and if appropriate and with the patient's consent, their families, to be involved in SAER from the start of the process. This ensures that their voices are heard and that we review areas that are important to them and answer any questions that they may have. As part of this we offer the opportunity to meet with the people carrying out the review once the report is completed as well, so that the patient and family can go through with the team and if there are any questions or comments, this can be looked at. This is irrespective of whether a SAER meets the criteria of DoC or not.

This year has highlighted to us the need to look more closely at service user experience, not just within the clinical services of NHS Orkney, but also when they are involved in SAER. We are looking at ways to gain feedback from people involved in SAER and feed this back into the policy and processes. Alongside this the experience of staff who are involved in SAER and the support we offer them is also being looked at to strengthen our existing offers.

We have continued to engage with the Health Improvement Scotland (HIS) Adverse Event Network and will continue to do this, being part of any work that looks to standardise incident reporting and learning across Scotland. These networks provide invaluable support in sharing ideas, resources and learning and we look forward to continuing this in the coming year.

11. Other Information

As required by the legislation, we have notified Healthcare Improvement Scotland that this report has been published on our website **(29/08/2025)**. We have also shared it with the Adverse Events Community of Practice or stakeholders.

The organisational duty of candour lead in NHS Orkney is Dr Anna Lamont, Medical Director. If you want to find out more about DoC within NHS Orkney please contact Kat Jenkin, Head of Patient Safety, Quality and Risk, via kat.jenkin@nhs.scot.