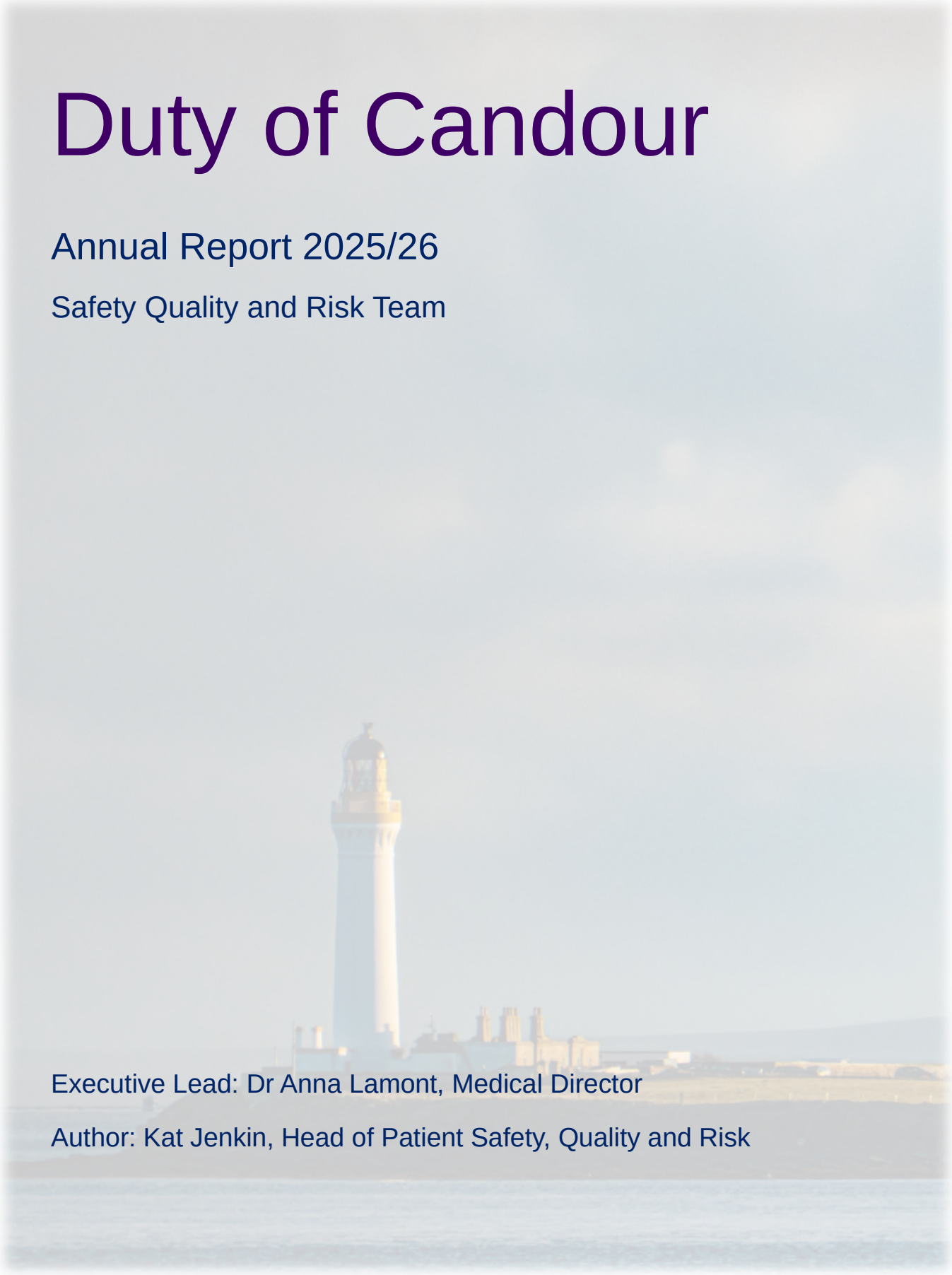
Duty of Candour

Annual Report 2025/26

Safety Quality and Risk Team



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NHS Orkney

Duty of Candour Report 2025/26

1. Introduction

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement that supports openness when serious harm has happened. It means that, when the criteria are met, the people affected are told what is known, receive an apology, are offered the opportunity to be involved in the review, and are told what the organisation has learned and changed as a result.

An important part of this duty is that we publish an annual report about how we have used the organisational Duty of Candour in our services. This report explains how NHS Orkney has operated the organisational Duty of Candour between **01 April 2025** and **31 March 2026**. We hope you find this report clear and helpful.

If you have any questions or would like more information about NHS Orkney, please feel free to contact us at:

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2. Background

The Duty of Candour legislation came into force on 1 April 2018. Revised non-statutory guidance was published by the Scottish Government in April 2025. The duty applies to organisations that provide health, care or social work services. It must be considered as soon as reasonably practicable when the organisation becomes aware that:

- 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[1]

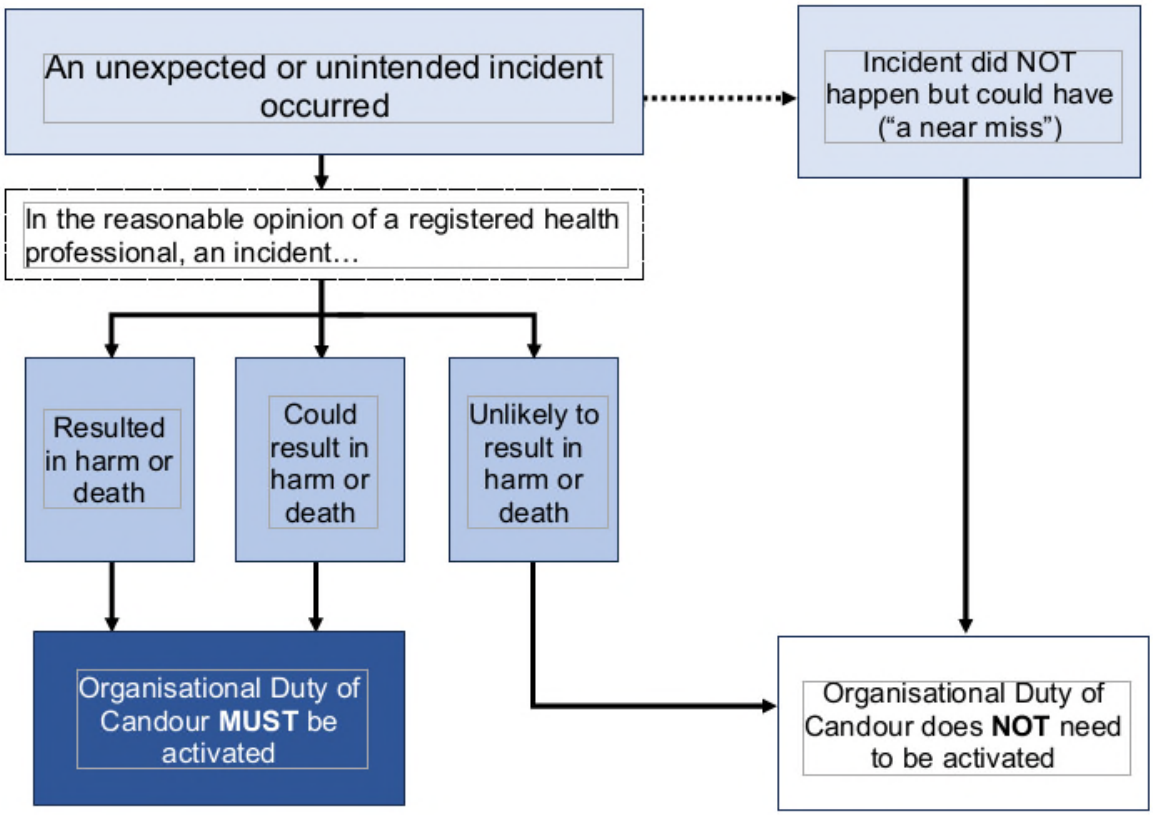
[1] Regulation 20

- that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition

If a person dies or experiences serious harm because of an unintended or unexpected adverse event that the organisation is responsible for, the Duty of Candour process should include the following:

- An apology is offered to the patient or their relative
- The patient or relevant person is told that a review will take place
- The patient or relevant person is offered the opportunity to ask questions for the review to consider
- The result of the review is shared with the patient / relative and a meeting is offered
- The organisation learns from the review and monitors actions until they are completed and embedded

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. NHS Orkney employs just under 800 staff who provide a range of primary, community-based and hospital services.

All adverse events are reported to the line manager and recorded on NHS Orkney's incident reporting system, currently Datix. Duty of Candour is considered as part of this process, with staff prompted to consider whether professional or organisational Duty of Candour may apply.

Each adverse event is assessed to understand the level of risk, the level of review needed, and whether the Duty of Candour criteria may be met.

During 2025/26, the Learning from Incidents Policy was reviewed and changed to a guidance document, which refers staff to the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland. The document was also renamed to align NHS Orkney language with Healthcare Improvement Scotland terminology, using "adverse event" rather than "incident".

Following this review, staff have been encouraged to undertake the new Duty of Candour eLearning. NHS Orkney continues to assume that category one adverse events meet the Duty of Candour threshold, with organisational Duty of Candour undertaken as part of the Significant Adverse Event Review process.

Further detail about training and support for staff is set out in the section below.

4. Training and Support for Staff

NHS Orkney provides information on Duty of Candour to new staff and continues to promote the new Duty of Candour eLearning. This supports staff to understand when the organisational duty may apply, the importance of openness with patients and families, and the steps required when a Duty of Candour event is identified.

During 2025/26, NHS Orkney has also considered how best to strengthen training and support for staff involved in adverse event reviews, including Significant Adverse Event Reviews and the most serious category one adverse events. This work is targeted towards senior nursing staff, midwives and allied health professionals, recognising that these staff groups often support reviews, identify learning and help ensure improvement actions are taken forward within services.

To support this, NHS Orkney has included adverse event review training within the leadership development course. This will help build confidence, consistency and shared understanding among senior clinical leaders who may be asked to lead, contribute to, or oversee reviews.

NHS Orkney is also exploring cross-agency work to support staff who act as investigators and reviewers for Significant Adverse Event Reviews. This is intended to increase resilience across the system, reduce reliance on a small number of individuals, and strengthen the support available to staff undertaking complex or distressing reviews.

We recognise that serious adverse events can be distressing for staff, as well as for patients, families and carers. NHS Orkney now has Peer Supporters in place. Any member of staff can contact a Peer Supporter if they need support following a distressing event at work. Occupational welfare support also remains available, including access to the employee assistance programme, Wisdom, counselling (through NHS Scotland) and Occupational Health.

NHS Orkney continues to develop and strengthen patient and staff support, recognising that people may need different types of support when they are involved in adverse event or Duty of Candour processes. Recommendations from Significant Adverse Event Reviews and Duty of Candour reviews continue to be taken forward through local improvement plans, with oversight through established governance routes. The revised process introduced last year is now giving stronger evidence and assurance that actions are followed through and completed.

5. Support for the Relevant Person

The relevant person is usually the patient. Where the patient does not have capacity, or has died, the relevant person may be their next of kin, welfare attorney or another person legally acting on their behalf.

NHS Orkney recognises that adverse events can be distressing for patients, families and carers. In line with the Healthcare Improvement Scotland adverse event framework, we offer the relevant person the opportunity to be involved in the review process. This includes being given an explanation of what is known at the time, receiving an apology, sharing questions or concerns for the review to consider, meeting with the review team, receiving updates as the review progresses, and discussing the findings and learning once the review is complete.

A named person is identified for the relevant person. This gives continuity and makes sure they know who to contact if they need help, have questions, or want to raise concerns. The named person supports communication with the review team (if more than one reviewer), explains the review process, arranges meetings if needed, and signposts to further support.

Where additional support is needed, this may include signposting to their General Practice (GP), independent advocacy, bereavement support, counselling or other services depending on the needs and wishes of the relevant person.

6. Adverse events where Duty of Candour applied

During the reporting period, there were **no** adverse events where the organisational Duty of Candour applied. This means there were no unintended or unexpected adverse events that met the Duty of Candour criteria and were not related to the natural course of someone's illness or underlying condition.

Duty of Candour is considered through NHS Orkney's adverse event review process. During the reporting period, **five** Significant Adverse Event Reviews were commissioned. Significant Adverse Event Reviews include a wider range of events than those that meet the organisational Duty of Candour criteria. This means we review events where serious harm occurred, and events where there was the potential for serious harm, so that learning can be identified and acted on.

As part of each Significant Adverse Event Review, NHS Orkney considers whether any factors may have caused or contributed to the event and whether the Duty of Candour criteria apply.

Four Significant Adverse Event Reviews commissioned during this reporting period remain open. As these reviews are still in progress, it is not yet possible to confirm whether the Duty of Candour criteria apply. These reviews will be reported in next year's annual Duty of Candour report once they have concluded.

Two Significant Adverse Event Reviews were outstanding at the time of the last annual report. **One** has now been completed and did not meet the Duty of Candour criteria. The other review has been paused by an external agency and is outside NHS Orkney's control.

As there were no Duty of Candour adverse events during this reporting period, this report records that position. Any learning included in this report relates to Significant Adverse Event Reviews that were closed during the year. The remaining five open Significant Adverse Event Reviews will be reported in next year's annual report once they have concluded.

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 2025 and 31 March 2026, including the one outstanding from the 2024/25 report)*
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0

The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions were impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them from dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total events Duty of Candour was applied	**0**

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

As there were no adverse events where the organisational Duty of Candour criteria were met this year, this section describes how we supported the people involved in the two Significant Adverse Event Reviews that closed during the reporting period. One review related to the 2024/25 reporting period and one closed during 2025/26. In both reviews, NHS Orkney followed the expected steps to support openness, involvement and learning. This means:

- we informed the people affected, apologised to them and arranged meetings with them, and met them (where they wished to meet)
- we also took on board their views and listened to their concerns
- internally, staff reflected on the events, considered where systems did not work as intended, and identified what needed to change
- learning was shared through the monthly Clinical Quality Group and the quarterly Clinical Governance Group, as well as within the service. Learning is also included in quarterly Safety, Quality and Experience reports, which we continue to aim to share publicly in future to support openness and transparency.

In some cases, the patient or relevant person chose not to meet with us or did not wish to be involved in the review. We respect those choices and continue to offer involvement and support in a way that is led by the person affected.

8. What Has Changed / What Have We Learnt

For all Significant Adverse Event Reviews, whether or not Duty of Candour is suspected or confirmed, patients, families or relevant persons are offered an

apology, invited to be involved in the review, and given an explanation of what is known and what has been learned.

There were no adverse events during this reporting period where the organisational Duty of Candour criteria were met. However, NHS Orkney recognises the importance of being open and transparent, acknowledging when care or processes have not worked as intended, and ensuring that learning is identified and acted on. For this reason, we have included high-level learning from the Significant Adverse Event Reviews completed during the reporting period.

Due to the small number of reviews and the need to protect confidentiality, only limited detail can be shared in this public report. The learning below has therefore been summarised in a way that supports openness while reducing the risk of identifying the people involved. Although there appear to be only two actions, the first Significant Adverse Event Review was a multi-agency review across several sectors. For this reason, we have only included actions that relate to NHS Orkney.

- **Communication with staff at the start of a Significant Adverse Event Review:** One review identified learning about the initial communication with staff when informing them that a Significant Adverse Event Review had been commissioned. Clear, timely and sensitive communication is important so that staff understand the purpose of the review, how they may be involved, and what support is available to them.
  ACTION: Learning from this review has been used to strengthen how staff are informed when a Significant Adverse Event Review is commissioned, with an emphasis on clarity, openness, support and early explanation of the process.
- **Clear process for carrying out a procedure:** A second review found that there was no clear process for carrying out a specific procedure. The process had previously relied on a single point of knowledge, which created a risk of confusion and variation in practice across the service.
  ACTION: A clear process has now been developed and put in place to reduce risk and support consistent practice across the service. Learning has been shared with the service, and staff have worked together to make, implement and embed the process.

In line with national guidance, learning from these reviews is reported internally through NHS Orkney's governance routes. Learning summaries are also shared on the Adverse Events Community of Practice site, where this can support wider learning across NHS Scotland. Where other agencies have been involved, reports and recommendations are shared through the relevant governance processes to support cross-agency learning and follow-up.

NHS Orkney also shares action plans where this supports openness, transparency and accountability. This helps show how learning is being turned into improvement,

and how actions are monitored until they are completed and embedded. The annual Duty of Candour report is shared with NHS Orkney Board and the Board sub-committee with responsibility for clinical governance. This supports organisational learning and continued awareness of Duty of Candour responsibilities.

9. NHS Orkney Policies, Procedures and Guidance

During 2025/26, NHS Orkney reviewed its adverse event and Duty of Candour processes, as committed to in the previous annual report. This review included alignment with the revised Organisational Duty of Candour non-statutory guidance, which was published by the Scottish Government on 4 April 2025. The updated local guidance also aligns with the revised National Framework for Reviewing and Learning from Adverse Events in NHS Scotland and supports the use of Healthcare Improvement Scotland language, using “adverse event” rather than “incident”.

The review confirmed the need to maintain a clear process for identifying whether the organisational Duty of Candour criteria may apply, involving the relevant person, offering an apology, supporting staff and relevant persons, developing action plans and monitoring actions through established governance routes. Monitoring is led by the Safety, Quality and Risk Team and includes tracking Significant Adverse Event Reviews, reviewing whether Duty of Candour criteria have been met, checking that the required steps have been followed, and ensuring that learning and action plans are reported through the Clinical Quality Group and Clinical Governance Group until actions are completed and embedded.

We recognise that the 140-day timeframe for completing Significant Adverse Event Reviews has not been met for the majority of reviews this year. This is not where we want to be. The issue has been highlighted and escalated to ensure organisational awareness, scrutiny and support for improvement.

There have also been circumstances which have affected review progress. One review has been paused due to circumstances outside NHS Orkney’s control. Two outstanding reviews are expected to conclude shortly, but remain dependent on external expert opinion. Due to the size of NHS Orkney, there are occasions where we need support from other NHS Health Boards when specialist clinical expertise is not available within the Board. This support is valued, but is provided alongside colleagues’ existing clinical and organisational commitments, which can contribute to delay.

The remaining three open reviews are complex multi-agency reviews. Due to their nature, these reviews are more likely to extend beyond the 140-day timeframe, particularly where several agencies are involved, where information needs to be gathered from different organisations, or where actions and learning need to be considered across organisational boundaries.

Our focus for the coming year is to explore different ways of working to reduce review timeframes while maintaining the quality, fairness and learning value of reviews. This will include looking at the use of review teams, and working across agencies to increase resilience and provide support for complex reviews.

10. Conclusion

During 2025/26, NHS Orkney had no adverse events that met the organisational Duty of Candour criteria. This may change once the outstanding reviews are completed. Although there were no Duty of Candour events to report this year, we have continued to review Significant Adverse Event Reviews to support openness, transparency and learning. Due to the small number of reviews, detailed thematic analysis is limited. However, learning has been identified and acted on, including strengthening communication with staff when a review is commissioned and improving processes where variation in practice was identified.

This year we reviewed our adverse event and Duty of Candour processes, as committed to in the previous annual report. This included aligning local guidance with the revised Organisational Duty of Candour guidance and the revised National Framework for Reviewing and Learning from Adverse Events in NHS Scotland. The change from a policy to a guidance document, and the move to “adverse event” language, supports clearer alignment with national expectations and Healthcare Improvement Scotland terminology.

We continue to involve patients, families and relevant persons in reviews wherever they wish to be involved. This includes providing a named person for continuity, offering opportunities to ask questions or raise concerns, and sharing findings and learning once reviews are complete. We also recognise the impact that adverse events and reviews can have on staff. The introduction of Peer Supporters, continued access to wellbeing support, and the development of training for senior nurses, midwives and allied health professionals are important steps in strengthening support and capability across NHS Orkney.

We also recognise that the 140-day timeframe for completing Significant Adverse Event Reviews has not been met for the majority of reviews this year. This has been escalated to ensure organisational awareness and support for improvement. In the coming year, NHS Orkney will focus on reducing review timeframes while maintaining the quality, fairness and learning value of reviews. This will include exploring review teams, cross-agency working and continued engagement with Healthcare Improvement Scotland networks to share learning, increase resilience and strengthen how adverse events are reviewed across the system.

11. Other Information

As required by the legislation, we have notified Healthcare Improvement Scotland that this report has been published on our website 31 August 2026. We have also shared it with the Adverse Events Community of Practice and relevant stakeholders.

The organisational duty of candour lead in NHS Orkney is Dr Anna Lamont, Medical Director.

If you want to find out more about Duty of Candour within NHS Orkney please contact Kat Jenkin, Head of Patient Safety, Quality and Risk, via kat.jenkin@nhs.scot.