



# NHS Highland

## 1. Introduction

The requirements of the legislation relating to organisational Duty of Candour apply to all health and social care services in Scotland. Where unintended or unexpected events happen as a consequence of care or service issues that result in death or harm as defined in the Act, there is a requirement to ensure that the people affected understand what has happened, receive an apology, and are informed by the organisation of what has been learned and how improvements for the future will be made.

As part of the duty we are required to publish an annual report which describes how NHS Highland has implemented and operated the duty of candour procedures over the previous year.

## 2. About NHS Highland

NHS Highland serves a population of 323,620 people across 32,500 square kilometres in the north and west of Scotland (mid year population estimate for 2022, National Records of Scotland), making it one of the largest and most sparsely populated Health Boards in the UK. Our operational frontline services are provided through two distinct operational units – Highland Lead Agency and Argyll and Bute Health and Social Care Partnership.

Our aim is to provide high quality care for every person who uses our services, in hospitals, community, health and social care settings and in their own homes.

## 3. Requirements of the legislation

For duty of candour to apply, the patient/service user needs to have suffered a harm as defined below in Table 1 (not related to the natural course of someone's illness or underlying condition) AND for care or service issues to have contributed to this event i.e.

- A different plan and/or delivery of care may have resulted in a different outcome though uncertainty regarding impact on patient outcome/event.
- A different plan and/or delivery of care, on the balance of probability, would have been expected to result in a more favourable outcome, i.e. how the case was managed had a direct impact on the level of harm.

The requirements of the legislation can be found in the [The Duty of Candour Procedure \(Scotland\) Regulations 2018](#)

This includes detail of the requirement in relation to

- Communication with the relevant person and recording this information
- Notification

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- Offering an apology
- Meeting
- Review
- Sharing the findings from the review

### 4. Number and Nature of Duty of Candour incidents

In 2024-2025 42 cases met the criteria for declaring organisational Duty of Candour

**Table 1 shows the criteria for harm where Duty of Candour has been declared**

Nature of unexpected or unintended incident where Duty of Candour applies 1 <sup>st</sup> April 2024 – 31 <sup>st</sup> March 2025	Number
A person died	6
A person suffered permanent lessening of bodily, sensory, motor, physiological or intellectual functions	<5
<b>Harm which is not severe harm but results or could have resulted in:</b>	
An increase in the person's treatment	12
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	<5
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	<5
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.	5
<b>The person required treatment by a registered health professional in order to prevent:</b>	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0
Not recorded	16
<b>TOTAL</b>	<b>42</b>

The figures declared by operational area and over the last 5 years can be seen below in Tables 2 and 3

**Table 2**

Numbers by Operational Area	
Argyll and Bute	<5
HHSCP	7
Acute Services	30
Corporate	<5

**Table 3**

2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
22	53	36	29	30

Robust scrutiny of cases with a wide range of senior clinicians and managers in attendance has continued at weekly and monthly meetings in all operational units.

Some of the adverse events included in this report occurred prior to 1st April 2024 and were confirmed as duty of candour within 2024/2025. Adverse events which occurred within 2024/2025, where the investigation is ongoing and status of duty of candour has not yet been confirmed are not included in this years figures. These cases will be included in the 2025/2026 annual report.

### 5. To what extent did NHS Highland carry out the duty of candour procedure?

Of the 42 identified cases where Duty of Candour was confirmed, each one was reviewed to assess for compliance for the following elements recognising if it was not considered appropriate or where there was no response from the relevant person following attempts to contact them this would still count as compliance.

The relevant person was notified and informed of the adverse event
<p><b>Specifically in relation to duty of candour</b></p> <ul style="list-style-type: none"> <li>In 20 cases it has been recorded that the relevant person was contacted and informed of the adverse event – in 13 cases a date of initial contact has been recorded.</li> <li>This does not take into account any prior communication that may have occurred at the time of the incident by ward staff/clinical teams and recorded in the clinical records</li> <li>The recommended time frame of notifying the relevant person within 10 days of the procedure start day was not met in these 13 cases.</li> <li>Reasons why the procedure start date has been greater than one month since the incident date has not been recorded (procedure start date not recorded)</li> <li>In cases where the SAER process has been commissioned to review the incident, the recording of family contact is better than when other review methods are commissioned (SBAR, Case Assessment reviews)</li> </ul>
A named person for communication with the relevant person was identified and recorded
<ul style="list-style-type: none"> <li>In 22 cases a named contact has been recorded</li> </ul>
The preferred method of communication with the relevant person was established and recorded
<ul style="list-style-type: none"> <li>In 7 cases a preferred method of communication has been recorded</li> <li>In some cases where no preference has been recorded this may be attributable to no response being received from the relevant person</li> </ul>
A meeting was offered and the opportunity provided for the relevant person to ask questions
<ul style="list-style-type: none"> <li>In 10 cases a meeting was offered prior to the case being reviewed</li> <li>In 25 cases a meeting was offered but only on completion of the review</li> <li>In 7 cases a meeting was not offered or it is not known if a meeting was offered</li> </ul>
A review was undertaken
<ul style="list-style-type: none"> <li>A review was undertaken in all cases where Duty of Candour has been declared</li> </ul>
The review findings were shared
<ul style="list-style-type: none"> <li>Where a written apology has been provided this includes the findings of the review (see below)</li> </ul>
A written apology was provided
<ul style="list-style-type: none"> <li>In 36 cases a written apology has been provided to the relevant person</li> <li>In 1 case it is not recorded if a letter has been provided</li> </ul>

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<ul style="list-style-type: none"><li>• In the other 5 cases a letter was not sent as was deemed inappropriate for various reasons including cognitive capacity, length of time since incident, relevant person not engaging</li></ul>
Review completed within 3 months of the procedure start date
<ul style="list-style-type: none"><li>• In 3 cases the review was completed within 3 months from the date of the incident (procedure start date not recorded)</li></ul>

### Improvement since last year has been made in:

- Recording of the written apology sent to the relevant person

### Observations and areas identified for improvement

- A focus on identifying the procedure start date of the Duty of Candour process and following the process as laid out in the legislation with regard to notifying and offering to meet with the relevant person.
- The time frame of 12 weeks for completion of the process is not being met in the majority of cases. In some cases the length of time between the incident and a written apology has been in excess of a year.
- Often the written apology is the first organisational contact with the relevant person in relation to the process.
- A requirement to amend the recording system to more closely align with the statutory requirements of the act, ensuring all correspondence and contact with the relevant person is accurately recorded and ensuring a named person to communicate with and a preferred method of communication is also documented.
- The way in which the data is reported and extracted from the system needs to be amended.
- Changes to the current SBAR format to capture prior discussion with the relevant person at the time of the incident.
- Providing nationally available written information on the Duty of Candour process to the relevant person.
- Sign posting to relevant support services
- Consideration should be given as to current capacity vs requirements to support the Duty of Candour process – the current Quality and Patient safety resource has not materially changed since the introduction of the act. The legislation has inevitably placed a larger workload on involved teams.

## 6. Information on policies and procedures

Adverse events are identified through the incident reporting system (Datix) and also through complaints received by the Feedback Team. Through our adverse event management procedures we can identify incidents that may constitute duty of candour events and the adverse event policy has the requirements for duty of candour embedded within it. The policy and procedures were updated in line with the re issue of the National Adverse Events Framework in 2025. Complaints triaged as high level are considered for duty of candour and if activated this will be stated in the complaint response with the offer of a follow up meeting.

Each of the operational units have a weekly check-in meeting to identify cases which may trigger duty of candour and to establish what further investigation is required. The level of

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review depends on the severity of the event as well as the potential for learning. Monthly validation meetings also consider the output from investigations, ratify recommendations and confirm if Duty of Candour applies.

Staff have access to information on the intranet via our dedicated duty of candour page and training is available via the NES Education Scotland Duty of Candour e-learning module. For those staff frequently involved in the review process bespoke training can be provided by the CGST.

We recognise that adverse events can be distressing for patients, families and staff and that the SAER and DoC process undoubtedly present challenges to the workforce both from a psychological and capacity perspective. Our chaplaincy service are happy to help patients, families and staff if they need assistance in dealing with a distressing event. Additional support is available for all staff through our line management structure as well as through Occupational Health.

### **7. What has changed as a result?**

Introduction of structured simulation training in all theatres across NHS Highland to cover technical and non-technical skills including standardisation of language when escalating concerns.

Benchmarking in all theatres against NatSSIP standards.

Development of a Standardised protocol for vasectomy.

Development of a process for NHS Highland CMHTs to manage care of patients who DNA appointments.

All NHS Highland CMHTs to complete a psychosocial assessment for all referrals where there is an identified risk of suicide.

System of regular reviews of level of risk of suicide for patients on CMHT waiting lists.

Improvement to NHS Highlands paediatric sleep service to ensure there is a robust.

Development of guidance to support primary care colleagues to identify the most appropriate referral route for children with OSA.

Application of the use of alternative tools for assessment of pain in patients with cognitive impairment. i.e. Abbey Pain Chart or other.

A pilot of alternative methods to support the early identification of hip fractures, particularly where the patient is not able to communicate or has cognitive issues.

Development and augmentation of the out of hours patient flow service.

A review of completed DNA CPR documents in secondary care to gain a clear understanding of what is happening currently in terms of informing the family/patient a DNA CPR is in place and how this information is shared with primary care.

### **8. Additional Information**

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This is the 8th year of Duty of Candour being in operation and the organisation continues to learn and refine processes to ensure adherence to the requirements of the legislation. This year has identified challenges specifically the order in which the requirements of the act are delivered and also the accurate recording of relevant information and how this is extracted from our current system.

NHS Highland will continue to develop and refine our existing adverse event management processes and procedures to embed the principles of organisational duty of candour requirements in line with national guidance.

NHS Highland are moving to a new incident reporting system and this will allow a refresh of the recording of evidence.

Continued discussion and collaboration with senior management, medical and nursing leadership responsible for governance in the operational areas to improve our adherence to the requirement of the act.

Continued discussion and collaboration with other Duty of Candour Leads through the Adverse Event Networking Group to achieve greater consistency in application of the Duty between health boards.

Continued training and updates to those involved in the Duty of Candour process and recording of information.

This report will be cascaded via the Clinical Governance reporting structure for internal information.

As required, we have advised Scottish Ministers of this report and we have also placed it on our website.

If you would like more information about this report, please contact us using these details:  
[nhsh.highlandclinicalgovernance@nhs.scot](mailto:nhsh.highlandclinicalgovernance@nhs.scot)